Saint Clare's Hospital
MINISTRY HEALTH CARE
Sponsored by Sisters of the Sorrowful Mother

April 12, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore MD 21244-1850

To Whom It Concerns:

Subject: CMS-4105-P Comments

I am writing in opposition to CMS-4105-P. This proposed rule would add yet another layer of complexity in an already overly bureaucratic system with no tangible benefit for the patient or the provider.

I disagree with your assessment that the time involved would be 5 minutes per patient. Though the actual time in face-to-face contact may be 5 minutes, the system would require additional time to track, document, audit compliance, etc. I anticipate the total time spent in this activity would be closer to 20 minutes per patient for all involved activities.

This requirement would also negatively impact current support services staff (i.e., those charged with distribution of the notices). From a practical standpoint, the Business Office or Case Management departments would ultimately be responsible for fulfilling this requirement. Many smaller hospitals are not staffed 7 days a week in these functions. This requirement would force increased staffing, which will ultimately drive up the price of health care.

Given the current hospital environment of increasingly shorter lengths of stay, including one and two day lengths of stay, this requirement is not practical. It would often force physicians to make the discharge decision upon admission. Furthermore, with all involved with an acute care admission, this is one more step that is potentially stressful and confusing to Medicare recipients. Despite being helpful, this actually might be viewed as a negative intrusion.

Patients are familiar and comfortable with the process we currently have. In the rare instances of dispute, the Hospital-Issued Notice of Noncoverage process has worked quite well. We should not abandon a system that works for one that has many pitfalls with dubious benefits.

I strongly feel CMS-4105-P creates a system that can negatively affect consumers' perceptions, the physician/patient relationship, hospital staffing, and the resulting cost of health care. This proposal is a solution in search of a problem.

Please retain our current system for hospital discharges. It has met the needs of all in the past and will do so in the future.

Sincerely,

Mark Moser, LCSW.

Mark R. Moser, Manager
Care Coordination

/kb
Enclosures(2)

File Code: CMS-4105-P

2

Comments- CMS Re Medicare Program: Notification procedures for Hospital Discharges- 42 CFR Parts 405,412,422 and 489.

Background 11

Proposed two step notice process

The process remains administrative burdensome because of the logistics and additional resources needed to provide every patient a notice one day prior to discharge. The logistic and resource issues are as follows:

Hospitals typically discharge per day more Medicare patients than Home Health or a SNF. Due to the volume of discharges there will be an increase need for resources as the notice requires entry of beneficiary's name, date covered services would end and date financial liability would begin and then delivery to the patient to obtain a signature- in lieu of CMS desire to streamline, as rule states the notice is standardized. Delivering the notice has timing and problematic issues. They are as follows: patient not in room, patient incompetent and unable to reach legal guardian, doctor writes for same day discharge, patient leaves AMA. patient leaves prior to receiving notice, language barriers to mention a few.

Note that the patient is discharged when the doctor determines patient medically stable and writes discharge order. Is it necessary to expend resources on administering notices to Medicare patients who are satisfied with their care and discharge? There is a lot of variation making it significantly difficult to promote 100% compliance to administer the notice to all Medicare and Medicare Advantage patients.

The content of the notice does not seem much different than the HINN.

The difference is the HINN is focused on patients who are dissatisfied with discharge versus all Medicare patients. A HINN is given to a medically stable patient based on the physician discharge order. The patient is in need of skilled care and refuses discharge to home or a SNF. The patient has 48 hours upon receipt of the HINN to request an expedited appeal. My practice with the HINN is prior to administering the HINN; I review again the Message to Medicare letter with the patient. I encourage them to call the PRO with questions. I inform them if the physician determines them medically stable, he/she is dissatisfied and does not feel ready for discharge they will receive a HINN and have rights to appeal.

In conclusion, I recommend focusing on dissatisfied customers using the existing Medicare notices (i.e. Message to Medicare which is given to all Medicare patients and HINN which is given to patients dissatisfied with discharge), I recommend creating a standardized appeal process using the existing notices that afford the beneficiary a 2 step appeal process.

Respectfully Submitted:

Catherine H. Barkovich, Director Case Management
715 839 4344

William Newton Hospital

April 18,2006

RE: CMS-4105-P

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

Dear Sirs:

As a Certified Professional in Utilization Review working on the frontline in a small rural hospital, I feel compelled to comment on the above proposal.

You have proposed a process for a problem which does not exist and this process will leave a wake of confusion for the elderly and tax resources which are already overtaxed in the healthcare delivery field.

The delivery of a two-step discharge notification process will end up adding to the length of stay, thus increasing healthcare costs. It will further stretch the resources of all levels of the delivery system; physicians, nursing, discharge planning, utilization management. All this before the real nursing shortage and baby boom influx is fully appreciated.

The presumption that the first step would only take 5 minutes to deliver and the detailed notice would take about 60-90 minutes per notice exhibits a gross misunderstanding of the time consumption that the already existing notices take out of our days at this time.

Thank you for your consideration of the above comments.

Sincerely,

Linda Schumacher, CPUR

Linda Schumacher, CPUR
U.R. Coordinator
William Newton Hospital

PROVISIONS OF THE PROPOSED RULE
COMMENTS

This proposal was obviously drafted by individuals who have little or no concept of the administration of healthcare to Medicare recipients.

1. The level of comprehension in many/most Medicare recipients will not allow for understanding of the delivery of a notice of non coverage. Especially when there is no problem with their inpatient stay at the point you want the notice given. Medicare recipients, for the most part, only understand that this "wonderful" insurance that they have is supposed to pay for their hospital bill. They have no understanding of severity of illness and intensity of service criteria and that in itself is hard to explain when you issue a justified letter of non coverage. They feel bad, they can't take care of themselves, and many have no family available. Case Managers and Discharge Planners make a big difference in getting patients to the proper level of care in a timely manner. However, it will create more havoc if a patient is routinely given a letter of non-coverage on the day before. Why make it harder for the patient – you will simply confuse and frighten them!

2. This brings me to my next point. There is no way to deliver a non-coverage notice and just walk away. At that point someone has to explain to the patient that this is another useless piece of paper that will not effect them unless they decide not to be discharged as planned. Once again, you simply confuse and frighten them. When this happens, the hospital is made out to be the "bad guy" instead of the" powers that be" accepting this responsibility. Patients and families become frustrated and angry and the local hospital must take the time to try and explain – Can't be done in five minutes!!! And this does damage to the reputation of the hospital, its employees as well as physicians.

3. If you develop and give this letter of non-coverage to the patient the day prior to planned discharge and something happens, say you have upset them enough to cause chest pain, a hypertensive crisis, etc., and they can't be discharged, then you have to take more time and explain why they can now remain hospitalized and Medicare will continue to pay. That's more than five minutes and you will probably have to administer ANOTHER letter to reassure them that their coverage has been guaranteed. We might as well kill a few more trees. Not to mention the fact that it makes the hospital staff, the physician and anyone associated with this process look really stupid – not just inefficient, just plain stupid. And once again, who will get the blame? It sure won't be CMS.

4. Development of a tool to determine a patient's ability to understand such a notice is another bureaucratic waste of time. A simple mini mental exam tool already exists, but it certainly takes more that 5 minutes of someone's time to complete. A competent physician or case manager will already know whether a patient is able to understand this insanity or not.

5. Someone needs to get a real job in the real world of healthcare! Sitting in an office and determining how to waste more of a hospital's already limited funds by creating more work and confusion is not the way to streamline an already overtaxed system. You are simply wasting paper and manpower!

THIS PROPOSAL SHOULD BE SHREDDED BEFORE ANY MORE TIME AND PAPER ARE WASTED ON IT!!!!!

Submitted by: Linda McGrew RN, BSN, Case Manager
Athens-Limestone Hospital
700 West Market Street
Athens, Al. 35612

April 18, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
P.O Box 8010
Baltimore, MD 21244-1850

I am writing this letter in response to the proposal for notification procedures for hospital discharges. With an emphasis on appropriate length of stay for patients, the determination to discharge may be made in one or two days depending on test results and condition of patient. Requiring notification 24 hours prior to discharge will, in my opinion, increase length of stay and/or create public relations problems for the hospital or physician. Notification a day prior to discharge would also require a level of physician cooperation that does not exist in many hospitals. Why should the hospital be penalized if the physician does not cooperate by writing clear discharge plans in his progress notes?

Another factor is the time that is would take to issue these notices. I don't have the staff or the budget to implement the proposed notification process. Patients should be told when hospitalized, and Medicare should support in beneficiary information, that they will be in the hospital until their condition is stable and care needs can be met at another level of care. This decision point is sometimes difficult to predict. Requiring notification once this condition is reached will add another day to the LOS and increase wait times in ED, increase cost/case, and, more importantly, increase the Medicare beneficiary's exposure to infection, falls, and other untoward events that can be more harmful in the hospitalized elderly.

Carolyn Porter, RN, MSN
Director, Case Management

6

JANE PEARSON, M.D., P.A.
NEUROLOGY
520 ST. VINCENT'S PROFESSIONAL BUILDING I
2660 10TH AVENUE SOUTH
BIRMINGHAM, ALABAMA 35205
205-939-0196 FAX: 205-939-1083

April 17, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
P. O. Box 8010
Baltimore, M D. 21244-1850

Re: CMS-4105-P

The proposed changes for the notification procedures for hospital discharges will do nothing for patients and will add administrative burdens, which are costly. These rules are ridiculous and the supposition that it would only take five minutes per patient flies in the face of reality. If this rule is implemented, there should be a specific payment increase to all providers for delivering this information.

Sincerely,

Jane Pearson, M.D.
JP/ac

Hayes, Yolanda K. (CMS/OSORA)

From: Jones, Martique S. (CMS/OSORA)
Sent: Tuesday, April 25, 2006 2:59 PM
To: Hayes, Yolanda K. (CMS/OSORA); Johnson, Sharon B. (CMS/OSORA)
Subject: FW: Public Submission

See below, public comment on 4105-P.

Martique S. Jones
Director,
Division of Regulation Development-B
OSORA/RDG
Centers for Medicare & Medicaid Services
410-786-4674
Martique.Jones@cms.hhs.gov

>-----Original Message-----
>From: Whitcraft, Rosie [mailto:rosie.whitcraft@fda.hhs.gov]
>Sent: Tuesday, April 18, 2006 10:47 AM
>To: Jones, Martique S. (CMS/OSORA)
>Subject: FW: Public Submission
>
>
>
>-----Original Message-----
>From: no-reply@erulemaking.net [mailto:no-reply@erulemaking.net]
>Sent: Monday, April 17, 2006 3:39 PM
>To: OC AIMS Support
>Subject: Public Submission
>
>Please Do Not Reply This Email.
>
>Public Comments on Medicare Program; Notification Procedures
>for Hospital
>Discharges:========
>
>Title: Medicare Program; Notification Procedures for Hospital
>Discharges
>FR Document Number: 06-03264
>Legacy Document ID:
>RIN: 0938-AN85
>Publish Date: 04/05/2006 00:00:00
>Submitter Info:
>
>
>First Name: Janice
>Last Name: DeRoche
>Category: Health Care Industry - PI015
>Mailing Address: 741 Thayer Ave.
>City: Silver Spring
>Country: United States
>State or Province: MD
>Postal Code: 20910
>Organization Name: Holy Cross Hospital
>
>Comment Info: ================
>
>General Comment:Provisions of the Proposed Rules.
>
>The proposed Notification Procedure for Hospital Discharges
>does pose an
>undo

>burden on hospital staff and will result in longer lengths of stay.
>
>As a Director of Case Management in a large community hospital
>for 8 years I
>
>have a great deal of experience dealing with patients and
>families around
>discharge. Patients and families are notified of appeal
>rights at the time
>of
>admission. Patients do decide to appeal at times and appeals
>are processed
>efficiently.
>
>Part of our jobs is to manage people's expectations around
>healthcare. We
>must
>give patients and families the confidence they need to transition to a
>different
>level of care. We are able to do that by establishing trust,
>identifying
>their goals
>and matching resources to meet those goals. Adding the burden
>of a formal
>government notification is a step that can errode that trust. Some
>patients/families will also view it as an entitlement to stay in the
>hospital one more
>day.
>
>We also work diligently to discharge patients as soon as they
>are medically
>stable. Forcing 24 hr. notifciation on the organization would
>extend some
>stays
>simply becuase we cannot always be certain when someone is stable.
>
>Hospitals differ from rehab and homecare agencies in that
>patients have a
>much
>shorter LOS. Sometimes patients are admitted and discharged in
>about 24 hrs.
>
>with quick stabilization. The average LOS in my hospital is
>about 4 days.
>This
>does not allow a lot of time for 24 hr. notice. Most patients are
>discharged with
>followup: in nursing facilities, with homecare or in
>physicians' offices, to
>ensure
>good follow up in the least restrictive, least costly setting.
>This proposal
>creates
>an unnecessary barrier to timely discharges.
>
>As mentioned in the comments re: exceptional circumstances,
>where the notice
>
>could be given the same day for a one day stay it is mentioned
>that patients
>may
>receive virtually the same information twice (once in the
>important message
>from
>medicare and a second time with this proposed change). This is
>unnecessarily
>

>redundant.
>
>A recommendation: Require 24 hour notice of discharge for all
>admissions
>greater than 5 days.
>
>Since patients recieve the important message from Medicare notice at
>admission,
>they wouldn't be overly burdened with the same information
>again, unless
>they
>had a longer length of stay.
>
>My job is to carefully steward resources while ensuring
>appropriate care is
>given
>in an appropriate and safe environment. I firmly believe that
>this proposal
>will:
> 1. increase Lengths of stay
> 2. errode patient trust
> 3. increase healthcare costs
> 4. increase work loads (imagine the time it takes to explain the
>notification
>process).
>
>I do not believe the benefits outweigh the burdens.
>
>Sincerely,
>Jan DeRoche, RN, LCSW-C, ACM
>Director Case Management
>Holy Cross Hospital
>Silver Spring, MD 20910
>
>
>