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May 18, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-41050-P
P.O. Box 8010
Baltimore, MD 21244-1850

To Whom It May Concern:

The intent of this letter is to respond to the proposed New Discharge Notice Requirements (CMS-4105P). We wish to express our strong feelings regarding the negative impact this proposal will have financially on the Medicare program.

We feel that length of stay will increase, patients not requiring hospital care will stay needlessly, costs will increase and there will be an increase of staff time to administer.

Recently according to the Dartmouth Atlas Project, it was noted Medicare currently spends 75% of all resources on 12 chronic illnesses. The result of their study was increased stays or expenditures did not increase patient satisfaction or improve quality outcomes.

As discharge planners, we feel this would only increase patient anxiety. Due to the short length of stays, patients would need to receive this letter on the first or second day when they were acutely ill.

As discharge planners, we feel we are already working with patients and families in preparing for discharge, usually within the first 24 hours from date admitted.

This additional paperwork is an unnecessary formality which would take away from our time spent on direct patient care.

Please give this your serious consideration.

Rural Wisconsin Health Cooperative Social Work Roundtable Members

Nora Fisher, CSW
Kim Emerson, CSW
Maureen Kirk CISW
Judy Hamer CSW
Judy Juan CSW
Deanne Kath CSW
Elizabeth Julien MSW
Jan Carlson LCSW

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VHA

Memorial Medical Center

May 12, 2006

To Whom It May Concern:

We are writing in response to the request for comments on the proposed discharge notification process for Medicare and Medicare Advantage patients proposed by Centers for Medicare & Medicaid Services. As we understood the proposed process; it would require hospitals to provide a discharge notification letter to the Medicare and Medicare Advantage patients no later than one day before their planned discharge.

We believe the rules need to be further clarified to address the following:

~ If a patient is admitted for a one day stay, do they need a discharge letter? Clearly it cannot be provided in the timeframe prescribed in the proposed rules.

~ If a patient is issued the discharge letter and it is subsequently determined that the patient can go home that same day, do they have to stay until the next day in order for the letter to be provided in advance? This would drive up the cost of care.

~ What if the patient is ready to go home but no letter was given? Again delay in order to meet this notification will drive up the cost of care.

~ There are concerns that the patient/family will now be able to "negotiate" their length of stay in the hospital. Is this not taking the ability away from the physician's in making the discharge decision?

~ We foresee longer length of stays for the patients that do question and take issuance with the discharge letter. There are the costs of copying and mailing the charts, as well as, the cost of days in the hospital until the QIO makes a decision. What additional reimbursement will be provided and aligned incentives with physician community?

~ Once a discharge letter is given and the patient develops additional medical concerns that increases their length of stay is another discharge letter required to be given?

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~ It is concerning that CMS is underestimating the time it will take to provide, review and answer questions about the discharge notification letter with the patient/family.

~ There are concerns that should the hospital have waiting patients in the Emergency Department and Post-Acute Care Units, that discharges will be held up because the Medicare patient is required to receive the discharge notification letter the day before discharge. This will impede patient throughput and availability of appropriate beds for medical care.

Thank you for the opportunity to submit our comments for review.

Sincerely,

Kisha Hortman
Administrator, Patient Management Services
Memorial Medical Center
701 N. First Street
Springfield, IL 62781

The Health Network of
THE CHESTER COUNTY HOSPITAL
701 E. Marshall Street • West Chester, PA 19380 • www.cchosp.com

Richard M. Armstrong, Jr., Chairman
H. L. Perry Pepper, President
Mary Ellen Josephs, Secretary

Telephone: 610-431-5000

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attention: Melissa Musatto
CMS-4105-P
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-41-5-P

May 31, 2006

Dear Sir/Madame:

This letter is being written to express our concern in reference the proposed rule in "Medicare Program; Notification Procedures for Hospital Discharges," as published in the April 5, 2006 Federal Register. This rule as conceived will have many severe unintended consequences on the healthcare industry including issues related to patient throughput, length of stay, hospital capacity, Emergency Department crowding as well as Emergency Department diversions.

Two major components of concern are Operations and Finances.

Operational Issues:

- For the majority of patients receiving hospital care, it is difficult to predict with certainty whether patients will be cleared for discharge until the actual day of discharge. This is particularly true for complex medical and surgical patients admitted with co-morbidities and chronic disease whose care is also being managed by a whole host of other specialty physicians. Essentially, the majority of decisions regarding discharge are made in the evening before the day of discharge or sometime during the actual day of discharge making it almost impossible to comply with the proposed requirement of 24-hour notice.

- In order to comply with the provisions set forth in the proposed rule, hospitals would most frequently be giving the notice after the physician writes the discharge order. To comply with the 24-hour notice, would mean that patients would be staying an additional day in the hospital to comply with the rule even though discharge is appropriate and indicated.

- Additionally, discharges to tertiary care, psychiatric facilities and skilled care facilities would be hampered having a negative impact on patient care.

Financial Issues:

- As previously mentioned, the additional 24 hour would increase the hospital's length of stay. This in turn would negatively impact on our ability to keep our Emergency Department off divert. Throughput issues would increase resulting in lost beds for the community we serve.

- The timeframe mentioned to provide, explain and obtain the patient's signature on the required forms is grossly underestimated. It has been proposed that 5 minutes would suffice. In our estimation it will take at best 20-30 minutes to complete this task. Someone would have to explain the cumbersome

language as well as verbalize the intent of the notice. Further explanation will be needed to walk the patient through the appeal process. Seeking out family members and obtaining signatures for those patients who are unable to comprehend the notice will further complicate situations. As those of us that deal with daily operations in a hospital setting know, family members are not always readily available.

- This financial burden would also extend to the time allotted for the QIO expedited review as well as the cost associated with materials for both purchasing and storage of the required forms.

To summarize, this rule would negatively impact on the ability of acute facilities to discharge patients to the Appropriate level of care, increase the financial burden on hospitals which in turn would lead to increased Dissatisfaction of the healthcare consumer.

Recommendations

Convene a stakeholder group in concert with national hospital associations, key professional Groups, and consumer advocacy groups to develop a better perspective of the various constituency Group concerns and how best to address concerns about discharge planning.

Consider flexibility in your time requirements. The 24-hour requirement will be difficult if not impossible to operationalize. Also consider exempting those individuals going to an alternative level of care, i.e., tertiary care and psychiatric facilities.

Direct the Medicare Advantage plans to generate and deliver the notice of non-coverage to their customers since they will be making that decision. There should be a clear distinction between a decision by a Medicare Advantage plan to discontinue coverage for hospitalization versus a physician's decision to discharge a patient.

Institute a demonstration project to fully examine and discuss the ramifications of such an undertaking. Data would be collected and analyzed to better understand the process and it's implications on all involved.

Hopefully the concerns expressed above will result in some level of compromise that would better reflect the Reality of today's healthcare arena while keeping the patient as the focus of any and all interventions.

Sincerely,

Kathy Gillan, MSN, NHA, CCM
Director Case Management
The Chester County Hospital

SSM HEALTH · CARE℠

June 1, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Ladies and Gentlemen:

I am writing to express SSM Health Care's opposition to the proposed rule CMS-4105-P. While we applaud the intent of the rule to ensure fairness to patients, it will not achieve this shared goal. SSM Health Care operates 20 hospitals and two nursing homes in four states and employs over 23,000 people. The proposed rule would be detrimental to our patients, our staff and the quality of care provided at our community hospitals.

After extensive conversations within our system, the following points and questions summarize our difficulties with the proposed rule:

1. Unnecessarily burdens patients, family, physicians and acute facilities with added paper(s) and process(es) upon discharge

2. Proposed rule runs counter to push for advances in Health Information Technologies (HIT) and corresponding reductions in paper records

3. The average Medicare length of stay is less than 5 days, thus the notification will be due prior to a complete workup being completed

4. The patients covered in the rule are acutely ill, not stable like SNF and home health patients thus making discharge decisions a day-to-day decision

5. The process will increase length of stays as hospitals work to ensure the mandated 24 hours are met – thus increasing costs

6. The CMS estimated burden of five minutes per patient is grossly underestimated as this is a complex process about which the patients will have many questions; they will often also want their family to be there to help them understand and ask questions which will extend the required time even further

7. Will potentially place doubt in the patients' minds about whether the discharge order is being given by their physician or the hospital

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2002 Award Recipient

8. It is not clear if a patient can waive their right to 24 hour notice if it is not initially given

9. If notice is given on Monday and a clinical condition on Tuesday requires a patient to stay in the facility, will the hospital be required to provide another notice to reinstate hospital benefits for the remainder of the hospital stay?

10. If it is determined in the evening a discharge is appropriate for the following day, does the patient have to wait until the next evening or night to leave the hospital rather than leaving during the daylight hours?

11. The actual notice is likely to be administered by nursing staff – at a time when there is a near 10% shortage of nurses in the industry

12. If the patients have questions regarding the notice, are case managers or social workers expected to be on-call 24-hours a day to answer questions or will the patient have to wait until the following day thus extending their stay unnecessarily?

13. QIOs are not available for review of acute stays on weekends and holidays. How will these appeal requests be handled? Are hospitals required to keep the patient an additional two or three days until the chart can be reviewed by the QIO?

SSM sincerely appreciates the commitment of CMS to improving the nation's health care system and stands ready to assist in furthering both the quality and accessibility of care for all Americans. However, this proposed rule does not advance either.

Faithfully,

William C. Schoenhard

William C. Schoenhard, FACHE
Executive Vice President/COO

WCS:cr

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WakeMed

3000 New Bern Avenue
Raleigh, North Carolina 27610
919-350-8000

June 2, 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

Re: Medicare Program: Notification Procedures for Hospital Discharges, file code CMS-4105

Dear CMS,

The purpose of this letter is to comment on the Medicare program's proposed rule on Notification Procedures for Hospital Discharges. We work for WakeMed in Raleigh North Carolina. WakeMed is 752- bed private, not-for-profit health care system. We are extremely concerned about the impact this proposed rule will have on our acute care hospitals. Detailed comments are listed below:

Provisions of the Proposed Rule

1. Current CMS discharge planning regulations covered under the Utilization Review conditions of participation adequately cover the need for notifying a patient of his/her discharge status. There is a longstanding rule with the Social Security Act 1861 (ee) that a discharge planning evaluation must be completed and included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative). This requirement has been in place in the acute care setting for years.

2. Under the current discharge planning regulations there is no set time frame for identification of patients requiring a discharge planning evaluation other that it must be done as soon as possible. The timing is left up to the hospital, its staff, and attending MD/DO. We believe that imposing strict timing of any regulation will be problematic both for the patient/family and the hospital staff. Short stay patients (patient whose physician determines that the patient is ready for discharge that day) would not be able to meet the 24-hour notice requirement. We believe the timing of a discharge notice is dependent on what is appropriate for the individual patient and should be determined by the physician and health care team.

3. If this proposed rule is implemented, the number of appeals will increase significantly. This is especially true for patients who want to delay the discharge as long as possible or time the discharge so that it is as convenient as possible.

4. WakeMed is often close to or at full capacity. As a result of this proposed regulation we anticipate more appeals and discharge delays. Bed capacity for new patients will be compromised. Patients who would have been admitted to WakeMed may not receive the specialty care they require or may have to be admitted to another hospital. This is often not in the best interest of the patient as the other hospital maybe farther away from the patients home and family, may not have the best mix of services for the patient, may not accept the patients insurance (Out of Network) or the patients physician may not have admitting privileges.

5. We fear that the proposed regulation could potentially result in an adversarial relationship between the physician and the patient. Physicians will eventually begin dragging their feet on appropriate discharges where the family wants more time, to avoid the time and stress of the appeals process.

Regulatory Impact

6. Providing a standardized 24-hour notice poses on undo burden on the hospital, the physician, and the patient and family. Considering language barriers and limited English proficiency this proposed standardized notice would not be an easy task.

   CMS' estimate of the time requirements for the standardized largely generic notice of non-coverage is incomplete. There is no mention of the time it would take to complete the notice and then answer the questions from patients and/or their family. In addition, if the patient is not competent, a representative will need to be located and this could potentially result in significant delays.

   We estimate it would take 30 minutes per patient to prepare, deliver, and answer questions related to this notice. If the patient wishes to appeal, the process would take 2-3 hours to complete the letter, delver to patient and/or representative, copy the chart, etc.

   In addition, current requirements to provide each patient a list of post discharge providers, written discharge instructions, and a reconciled list of medications (all now regulated by CMS and JCAHO) make the discharge process extremely time consuming for staff and overwhelming for patients. Adding a notice of discharge is an unnecessary additional step that is not **value added.**

There is also no mention of the time it would take to train our staff on an initial as well as ongoing basis. Additionally there is no estimate of the cost to revise existing policies/procedures and develop work processes.

We estimate that our case management staff would have to hire 3 to 4 full time equivalents to meet the requirements of this rule as well as change our staffing mix to increase staffing on weekends and holidays.

We are concerned that resources necessary for preparing the patient and family for discharge will be diverted to prepare and deliver the 24-hour notice of discharge.

As a result of this proposed regulation, our hospitals can expect the following:

- Delays in discharges, increasing patient length of stay in an already capacity stressed system.
- Potential delays in access to care for patients requiring specialty and tertiary care services
- Increase in staffing costs

To summarize, the current system is working. This rule will divert resources from away from patient care. Medicare's conditions of participation adequately cover discharge notification. There is no need to revise the current system.

Please contact Sherri Branski at 919 350-6071 or Thomas Meehan at 719 564-0108.

Sincerely,

Sherri Branski

Sherri Branski RN, MSN, CMAC
Director, Clinical Resource Management

James Hartye MD
Physician Advisor, Clinical Resource Management

Rebecca Andrews
Vice President of Finance

ASANTE®
HEALTH SYSTEM

File Code - CMS – 4105-P
Medicare Program
Notification Procedures for Hospital Discharges

May 5, 2006

Proposed Rule Comment:

Once again, CMS is preparing to impose another unnecessary and burdensome requirement on hospitals, with their proposal to notify all Medicare beneficiaries in writing of impending discharge within 24 hours. To suggest that this process would only require 5 minutes per patient shows a complete lack of understanding of hospital operations. In addition, patients already receive the "Important Message from Medicare" on admission, which gives a detailed explanation of their right to appeal if they feel they are being asked to leave too soon. And it is inconceivable that preparation for the detailed termination notice would require 60 to 90 minutes. Is the QIO going to be available on weekends for case review?

CMS must understand that this action would require dedicated staff to follow up with each physician on a daily basis for an estimate of when he/she plans to discharge the patient. Since this function would likely fall to Case Management staff, just tracking alone would require additional FTE's, for the weekday and weekend. It isn't as though they are dealing with only a few physicians. There are hundreds of physicians on the medical staff that would require hounding on a daily basis. Actually, with complex cases where there is intense involvement by the hospital discharge planner, there is more predictability than on straightforward cases, where there is rapid response to treatment.

The suggestion that this hospital requirement would level the playing field, since Home Care Agencies and Skilled Nursing Facilities have similar notification requirements is completely absurd. Those agencies and facilities generally have a more predictable patient population and longer lengths of stay. When removing outliers, our Medicare inpatient length of stay is approximately 4 days. What about "inpatient only" procedures that only remain overnight or patients who meet InterQual acute criteria on admission but respond quickly to treatment? Why should they be given a 24-hour notice, when they meet InterQual discharge screen criteria? What happens when the anticipated discharge does not occur on that day? Does the patient get another 24 hour notice?

Instead of implementing a new and redundant process, it would seem prudent for CMS to pay attention to some other glaring Medicare problems, such as Observation Services, which cost hospitals an enormous amount to monitor for compliance. Fifty percent of the Utilization Management staff's time involves Observation tracking. Every time CMS issues a clarification of rules, the process gets worse, i.e., Condition Code 44. Before adding yet another barrier to efficient movement along the continuum of care, it would seem prudent to finally put this one to rest. That can be done by designating all admissions of 24 hours or less as Outpatient/Observation. Another murky area needing attention is self-administered drugs in the Outpatient/Observation setting. Part D didn't help Medicare beneficiaries in this instance.

It's incredible that CMS is proposing to add more red tape to already over-regulated/over-burdened hospitals. Physicians decide discharge, not hospital staff. As with Observation vs. Inpatient, the physician will have no financial incentive to comply. In addition to requiring additional staff to administer, this proposed rule will increase length of stay and inevitably lead to an increase in the cost of healthcare. Furthermore, it's preposterous to believe that hospitals would have the ability to comply with this requirement even a majority of the time.

Today's Medicare population is the most entitled and protected population in the nation. Please consider the ramifications of this proposal.

Very sincerely,

Cam Christensen

Cam Christensen, RN, BS, CPUR
Director of Resource Management

NSCLC
National Senior Citizens Law Center

Oakland Office: 1330 Broadway, Suite 525 Oakland CA 94612, Phone: (510) 663-1055 Fax: (510) 663-1051

May 30, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS - 4105 - P
Mail Stop C4-26-05,
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Medicare Program; Notification Procedures for Hospital Discharges
File Code CMS - 4105 - P71 Fed. Reg. 17052 (April 5, 2006)

Dear Sir or Madam:

The undersigned non-profit organizations work to obtain Medicare coverage for beneficiaries, and to enforce rights to related health care for low-income people, seniors, and persons with disabilities. We appreciate the opportunity to submit the following comments regarding the Centers for Medicare & Medicaid Services' (CMS) proposed rules concerning notification procedures for hospital discharges of Medicare patients.

I. BACKGROUND

We believe it is essential that Medicare beneficiaries receive adequate notice of the reasons for the planned termination of their hospital services and of the available procedures for appeal of the termination decision. This is especially true because hospitals and Medicare Advantage (MA) plans have financial incentives under the PPS and capitation reimbursement systems to discharge patients as soon as possible, which creates a risk of premature discharge in some cases.

The system for notice to Medicare beneficiaries adopted by CMS in the April 4, 2003 final rule on hospital discharges (68 Fed. Reg. 16652) did not provide adequate protections for patients. Furthermore, its deviation from the proposed regulation for terminations of care by hospitals and the existing regulation for terminations of hospital care by MAs ignored established administrative procedures. Contrary to CMS's assumption in adopting the April 4, 2003 rule, the Important Message From Medicare (IMM) given upon admission does not give Medicare patients fair notice of discharge rights for a number of reasons. It is likely to be overlooked, since it is included with a quantity of other paper work related to urgent matters concerning hospital admission and treatment. In addition, its timing is wrong, because information in the IMM is likely to be forgotten by the time discharge occurs.

Furthermore, the trigger for giving more detailed notices (The NODMAR and HINN) in the 2003 system, is that the patient "expresses dissatisfaction" with the discharge decision. This trigger is too vague and subjective, and its determination is left up to the hospital or MA that would not be likely to welcome an appeal of its discharge decision. Not surprisingly, therefore, few detailed discharge notices have been given under this system, even to patients who did know to complain about a planned discharge. The problem was further exacerbated by the fact that there has been little or no effective monitoring as to whether detailed notices were given to dissatisfied patients.

Both the Medicare statute and the Constitution require adequate notice and appeal rights before Medicare coverage of hospital benefits can be terminated. The April 4, 2003 rule did not comply with these requirements. The changes currently proposed in notice procedures are the result of a settlement agreement in a lawsuit challenging notice procedures adopted in the April 4, 2003 regulation. Weichardt v.Thompson, C.A. No. 03 5490 VRW (N.D.Cal. Settlement Agreement, October 28, 2005). If the proposed regulations effectuating the settlement are not adopted substantially in their current form, the legal challenge will most likely be reactivated.

II. PROVISIONS OF THE PROPOSED RULE

We agree that the two-step notice process described in the proposed rules is a significant improvement over the process adopted in the April 4, 2003 final rule.

a. Initial, standardized notice

The proposed initial notice will be given at an effective time, when discharge is fairly imminent, so that the information contained in it should be far more meaningful to patients than references to discharge given in the IMM. Again, the precise timing of this notice is very important: beneficiaries must be given sufficient advance notice so that they and their families can analyze their options and take the necessary steps to initiate an appeal before it is too late. The weakened condition of elderly or disabled Medicare hospital patients makes it difficult for them to make quick decisions, and their families are often only available to assist at limited times. For these reasons, we strongly oppose the suggestion in the proposed regulation that it might be sufficient to give the standardized notice on the day of discharge. We would prefer that patients be given the notice 2 days before the planned discharge, as is the case for SNF, HHA and CORF patients, rather than 1 day as specified in the proposed regulation. If 1 day advance notice is retained, 42 C.F.R. 405.1205(b)(1) should specify that it must be given no later than noon on the day before the proposed discharge.

From the standpoint of the patient's decision-making needs, there would appear to be no maximum time before discharge in which the standardized notice should be given, but it seems unlikely that accurate decisions about medical necessity of continued inpatient care could be made more than 2 days in advance of discharge.

Of great importance is the exact language of the initial standardized notice, since it must contain sufficient information to enable the patient to understand her various options, together with the consequences of each option. The language of the proposed standardized notice is set

out at 71 Fed. Reg. 17104 (April 5, 2006). This notice language is clear and well designed to accomplish the goal, but if it were to be changed so that the content were less clear, the entire hospital notice and expedited appeal process would be insufficient. For this reason it is key to our support of the proposed regulations that the content of the proposed standardized notice not be altered.

b. Detailed notice to beneficiary

Similarly, the second, detailed notice that is to be given to beneficiaries who wish to appeal must contain specific facts upon which the discharge decision is based. Proposed Section 405.1206(e)(1) describes the content of the detailed notice. This level of detail is needed to enable the beneficiary to understand why she is being discharged, and to enable her to gather and submit evidence contradicting these alleged facts should she decide to request an appeal. It is also likely that in some cases the process of attempting to prepare this specific notice will make the hospital or MA aware that discharge is in fact not medically appropriate, and spark voluntary withdrawal of the discharge decision. For these reasons, it is essential that the current requirements for the detailed notice not be diluted.

The proposed regulations do not give the provider much time for preparation of this specific notice, but it must be sufficiently detailed or it will not accomplish its protective purpose. If the specific notice is delivered to the beneficiary belatedly, she should be given additional time in which to submit her position about the discharge to the QIO.

It is important that the QIO reviewing agency is instructed to monitor the adequacy of the notice given (42 C.F.R. § 405.1206(d)(2)), so that beneficiaries will not be discharged when the reasons are insufficiently clear. The reviewing agency must also insure that if the specific notice is not delivered timely to the beneficiary, she will have additional time before discharge or imposition of payment in which to prepare a response. We urge inclusion of penalties for providers who do not comply with these requirements in order to increase compliance. The prohibition on hospital charges for continuing services when notice has not been given (42 C.F.R. 412.42(c)(3)), does not provide an effective incentive for compliance, because patients do not know of their right to receive ongoing care when this notice has not been given.

III. COLLECTION OF INFORMATION REQUIREMENTS

Hospitals and Medicare Advantage plans will certainly object to the effort required to deliver the standardized notices and to prepare and deliver the detailed notices to patients. These objections may stem not only from the wish to avoid preparation and delivery tasks, but also from the wish to avoid expedited review of their decisions to discharge patients.

In evaluating hospital/MA objections to the proposed notification procedures, it is important to bear in mind that adequate protections against premature discharge are even more needed in the hospital setting than they are in the SNF, HHA, CORF and hospice settings because of the critical level of hospital services. One of the advantages of the two-step notice process proposed here is its similarity to the expedited appeal process used for discharges in those less intensive care settings. Acute care providers are at least as capable of complying with

these requirements as SNF, HHA, CORF, and hospice providers. Adoption of the proposed uniform system for Medicare terminations and appeals in all care delivery settings will make it easier for beneficiaries, their relatives, and the public to understand and utilize the expedited appeal process.

Thank you for your consideration of these comments.

Sincerely yours,

Joanne Finberg
Directing Attorney
National Senior Citizens Law Center

On Behalf of:

Arizona Center for Disability Law
California Health Advocates
Center for Health Care Rights, Los Angeles, CA
Families USA
Legal Assistance for the Elderly, San Francisco, CA
National Health Law Program
Medicare Advocacy Program of Greater Boston Legal Services on behalf of its eligible clients
Medicare Rights Center
Protection and Advocacy, Inc. of California
Senior Citizens Law Office, Albuquerque, NM
Vermont Legal Aid
William Morris Institute for Justice, Phoenix, AZ

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LEE PHYSICIAN GROUP

THE CHILDREN'S HOSPITAL

THE REHABILITATION HOSPITAL

May 19, 2006

Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Attention: CMS-4105-P
PO Box 8010
Baltimore, Md. 21244-1850

To Whom It May Concern:

I am in receipt of and appreciate the opportunity to comment concerning CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. Your proposal has significant implications for the Lee Memorial Health System that are detailed in a 2-page attachment.

Your consideration of these remarks is appreciated.

Sincerely,

Mark Greenberg MD
Corporate Medical Director

Background

While I can appreciate the rationale behind the proposed Medicare Hospital Discharge Requirements, the position of the Lee Memorial Health System is that these provisions, as you determined in 2003, aren't necessary in every case and will still pose a significant administrative burden to hospitals.

Provisions of the Proposed Rule

Of particular concern to this organization:

- In terms of volume, based on FY 2005 average Medicare inpatient discharges/day (excluding deaths), our System would be required to distribute 54 letters daily
- Your proposed requirement is more than a clerical function. Clinical input will be necessary to ensure that both Discharge & any subsequent HINN notices are accurate and timely
    - HINNs will provide more individualized detail (facts specific to the beneficiary, coverage and /or policy citations) than is currently required
        - Staffing and resource allocation will need to be addressed in order to provide 7 days/week clinical & clerical support
- Should the beneficiary request an expedited appeal, there is potential for extended length of stay while hospitals wait for the QIO to make a determination, unless CMS ensures they too are operational 7 days/week
- Your 2 step process is actually 3 steps since hospitals are still required to provide the "Important Message" at the time of admission
- Certainly hospitals are cognizant of the need, when patients lack capacity to make healthcare decisions, to communicate with someone willing to act on their behalf
    - Proposal will insert additional steps into our process i.e. duplicate documentation & retention (Hospital Interdisciplinary Notes, our current process, and the Notice of Discharge)
- Refusal to sign also entails additional record keeping as well as document retention
- Although our Healthcare System is not contracted with any of the Medicare HMO Plans, there is great potential for Plans to shift responsibility to hospital providers
    - At a minimum, the communication/coordination between Medicare HMOs & hospital providers will increase
    - When HMO decisions are appealed, will hospitals be expected to assume the additional burden of copying & submitting charts (to accompany the MA case file) to meet QIO review timeframes for both in-state & out-of-state HMO Plans?
    - Hospitals that contract with HMOs could see their agreements amended to delegate this responsibility in its entirety to the provider
- Hospitals have created efficiencies to reduce average LOS.
    - The "day prior to discharge" notice requirement is especially burdensome for shorter length of stay patients
    - Care is individualized, as are physicians' discharge decisions. Although clinical staff anticipate the discharge date, it's not an exact science. Are hospitals expected to update notices as discharge plans change to ensure the "day before discharge" parameter is met?

You indicate the "Important Message from Medicare" provides much of the same information about appeal rights. Why the redundancy? From a quality improvement perspective have you identified a problem significant enough that it requires an across-the-board solution rather than corrective action with individual aberrant hospitals?

Given the factors listed above, I respectively request that you reconsider and reject this proposed change as unnecessary, and rely on hospitals to adhere to your current requirements i.e. "Important Message" to every admission and HINNs to address coverage and medical necessity only when necessary.

FLORIDA HOSPITAL ASSOCIATION
An Association of Hospitals & Health Systems

May 31, 2006

Mark B. McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Attention: CMS-4105-P

Dear Dr. McClellan:

The Florida Hospital Association, on behalf of its member hospitals and health systems, appreciates the opportunity to comment on the proposed notification procedures for hospital discharges contained in the April 5 *Federal Register*. While we recognize the intent to establish a process for hospitals that is similar to that of home health agencies and skilled nursing facilities, and that it is important for beneficiaries to know their rights as hospital patients, the proposed rule creates a process that is unnecessarily burdensome, is out of sync with standard discharge planning and physician discharge order patterns, works at cross purposes with the movement to electronic medical records, and appears to confuse the issue of beneficiary financial liability and the process for deciding when a patient no longer needs hospital-level inpatient care and needs to go home or transfer to another level of care.

The preamble to the proposed rule references hospital compliance with a "two-step notice process," yet CMS actually proposes a three-step process on hospitals. It must be remembered that hospitals already have a two-step process that begins with the delivery of the Important Message from Medicare (IMM) at admission. This is followed by the provision of a detailed notice when there is a question about the appropriateness of a planned discharge.

For an average Medicare length-of-stay of six days, a three-step process in unreasonable. The IMM was expressly required by Congress to ensure that Medicare beneficiaries would know their discharge rights. The requirement was issued in response to concerns of "quicker and sicker" discharges with the implementation of the inpatient prospective payment system. Without Congressional action to eliminate the IMM, the procedures proposed by CMS result in a three-step process for hospitals.

In addition, it could be argued that by requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS often would be requiring an extra day of inpatient care after the patient is ready for discharge. Except for a small percentage of uncomplicated patients who are undergoing a procedure with a fairly predictable postoperative course, it will be difficult – if not impossible – to deliver an advance written notice the day before the "planned" discharge. It is the physician, and not the hospital, who makes the discharge decision. This is most often made during rounds when the physician confirms that the

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patient's physical status no longer requires hospital level inpatient care and this is usually the evening before the day of discharge or the morning of discharge. When a physician determines that a patient is clinically stable and safe for discharge, the right thing to do is to discharge the patient in a timely manner, and not wait for a defined 24-hour notice period before discharge. It is unclear under the proposed rule as to the needed actions when, after delivery of the discharge notice, the patient's condition deteriorates and makes discharge inappropriate. Would an elevated temperature or other complication ultimately require that a second discharge notice be issued? How are expected one or two-day admissions to be handled – do we provide the discharge notice at the time of admission?

The proposed rule requires that the beneficiary or their representative sign a copy of the 24-hour discharge notice, documenting both receipt and understanding. Requiring that the notice be signed is at cross purposes with the move to electronic medical records – particularly with the requirement that the form be retained in a hard copy format.

The burden estimate included in the proposed rule is five minutes per patient to prepare and deliver the notice. This estimate does not allow for the staff time to explain the contents or to wait while the patient or their representative reads the notice – both actions that are necessary before you could expect the beneficiary to sign that they understand the notice.

The draft language contained in the notice appears to be designed to create doubt that a planned discharge is appropriate. Questions about the appropriateness of a discharge order generated solely by the language in the notice could result in increased appeals by the beneficiaries and an increased workload for hospitals and QIOs.

The purpose of providing notice at discharge needs to be clarified. If it is to notify the beneficiary of his or her appeal rights, that has already occurred at admission through the IMM. If the purpose is to ensure that beneficiaries have advance notice of their expected discharge so that they and their families can be ready, that is accomplished through the required discharge planning process that begins at, or shortly after, admission. If the purpose is to notify beneficiaries that they could become financially liable if they stay beyond the point that they need acute inpatient stay, then the notice should be reserved for the limited occasions when the hospital needs to establish that liability – and provided through revision of the current notice (Hospital Advanced Beneficiary Notice of Non-Coverage) rather than with another step in the process.

Finally, the proposed rule addresses the requirements for discharge notice to Medicare Advantage enrollees. The communication of information regarding discharge and non-coverage of continued stays should be the responsibility of the Medicare Advantage plan. The plans should prepare both the Generic Notice, if required, and the Detailed Explanation, when necessary, and to deliver such notices to their enrollees.

Again, while we believe that CMS has a legitimate interest in ensuring that Medicare patients are notified of their rights related to an expedited determination when they disagree with a planned hospital discharge, the rule as proposed is untenable as it creates both operational problems for hospitals and potential increased lengths of stay that will negatively impact

available beds and access to patient care. In addition, it does not appear that CMS has carefully or adequately considered the financial implications of its proposed process. We urge CMS to retain the current two-step process and, if more explicit information about a patient's appeal rights is needed, to revise the Important Message appropriately.

Should you have any questions on these comments, please do not hesitate to contact me at (407) 841-6230 or via email at kathyr@fha.org.

Sincerely,

Kathy Reep
Vice President/Financial Services

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NALTH NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
150 York Street, Stoughton, Massachusetts 02072 (781) 344-0600 Boston line (617) 364-4850 FAX (781) 344-0128

May 26, 2006

By Overnight Mail

Mark McClellan, M.D., Ph.D.
Department of Health and Human Services
Attention: CMS-4105-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Rule Medicare Program;
Notification Procedures for Hospital Discharges –
File Code CMS 4105-P

Dear Dr. McClellan:

These comments are submitted on behalf of the National Association of Long Term Hospitals (NALTH) on proposed rules published on April 5, 2006 at 71 Fed. Reg. 17052. NALTH's membership serves approximately one-third of the Medicare beneficiaries who are admitted to long-term care hospitals (LTCHs) in the United States. The membership of NALTH is diverse and includes both not for profit and for profit institutions, LTCHs with Medicare approved teaching programs, LTCHs located in urban as well as underserved rural areas, LTCHs which are owned and operated by large integrated health care systems throughout the United States, and publicly owned LTCHs.

NALTH strongly objects to the proposed rules' new requirements for hospital discharge notices. The proposed rules assume that administrative processes pertaining to provider initiated notices of beneficiary appeal rights which are applicable to skilled nursing facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), and hospices may appropriately and efficiently be grafted onto the hospital discharge planning process. If the proposed rules are adopted they will subject Medicare beneficiaries to unnecessary confusion.

Additionally, adoption of the proposed rules will predictably result in unnecessary administrative burdens placed on hospitals with significant delays in patient discharges. NALTH recommends that the current rules governing hospital discharge notices remain in place with no changes because the addition of a two-step notice process will prevent timely and smooth discharges and will not be efficient or cost effective. Instituting the proposed two-step notice process is not in the best interest of Medicare beneficiaries who will merely be confused by receiving a standardized, generic notice of non-coverage and discharge when they are in agreement with an impending hospital discharge.

Scope of Proposed Rule

The proposed rule defines a "discharge" as follows:

> (2) For purposes of §405.1204, §405.1205, §405.1206, and §405.1208, a discharge from the inpatient hospital level of care is a formal release of a beneficiary from the inpatient hospital level of care or, a complete cessation of coverage within the inpatient hospital level of care."

Proposed 42 C.F.R. §405.1205(a)(2). NALTH requests CMS to clarify that a "discharge" does not include a beneficiary who exhausts Medicare Part A benefits. The exhaustion of Part A benefit days is the "cessation of coverage" and is considered a "discharge" under Medicare program billing standards. See 42 C.F.R. §412.503(2). NALTH recommends that the proposed definition be revised to include such a clarification.

Provisions of the Proposed Rules – Proposed Two-Step Notice Process

The statute governing a hospital's discharge planning process requires the Secretary to "develop guidelines and standards for the discharge process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care." See Section 1861(ee)(2) of the Social Security Act. The proposed rules will lead to unnecessary delays in discharge and a difficult transition process.

A Two-Step Notice Process is Not Appropriate for a Hospital

The proposed rules are modeled after notice of non-coverage notices applicable to non-hospital post acute care facilities. There are, however, important distinctions in discharge planning for hospitals as compared to post acute care settings such as HHAs, SNFs, CORFs and hospices. For example, under federal regulations promulgated under the Omnibus Budget and Reconciliation Act of 1986 (OBRA), SNFs are required to provide at least thirty (30) days written notice of discharge, subject to exceptions. 42 C.F.R. §483.12(a)(5). That time frame does not apply to long-term care hospitals where, due to the medically complex nature of the patients' conditions, it is not feasible to plan as far in advance of discharge.

It is easier for a HHA, SNF, hospice and CORF, which generally have focused areas of care, to predict when it will be safe and medically appropriate to discharge a patient than for a LTCH to make such a determination. It is more difficult for a physician to predict the discharge of a LTCH patient who suffers from complex medical conditions and whose stability may fluctuate dramatically from day to day. A hospital discharge plan providing for discharge on the following day often changes if there is a change in the condition of the patient overnight or the next morning. Often, a physician at a LTCH is not able to make a final determination as to whether it is medically appropriate and safe to discharge a patient until the anticipated day of discharge. Therefore, at the very least, in the event the proposed rule is adopted (which NALTH strongly opposes), hospitals should be able to deliver the standardized, generic notice on the day of discharge. Any other result will lead to multiple discharge plans and confusion and anxiety for beneficiaries whose conditions change overnight.

The proposed rule will create undue emotional distress and confusion for beneficiaries. Providing a generic, standardized written notice of discharge, when the hospital, attending physician and beneficiary are in agreement, will lead to confusion. The notice will cause a beneficiary who was in agreement with the discharge (including the location) to question whether to file an appeal. It also serves no legitimate purpose to require a hospital to issue a standardized, generic notice of non-coverage and discharge to a patient when the information contained in the standardized, generic notice (with the exception of the patient's name, the date on which covered services would end, and the date the patient's financial liability would begin) is virtually identical to the information which has already been provided to the patient in the "Important Message from Medicare". It is noteworthy that the "Important Message from Medicare" regarding hospital discharge and Medicare appeal rights is not provided by HHAs, SNFs, CORFs, and hospices. The standardized, generic notice would merely be duplicative and confusing to the hospital patient. NALTH recommends that instead of adopting the proposed two-step notice process, CMS incorporate the patient specific information (i.e., patient's name, date covered services would end, and date patient's financial liability would begin) in the "Important Message from Medicare."

Furthermore, there are currently thirteen (13) versions of nine (9) hospital notices of non-coverage that may be issued to a beneficiary, prior to and during his/her hospitalization, depending on the circumstances (for example, notice of non-coverage on preadmission review, notice of non-coverage on same day as admission, etc.). In contrast, there are only three (3) CORF notice forms, five (5) HHA notice forms, three (3) hospice notice forms, and four (4) SNF notice forms. See CMS Manual System, Pub. 100-004 Medicare Claims Processing, Transmittal 594, June 24, 2005, Change Request 3903. See and compare pages 52-53 and pages 8-9 which are attached. There is no need to add to the list of hospital issued notices.

The proposed rule will also lead to significant delays in discharge. Such delays are not in the best interest of quality care and patient safety. For example, a patient who remains in a hospital longer than is medically necessary would be at risk of contracting an infection. The current process facilitates a timely and smooth transition because a

hospital is required to issue a notice of non-coverage only if a patient objects to a discharge which is infrequently the case.

The Two-Step Notice Process Creates an Incentive for Hospitals to Prematurely Issue a Standard, Generic Notice of Non-Coverage and Discharge

The proposed rule creates an incentive for hospitals to issue a standardized, generic notice of non-coverage and discharge early in a patient's stay to avoid delays in discharge. Under the best case scenario outlined below, a hospital discharge would be delayed at least 2 ½ days if a beneficiary requests an expedited determination.

Best Case Scenario

Monday	Hospital issues a generic, standardized notice of non-coverage and discharge
Tuesday noon	Beneficiary requests expedited review QIO notifies hospital
Close of Business Tuesday	QIO reviews whether hospital issued generic notice is valid Hospital provides QIO with copies of all pertinent medical records Hospital provides beneficiary with detailed notice of non-coverage and discharge
Wednesday	QIO reviews all pertinent medical records QIO confers with beneficiary/beneficiary's representative QIO discusses case with hospital[1]
Close of Business Wednesday	QIO issues a written determination
Thursday noon	If QIO agrees with hospital, patient is discharged

If a standardized, generic notice of non-coverage is issued on a Friday, and a beneficiary requests an expedited review by the following Monday at noon, the discharge would be delayed at least 4 ½ days. NALTH believes that these time frames for completing an expedited review are unrealistic. As a practical matter, it is unlikely that the hospital

[1] It would seem to be more beneficial for the QIO to confer with the beneficiary/beneficiary's representative and to confer with the hospital after reviewing the medical records which would mean that the QIO would not be required to render a determination until close of business Thursday in the above example.

would be able to provide the QIO with copies of all pertinent medical records and the beneficiary with a detailed notice of non-coverage and discharge on the same day that the beneficiary requests an expedited review, and it is also unlikely that the QIO would be able to review all pertinent medical records, confer with the beneficiary or his/her representative, discuss with the hospital why the hospital believes the discharge is appropriate, and issue a written determination in only 1 ½ days. Also, some NALTH member hospitals do not have case manager/social workers involved in discharge planning available on the weekends so many weekend discharges would be delayed even longer.

The Waiver of Liability Provision Also Should Apply to the Hospital

The discussion in the preamble to the proposed rule on waiver of liability states that any beneficiary who requests an expedited determination by a QIO will not be financially liable for services (except for co-insurance and deductibles) provided before noon of the day after the QIO issues a determination, citing 1869(c)(3)(C)(iii)(III) of the Social Security Act. Section 1869(c)(3)(C)(iii)(III) incorporates by reference to Section 1154(e)(4), the waiver of liability statute contained in Section 1879(a)(2). Section 1879(a)(2) excepts not only an individual but also a provider from additional financial liability if the provider "did not know, and could not reasonably have been expected to know, that payment would not be made..." Therefore, the proposed waiver of liability provision also should be applied to the hospital. NALTH recommends that 42 C.F.R. §405.1206(f)(2) of the proposed rule be amended to provide that in the event a beneficiary requests an expedited determination by a QIO, the hospital will not be financially responsible for services provided before noon of the day after the QIO issues a determination and that the hospital will be paid by the Medicare program during that time period including any outlier payments that may result therefrom.

The Proposed Sanctions are Unduly Harsh

Under the proposed rule, a hospital would be required to deliver the standardized generic notice and, in the event a beneficiary requests a QIO review, the detailed notice as a condition of its Medicare provider agreement. Failure to do so would be a ground for terminating the Medicare provider agreement. It also would prohibit the hospital from charging a beneficiary for continued hospital services. Given the administrative burdens imposed by the proposed rule, these sanctions are unduly harsh. NALTH recommends that they be withdrawn.

Recommendations

In the event the proposed sanctions are adopted, NALTH urges CMS to provide a six month grace period to allow adequate time for LTCHs to revise their current discharge procedures and put administrative mechanisms in place to implement the rule.

Regulatory Impact

The regulatory impact statement does not assess increased Medicare program expenditures and costs which would result from the proposed rule. By delaying patient discharges the proposed rule will inevitably result in increased outlier expenditures by extending the stay of patients on cost outlier status and creating new cases which would become cost outliers due to an extended stay.

CMS underestimates the time that will be expended by hospitals in order to comply with the proposed rule. CMS fails to include the additional time that will be required to counsel patients and their families if the proposed rule is adopted. CMS also fails to consider the additional time that will be expended by QIOs in conducting reviews as a result of the proposed rule. CMS also underestimates the additional costs the proposed rule will place on hospitals. CMS only accounts for a $2.50 cost per standardized, generic notice of non-coverage and discharge and a $45.00 cost per detailed notice, for an estimated total cost per provider of approximately $7,000.00. However, CMS has not considered the additional cost and time associated with copying medical records which are usually voluminous in a long-term hospital stay. CMS has failed to consider the additional costs for counseling patients and their families. In addition, CMS also has failed to consider the additional costs for QIO review.

For the foregoing reasons, NALTH urges CMS to withdraw the proposed rules. NALTH thanks you for your consideration of these comments.

Sincerely,

Edward D. Kalman
General Counsel

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 594

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JUNE 24, 2005

Change Request 3903

Transmittal 577, CR 3903, dated June 3, 2005 is rescinded and replaced with Transmittal 594. In chapter 3, Exhibit 1-Hospital Issued Notices of Noncoverage-Ten Letters, was erroneously omitted from the transmittal page. The deletion of this exhibit is now being corrected via this transmittal. All other information remains the same.

SUBJECT: Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare

I. SUMMARY OF CHANGES: This expedited review process, modeled on an existing Medicare managed care process, is effective under regulations July 1, 2005. It allows beneficiaries in specific care settings, home health, hospice, Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facility (SNF) and swing bed, the right to appeal a pending discharge from a period of covered care to a Quality Improvement Organization (QIO). This process is similar to the QIO review of inpatient hospital discharges that has existed for some time.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : July 1, 2005
IMPLEMENTATION DATE : July 1, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/130 - Coordination With the Quality Improvement

	Organization (QIO)
D	3/130.1 - Limitation on Liability Provision
D	3/130.2 - General Responsibilities of Hospitals, Quality Improvement Organizations (QIOs), and FIs
D	3/130.3 - Placeholder for Instructions for FI/QIO Coordination - (Now in Discussion Within CMS)
D	3/130.4 - QIO Monitoring of Hospital Notices for Denial of Continued Stay of Inpatient Care Under PPS
D	3/130.5 - Issuance of Hospital Notices of Noncoverage
D	3/130.5.1 - Content of HINNs
D	3/130.5.2 - QIO Monitoring of HINNs
D	3/130.5.3 - Notices in Investigational/Experimental Procedures Situations
D	3/130.6 - Beneficiary Liability
D	3/130.7 - Provider Liability
D	3/130.8 - Right to a Reconsideration
D	3/130.9 - Model Hospital Issued Letters
D	3/Exhibit 1 - Hospital Issued Notices of Noncoverage-Ten Letters
R	30/20 - Limitation on Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed
R	30/80 - Hospital-Issued Notices of Noncoverage (HINN)
D	30/80.1 - When and to Whom a Hospital ABN Should be Given
D	30/80.1.1 - Admission or Pre-Admission Hospital ABNs
D	30/80.1.2 - Continued Stay Hospitals ABNs
D	30/80.1.2.1 - Attending Physician Concurs
D	30/80.1.2.2 - Attending Physician Does Not Concur
D	30/80.1.2.3 - Advance Continued Stay Hospital ABN
D	30/80.1.3 - Combined Notices in Swing Bed Situations
D	30/80.1.4 - Combined Stay Hospital ABN in Swing Beds Treated as SNF Beds
D	30/80.1.5 - Delivery of Hospital ABN
D	30/80.1.6 - Qualified Recipients of Hospital ABNs
D	30/80.2 - Issuing the Appropriate Hospital ABN
D	30/80.3 - Hospital ABNs (HINNs)
D	30/80.3.1 - Hospital ABN Content Standards

D	30/80.3.2 - Hospital ABNs Model Language
D	30/80.3.3 - Hospital ABN Header Text
D	30/80.3.4 - Hospital ABN End Text
D	30/80.3.5 - Messages for Body of Hospital ABNs 1-9
D	30/80.3.5.1 - Hospital ABN 1 Message - Admission or Preadmission
D	30/80.3.5.2 - Hospital ABN 2 Message - Continued Stay (Attending Physician Concurs)
D	30/80.3.5.3 - Hospital ABN 3 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes from Acute to NF Level of Care)
D	30/80.3.5.4 - Hospital ABN 4 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes from Acute to SNF Level of Care)
D	30/80.3.5.5 - Hospital ABN 5 Message - Continued Stay (QIO Concurs)
D	30/80.3.5.6 - Hospital ABN 6 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to NF Level of Care)
D	30/80.3.5.7 - Hospital ABN 7 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to SNF Level of Care)
D	30/80.3.5.8 - Hospital ABN 8 Message - Continued Stay - Swing Bed Only (Patient Changes From SNF to NF or Custodial Care)
D	30/80.3.5.9 - Hospital ABN 9 Message - Direct Preadmission/Admission to NF Swing Bed
D	30/80.3.6 - Hospital ABN 10 Message - Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization
D	30/80.4 - Signature Requirements
D	30/80.4.1 - Acknowledgement of Receipt
D	30/80.4.2 - Beneficiary Signature Refusal
D	30/80.4.3 - Signature Requirements Under Special Circumstances
D	30/80.5 - QIO Review Authority for Hospital ABNs
D	30/80.6 - QIO Monitoring of Hospital ABNs
D	30/80.6.1 - Ongoing Monitoring
D	30/80.6.2 - Inappropriate Hospital ABN

D	30/80.7 - Notices in Investigational/Experimental Procedures Situations
D	30/80.8 - Beneficiary Liability
D	30/80.8.1 - Preadmission Hospital ABNs
D	30/80.8.2 - Admission Hospital ABNs
D	30/80.8.2.1 - Hospital ABN Issued on the Day of Admission
D	30/80.8.2.2 - Hospital ABN Issued After the Day of Admission
D	30/80.8.3 - Continued Stay Hospital ABNs
D	30/80.8.3.1 - For Hospital ABNs Issued With the Concurrence of the Attending Physician
D	30/80.8.3.2 - For Hospital ABNs Issued With the Concurrence of the QIO, or with the Concurrence of the Attending Physician
D	30/80.8.4 - Grace Days
D	30/80.9 - Provider Liability
D	30/80.10 - Right to a Reconsideration
D	30/80.10.1 - QIO Disagrees with the Hospital's Determination
D	30/80.10.2 - QIO Agrees with the Hospital's Determination
R	30/130.1.1 - Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services
R	30/130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds
R	30/130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Original Medical Benefits: ED Notices and Relation to Other Liability Notices

TRIGGERING EVENT/ SCENARIO	Covered Care Reduction	Covered Care Discharge/ Termination	Covered Care Special Cases	Noncovered[i] Initiation, Reduction, Termination	Not Any Defined Medicare Benefit[ii]
Benefit/Type of Bill (TOB)	**1**	**2**	**3**	**4**	**5**
CORF **75x TOB** **(Part B)**	ABN	**ED Notice(s)** **AND** ABN **if** option to continue noncovered care	None	ABN	None, optional notice[iii]
HH **32x, 33x/ 34x*** **(Part A-B)/(Part B)** *** with therapy plan of care**	HHABN	**ED Notice(s)**, unless special case, **AND** HHABN **if** option to continue noncovered care	End care for HHA business need – HHABN[iv]	HHABN	HHABN; if prior to accepting patient[v], HHABN-- phasing out optional notice
Hospice **81x, 82x** **(Part A)**	ABN, if any	**ED Notice(s)** **AND** ABN **if** option to continue noncovered care	None	ABN	None, optional notice
SNF **21x / 22x** **(Part A)/(Part B)**	Skilled Nursing Liability Notice [VI]	**ED Notice(s)**, unless special case, **AND** Skilled Nursing Liability Notice **if** option to continue noncovered care	At exhaustion of Part A benefits – Skilled Nursing Liability Notice	Skilled Nursing Liability Notice	None, optional notice
Swing Bed **18x** **(Part A)**	Skilled Nursing Liability Notice, if any	**ED Notice(s)**, unless special case, **AND** HINN **if** option to continue noncovered care	At exhaustion of Part A benefits – Skilled Nursing Liability Notice	HINN	None, optional notice

i Meaning specific policy reason for limitation of coverage: care not reasonable/necessary, benefit requirement not met/exhausted.

ii Meaning always excluded from coverage under the original Medicare program by law (i.e., 1862), or not meeting the definition of a Medicare benefit.

iii Optional notices including specific Medicare Notice(s) of Exclusion from Medicare Benefits (NEMB).

iv Special requirement for home health under the Lutwin decision.
v HH COPs require notification if HHA intends charge potential patient for assessment when subsequently deciding not to accept patient.
[VI] Notice found in Publication 100-4, Chapter 30, Section 70.

List of HINN Letters and Applicable Requirements

Letter #/Type	Situation	Statutory Requirement*	Patient Liability Prior to/if no QIO/QIC Review**	Anticipated Result for Patient Care
Letter 1 – Preadmit. (a)	Preadmission: will not admit for covered stay – no concurrence required	1879, 411.404	Entire Part A stay upon receipt of pre-admission notice	No admission or noncovered admission
Letter 1-Admission (b)	Admitted as hospital inpatient, but notice of noncoverage given on or ***before*** 3PM same day – no concurrence required	1879, 411.404	All Part A services after receipt of the notice	Physical discharge or end of covered stay
Letter 1-Admission (c)	Admitted as hospital inpatient, but notice of noncoverage given ***after*** 3PM same day- no concurrence required	1879, 411.404	All Part A services for days following the date of the notice	Physical discharge or end of covered stay
Letter 2 - Cont. Stay	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2), liability does not begin until the day following notice; (2) for IPPS and other hospitals subject to 412.42 ("IPPS+"), liability begins the third day following receipt of the hospital notice	Physical discharge or end of covered stay
Letter 3 - Cont. Stay /Combo	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2), liability does not begin until the day following notice; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	End of covered hospital-level (acute) stay, discharge or start of noncovered swing bed stay (NF)
Letter 4 - Cont. Stay /Combo	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	N/A for Part A, as long as no insistence on continued hospital level services	Change to covered swing bed stay (SNF-level of care) or discharge
Letter 5 - Cont. Stay	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2) liability begins noon the day after the HINN is given; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	Physical discharge or end of covered stay

Letter #/Type	Situation	Statutory Requirement*	Patient Liability Prior to/if no QIO/QIC Review**	Anticipated Result for Patient Care
Letter 6 - Cont. Stay /Combo	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	All Part services: (1) Except as in (2) liability begins noon the day after the HINN is given; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	End of covered hospital-level (acute) stay, discharge or start of noncovered swing bed stay (NF)
Letter 7 - Cont. Stay /Combo	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	N/A for Part A, as long as no insistence on continued hospital level services	Change to covered swing bed stay (SNF-level of care) or discharge
Letter 8 Cont. Stay	**DISCONTINUED July 1, 2005 Use expedited determination notices for end of covered swing bed stay**			
Letter 9 Preadmit. (a)	Preadmission: will only admit to noncovered swing bed (NF) – no concurrence required	1879, 411.404	Entire Part A stay upon receipt of pre-admission notice	No admission or noncovered swing bed admission
Letter 9 - Admission (b)	Admitted to NF swing bed ***before*** 3PM same – no concurrence required	1879, 411.404	All Part A services after receipt of hospital notice	Physical discharge or continued noncovered swing bed stay
Letter 9 - Admission (c)	Admitted to NF swing bed ***after*** 3PM same day – no concurrence required	1879, 411.404	All Part A services on days following the date of the hospital notice	Physical discharge or continued noncovered swing bed stay
Letter 10 – Notification of Hospital Request	Informs beneficiary QIO opinion is being sought by hospital on discharge, attending physician has not concurred	1154(e)(2) /405.1208 (b)(1)	N/A; note Letter 10 must precede Letters 5-7	N/A

* For reasons of space, regulation citations have dropped "42 CFR".

** Fills blank for effective date of notice. See E, and F. above in this section for impact of QIO/QIC review. Note that even if review occurs, the provider's notification on coverage in HINN may be upheld, but if the beneficiary requests the review, liability will not start until after

the QIO decisions as per 1154; if hospital requested review, the QIO will specify when liability begins.

APPLETON MEDICAL CENTER

100 Top Hospitals National

THEDA CLARK MEDICAL CENTER

May 18, 2006

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

RE: NOTIFICATION PROCEDURES FOR HOSPITAL DISCHARGES
"PROVISIONS OF THE PROPOSED RULE"

To Whom It May Concern:

Our hospital system is committed to the belief that all patients are entitled to be clearly informed of both their benefit coverage and appeal rights no matter what their pay source. However, we would like to strongly assert that the provisions of the proposed rule related to Notification Procedures for Hospital Discharges are unnecessary from a patient's rights perspective and would be overly burdensome to hospitals.

CMS notes that the proposed rule is similar to one already in effect for home health, SNF and hospice care. However, we believe that CMS needs to acknowledge the fundamental differences between acute care settings, where a patient's medical condition is subject to rapid changes, and home health, SNF and hospice care which, by it's nature, assumes a more stable patient condition.

Discharge from the hospital requires that patients meet certain recovery milestones depending on their diagnoses and/or procedures. These recovery milestones are well established criteria utilized through evidence based guidelines. While we can predict that these milestones need to be present in order to safely discharge the patient, we cannot always predict a day ahead of time when a patient will meet those milestones. In addition, our patients understand that once they meet those milestones they will be ready for discharge *that* day, not the next day.

Given the fact that we cannot always predict with certainty when a patient will be ready for discharge, we believe we will be issuing notices simply to maintain compliance. There are many instances in which the patient may or may not be ready for discharge the next day due to the rapidly changing circumstances inherent to acute care. Therefore, a high number of notices would be inaccurate and would have to be rescinded and then re-issued.

In addition to the above, more than 50% of the inpatient population at our hospitals consists of 1, 2 and 3 day stays. The "Important Message from Medicare" is already provided to patients on admission. A second notice for these patients would be duplicative as it would need to be given almost on the heels of the first.

Finally, we believe that CMS has underestimated the amount of time it would take for processing and delivery of the notices. A provider's discharge estimate (whether documented in the medical record or relayed verbally to the care team and patient) would need to be transmitted to staff who would then process, deliver and explain the notice. We believe that 5 minutes per patient grossly underestimates the amount of time this would take. (As noted above, this also does not take into account rescinding and then re-issuing notices.) In addition, the rule does not specify whether or not the notice would be a part of the permanent record since it is an individualized document. If it needed to become a part of the record there would be additional work related to scanning the documents for storage since the rest of the record will shortly exist only in an electronic form.

In summary, we believe that our patients are well informed of their rights under Medicare and that, due to the use of evidence based guidelines, they understand that when they meet established discharge criteria they will be ready for discharge from the hospital. Our hospitals have excellent outcomes, low re-admission rates and high customer satisfaction scores. Imposition of the proposed rule is unnecessary, will create a burden on hospitals for compliance and will contribute to the continued escalation in health care costs. We strongly urge CMS to forgo implementation of this rule.

Very truly yours,

Maribeth Hetherington

Maribeth Hetherington
Vice President
ThedaCare Hospitals

Eileen Olson

Eileen Olson RN, BSN
Manager, Care Management
ThedaCare Hospitals

CLAY COUNTY CCMC MEDICAL CENTER

"The heart of healthcare"

May 25, 2006

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

To Whom It May Concern:

I wish to refer to file code CMS-4105-P, regarding Notification Procedures for Hospital Discharges. This proposed rule could create difficulties for a hospital our size. The staff responsible for issuing this type of notice is limited and not available on a 24-hour basis. Because of this it has been difficult at times to keep up with the Skilled Nursing Facility (Swing Bed) Provider Non-Coverage notices in a timely manner. If the Notification Procedures for Hospital Discharges follows similar guidelines, this could indeed create hardships for our hospital staff.

Sincerely,

Joan Steenbock RN

Joan Steenbock, RN
Utilization Management

South Shore Hospital

55 Fogg Road
South Weymouth
Massachusetts
02190-2455
southshorehospital.org

(781) 340-8000

May 24, 2006

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

This letter is our institution's public comment regarding the April 5, 2006 publication by CMS of a notice of proposed rulemaking (NPRM), CMS-4105-P CMS, which revises the discharge notice requirements in the inpatient hospital setting. The rule proposes establishing a new two-step process for all hospital discharges, both for original Medicare and Medicare Advantage patients.

As the Director of Case Management and the designated representative for South Shore Hospital on this particular proposal, I write to voice our overall opposition as well detail our specific concerns with this ruling. We also advise that the existing process be maintained.

The negative impact on the provider is that it will:

1) Increase the length of stay:

Requiring a 24 hour notice will deter discharges which are made when the physician rounds. The majority of patients are notified of the discharge by their physician at that time and care is not that precise or predictable in this era of short hospital stays and increasingly sophisticated technology. SSH is a Top 100 Hospital as rated by Solucient in 2005 and already has a medical-surgical LOS 20% lower than similar hospitals in our region, with consistently highly rated patient outcome indices.

2) Result in Duplication of letters:

Non-coverage letters are already served when discharge is inappropriately refused. Appeals are now processed through the QIO while the patient remains hospitalized.

3) Increase costs:

The length of stay will increase to meet the 24 hour notice requirement as well as the increase in administrative overhead for printing, filing, appealing and personnel time to serve and handle the increased paperwork, primarily by case management. This proposed regulation is paradoxically being proposed at the same time that both the industry and the government are actively working to decrease costs.

4) Increase time:

There will be an increase of time by some members of the staff attempting to explain this to patient and family, thus diverting finite resources away from providing direct patient care.

5) Be a challenge for an increasingly aged population to understand:

As the patient population ages, there are many more cognitive issues which interfere with understanding complex administrative systems, as seen in the Medicare Part D drug prescription experience. It will be a necessity to educate involved family members so that they may also understand this new process.

6) Increase of appeals:

More patients will file appeals since their hospital stay can be extended during that appeal process. The appeals process is labor intensive and involves staff for copying, printing, tracking, filing and communicating.

7) Increase in manual processes:

In a time of automation we would be introducing a manual process for delivery, appeal, and for retention of notices. This is in direct contrast to the CMS goal of automation.

8) Erosion of trust between the patient and providers:

As the communicator of what may well be perceived as a negative message, the essential trust developed between the healthcare providers and the patient will be compromised. It is already difficult to give non-coverage notices and to discharge before patients (or their families) feel they are able or want to leave, but to now add this additional message will be devastating to any relationship built during the hospitalization.

9) Negative impact on patient flow:

Adding time to a discharge (24 hrs) increases the overall length of stay which virtually diminishes bed availability and negatively impacts patient flow. There is already a challenge nationally of bed availability and concomitant problems with flow and this proposed regulation will only magnify this urgent issue. Patients do not currently understand how their individual decisions impact total flow, and this new regulation will further increase ED waits and reduce bed availability by increasing LOS.

In summary, the proposed regulation adds burden on the hospitals without a commensurate gain for the patients we serve. With reimbursement being limited and the costs of healthcare rising, it is unrealistic to expect that this regulation will be implemented without the adverse outcomes outlined above.

We respectfully request that CMS withdraw the proposal from further consideration because of the negative impact it will have on the patients we serve and their providers as detailed above. I would request that the current process be maintained with patients being told upon admission what their expected date of discharge is based on the GMLOS (Geometric Mean Length of Stay) and that they be verbally informed of their right to appeal their discharge and to be educated on what the outcomes may be. Furthermore, only if the patient wants to appeal after being verbally informed will written notices be provided.

Please contact me at 781-340-8821 if further information or explanation is needed on this letter of comment.

Sarah P. Rosenburgh

Sarah P. Rosenburgh, RN, MPS
Director, Case Management

Cc: Timothy Quigley, VP Nursing/CNO
Rick Pozniak, Director/Public Affairs

SAUK PRAIRIE MEMORIAL
HOSPITAL & CLINICS

May 18, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-41050-P
P.O. Box 8010
Baltimore, MD 21244-1850

To Whom It May Concern:

The intent of this letter is to respond to the proposed New Discharge Notice Requirements (CMS-4105P). We wish to express our strong feelings regarding the negative impact this proposal will have financially on the Medicare program.

We feel that length of stay will increase, patients not requiring hospital care will stay needlessly, costs will increase and there will be an increase of staff time to administer.

Recently according to the Dartmouth Atlas Project, it was noted Medicare currently spends 75% of all resources on 12 chronic illnesses. The result of their study was increased stays or expenditures did not increase patient satisfaction or improve quality outcomes.

As discharge planners, we feel this would only increase patient anxiety. Due to the short length of stays, patients would need to receive this letter on the first or second day when they were acutely ill.

As discharge planners, we feel we are already working with patients and families in preparing for discharge, usually within the first 24 hours from date admitted.

This additional paperwork is an unnecessary formality which would take away from our time spent on direct patient care.

Please give this your serious consideration.

SAUK PRAIRIE MEMORIAL HOSPITAL AND CLINI

Maureen Kirk Barbara F. Oelke

Maureen Kirk, CISW Barbara Oelke, CSW

80 First Street, Prairie du Sac, WI 53578 608/643-3311 PH 608/643-7151 F www.spmh.org

THE
McDOWELL
HOSPITAL
A MISSION HOSPITAL

May 18, 2006

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

Re: "PROVISIONS OF THE PROPOSED RULE"

Dear Sirs:

Small, rural hospitals of less than fifty (50) beds would find this new rule to be an unfair burden on multiple levels, not limited to the following:

1. Training – Financial cost and time to adequately train the Discharge Planning Staff to deliver the standardized notice and to deliver the more detailed notice if the patient requests a QIO review. The staff would also have to be trained to handle the QIO review, if necessary. Physicians would also require training on this new rule and the role they would have in the process.

2. Staffing – Small, rural hospitals usually do not have Discharge Planning staff in house on the weekends and holidays. Normally, facilities have personnel on voluntary call in case there are emergencies. This proposal would cause mandatory on-call personnel or staffing the Discharge Planning office on weekends and/or holidays causing the need for additional staff. This would also mean an additional financial burden and would mean attempting to hire additional qualified staff in a limited job market.

3. Duplication of Services – Medicare patients receive the "Important Message from Medicare" at the time of admission. The patients sign the message that shows their understanding of their rights and their right to appeal. The patient has enough to deal with near the time of discharge and does not need other burdens to confuse them.

4. Length of Stay – The average length of stay at our facility for FY06 runs between 3.20-4.04 days. What need would the patient have for back-to-back messages stating the same information?

Our facility does not see a problem with the current process; therefore, we see no need to change it. We do believe this will be a time consuming, financial burden on all hospitals, especially small, rural facilities. We respectfully request this provision not be placed into effect.

Sincerely,

Sonya Greck

Sonya Greck
Chief Executive Officer

SG/ks

May 25, 2006

By Overnight Mail

Mark McClellan, M.D., Ph.D.
Department of Health and Human Services
Attention: CMS-4105-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Rule Medicare Program; Notification Procedures for Hospital Discharges – File Code CMS 4105-P

Dear Dr. McClellan:

These comments are submitted by the Yale New Haven Hospital (YNHH) on proposed rules published on April 5, 2006 at 71 Fed. Reg. 17052. YNHH is a nonprofit, 944-bed, tertiary care hospital located in New Haven, Connecticut which serves as a teaching hospital for the Yale School of Medicine. The Hospital provides over 250,000 days of inpatient care per year. YNHH is a major provider of health care services within the State of Connecticut. The Hospital also provides comprehensive tertiary care services to patients referred to it from throughout the New England region as well as from foreign countries.

YNHH is of the view that, if adopted, the multiple notices required by the proposed rule[1] will unduly burden the hospital discharge planning process, unnecessarily confuse beneficiaries, and result in needless hospital costs that are likely to increase Medicare program expenditures. Accordingly, as explained below, YNHH believes that the Regulatory Impact Statement included within the preamble of the rule is inadequate and fails to account for increased hospital costs and Medicare program expenditures which would inevitably flow from the proposed rule. In addition, the proposed rule is antagonistic to the stated statutory goal of the Secretary to foster a "timely and smooth" discharge process which protects the interest of Medicare program beneficiaries. For

[1] YNHH requests CMS to clarify that the proposed rule only applies to patients who are discharged with Medicare Part A benefit days remaining and not to patients who exhaust Medicare Part A benefits, since the latter would receive the appropriate notices provided by subsequent payors such as the Medicaid program and Medigap insurers. We are inviting the Secretary's attention to this issue because Medicare billing standards, as a categorical matter, deem patients who exhaust Part A benefit days and who continue as inpatients (so-called crossover cases) to have been "discharged".

20 York Street
New Haven, CT 06510-3202

these reasons, YNHH recommends that the current rules governing hospital discharge notices remain in place with no changes.

Provisions of the Proposed Rule – Proposed Two-Step Notice Process

The statute governing a hospital's discharge planning process requires the Secretary to "develop guidelines and standards for the discharge process in order to ensure a **timely and smooth** transition to the most appropriate type of and setting for post-hospital or rehabilitative care." (emphasis added). See Section 1861(ee)(2) of the ocial Security Act. The proposed rule in some cases will lead to unnecessary delays in discharges and will make discharge transitions more difficult. We believe the proposal may unduly complicate discharge decisions made by attending physicians and agreed to by beneficiaries. We are concerned that the proposed rule does not accommodate fundamental differences between discharge timing and planning between hospitals and non hospital Medicare provider types and that the proposed rule will unnecessarily result in multiple discharge plans creating uncertainty and confusion for beneficiaries.

A Two-Step Notice Process is Not Appropriate for an Acute Care Hospital

a. Differences in Average Length of Stay

Fundamental differences exist between acute hospitals and other non-hospital providers such as home health agencies (HHAs), skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs). One major difference is the average length of stay (ALOS) of patients. The Medicare covered ALOS per beneficiary admission to a SNF was 24.9 days in 2003[2]. See MedPAC's March 2006 Report to Congress, Chapter 4A, page 174. At the 90th percentile, Medicare beneficiaries have a 147 day length of stay in a hospice. See MedPAC's June 2004 Report to Congress, Table 6-2, p. 142. The ALOS at an acute hospital is dramatically shorter than the ALOS at a SNF or hospice. YNHH's ALOS is only 5.4 to 5.6 days. The difference in ALOS between hospital and non-hospital settings raises significant questions as to the appropriateness and feasibility of CMS mandating that hospital patients receive a generic notice of appeal rights one (1) day prior to discharge.

b. Differences in Initiating the Discharge Planning Process

At a hospital, discharge planning is instituted earlier following an admission than it is in a HHA, SNF, CORF, and hospice. The discharge planning process is qualitatively different and entails different procedures than in other non-hospital settings. At an acute care hospital like YNHH, the discharge planning process is instituted upon a patient's

[2] A significant segment of Medicare patients admitted to SNFs remain for longer periods than are "covered" by the Medicare program and are "discharged" under a myriad of Medicare program, private insurer and other discharge standards.

admission to the hospital. A team works with the patient and his/her family throughout the hospital stay addressing the patient's and family's questions regarding the discharge process and putting in place an appropriate discharge plan to ensure a safe, timely and smooth transition to an appropriate post-acute setting.

The hospital discharge planning process is subject to a comprehensive regulatory scheme containing detailed standards and procedures. To comply with Medicare-Medicaid conditions of participation, a hospital must have a discharge planning process that identifies all patients requiring discharge planning early on in their hospitalizations. 42 C.F.R. §482.43(a) and (b). The hospital is required, among other things, to complete a discharge planning evaluation, to discuss it with the patient, and to counsel the patient and family members/interested persons to prepare them for post-hospital care. See, e.g., 42 C.F.R. §482.43(b)(6) and (c)(5). A hospital is required to provide patients in need of home health care or post hospital extended care services with a list of HHAs and SNFs that are available. 42 C.F.R. §482.43(c)(6). Similarly, as a condition of accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), a hospital is required to comply with standards and procedures governing hospital discharges. Among other things, these standards and procedures require that:

- the discharge planning process be initiated early on in the admission.
- patients be informed in a timely manner of discharge planning.
- discharge planning involve, among others, the patient and family members.
- patients be provided with information on the reason they are being transferred and alternatives to transfer, if any.
- patients be provided with information on the reason they are being discharged and the anticipated need for care, treatment and services post discharge.
- patients and/or those responsible for providing continuing care be provided with written discharge instructions.

See P.C. 15.20 of the Comprehensive Accreditation Manual for Hospitals: *The Office Handbook*, 2004 published by JCAHO.

c. Differences in Predictability of Discharge

Given the long-term nature of SNF and other post-acute non-hospital provider stays, the day of a patient's discharge from these facilities may be more predictable than the day of a patient's discharge from an acute care hospital. A hospital discharge plan providing for discharge on the following day often changes if there is a change in the condition of the patient overnight or the next morning. There are a number of clinical reasons why a patient who is scheduled for discharge the next day may require a postponement of the discharge. For example, a patient may develop a new temperature reading requiring further clinical follow up; a blood study or test result may indicate further study is required to be completed while the individual remains as an inpatient; or a patient may have an adverse reaction to a medication requiring further changes to his/her treatment plan. Often, a physician at an acute hospital is not able to make a final

determination as to whether it is medically appropriate and safe to discharge a patient until the day of discharge.

Discharge planning for acute care patients can be a difficult and complex process and can be unpredictably delayed while post acute care medical resources are secured which are necessary to provide for a patient's post acute care needs.

A Two-Step Notice Process Will Confuse Beneficiaries

In the preamble to the proposed rule, CMS acknowledges that the "Important Message from Medicare" which patients receive on admission contains much of the same information concerning appeals as is contained in the proposed "standardized" notice of appeal rights. As discharge planning commences for many patients at or prior to admission to a hospital, patients would encounter similar and seemingly redundant notices concerning appeal rights within several days subsequent to admission. YNHH submits that it would be inappropriate for a patient to be bombarded with multiple notices of appeal rights within days following admission. Such multiple, duplicative notices are likely to intrude on and interfere with the orderly discharge planning process. Thus, in the acute hospital setting, the best interests of beneficiaries are served if they do not receive duplicative information previously provided on admission. The point is underscored in the case of a patient who is discharged within a day or several days subsequent to admission.

The proposed rule will predictably cause beneficiaries undue emotional distress and confusion. Requiring that a beneficiary be provided with a generic, standardized written notice of discharge, when there is agreement among the hospital, attending physician and beneficiary, may lead to confusion. A patient who has discussed his/her discharge with his/her attending physician and hospital staff and has agreed to the discharge plan will question why the hospital is issuing another notice of appeal rights. Other than the beneficiary's name, the date the covered services would end, and the date the patient's financial liability for continued services would begin, all of the information which would be contained in the standardized, generic notice of non-coverage and discharge is already contained in the "Important Message from Medicare" which is provided to all beneficiaries upon admission. It is an unnecessary administrative burden and will merely confuse beneficiaries to provide them with two notices that are almost identical[3].

[3] In the case where a beneficiary's discharge is delayed, the proposed rule would result in multiple redundant notices provided to a beneficiary who had essentially received the same information a few days earlier upon admission.

In fact there are currently as many as thirteen (13) versions of nine (9) hospital issued notices of non-coverage that may be provided to a beneficiary by a hospital, prior to and during his/her hospitalization, depending on the circumstances, such as:

- notice of non-coverage on preadmission review,
- notice of non-coverage on same day as admission.

See CMS Manual System, Pub. 100-004 Medicare Claims Processing, Transmittal 594, June 24, 2005, Change Request 3903, pages 52-53 which are attached. Patients admitted to SNFs and other non-hospital settings do not, as a practical matter, receive the same number and volume of notices. Id. at pages 8-9. Adding essentially new redundant discharge notices to what is already a long list of hospital issued notices will likely result in confusion and not enhance the discharge planning process.

The Two-Step Notice Process Will Interfere with Hospital Operations and Administration

If adopted the proposed rule also would create operational and administrative confusion at hospitals. The proposed rule would create different classes of patients who would or would not receive the proposed generic notice depending on their status. Patients who are transferred from an acute hospital to another hospital, including an IPPS exempt rehabilitation, psychiatric or long-term care hospital, would not receive the new generic notice since they would remain at a hospital level of care and continue to use their hospital Medicare benefit days. Patients who are ultimately determined to have been admitted on observation status for up to 2 ½ days (72 hours) in an acute hospital without being "admitted" as an inpatient would not receive the new generic notice. 42 C.F.R. §419.2(b)(3). When these beneficiaries enter the hospital it is not known whether they will become registered inpatients. Observation patients do not use inpatient benefit days and are treated as outpatients by the Medicare program for both payment and benefit purposes. Observation patients may have the same "stay" in a hospital as inpatients but are not "discharged" because they are not assigned inpatient status. Under the proposed rule hospitals would be required to institute new and cumbersome administrative mechanisms to track which patients do and do not receive multiple notices of appeal rights.

The Waiver of Liability Provision of the Proposed Rule should be Expanded to Include Hospitals.

The waiver of liability statute set forth in Section 1879(a)(2) of the Social Security Act applies to both providers and beneficiaries:

> "both such individual and such provider of services or such other persons, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under part A or part B."

The proposed rule, however, only applies to beneficiaries:

> "(2) *Timely filing and limitation on liability.* If a beneficiary files a request for an expedited determination by the QIO in accordance with paragraph (b)(1) of this section, the beneficiary is not financially responsible for inpatient hospital services (other than applicable coinsurance and deductible) furnished before noon of the calendar day after the date the beneficiary (or his or her representative) receives notification (either orally or in writing) of the expedited determination by the QIO."

Proposed 42 C.F.R. §405.1206(f)(2).

The discussion of waiver of liability in the preamble to the proposed rule cites Section 1869(c)(3)(C)(iii)(III) of the Social Security Act, which incorporates by reference to Section 1154(e)(4), the waiver of liability statute contained in Section 1879(a)(2). Since the waiver of liability statute applies to both providers and beneficiaries the proposed rule on waiver of liability also should apply to both. YNHH recommends that the proposed provision on waiver of liability be revised to clearly provide what the statute requires, namely, that if a beneficiary files a request for an expedited determination by the QIO, the hospital will not be financially responsible for inpatient hospital services while the QIO determination is pending and the Medicare program will pay the hospital for such services, including cost outlier payments, while the QIO determination is pending. In the case where the proposed new notice results in a de facto extended stay which triggers the cost outlier threshold, it is apparent that stay and attendant cost are beyond a hospital's control and that the hospital is entitled to cost outlier payments.

The Proposed Rule May Lead to Further Backups in Emergency Departments

It is public knowledge that there is a shortage of acute care hospital beds throughout the nation. Due to the shortage of acute care hospital beds, many hospitals are on emergency department diversion status. The United States General Accounting Office (GAO), in a Report to the Ranking Minority Member, Committee on Finance, U.S. Senate on "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities" GAO-03-460, March 14, 2003, states in a summary of its findings that:

> "While no single factor stands out as the reason why crowding occurs, GAO found the factor most commonly associated with crowding was the inability to transfer emergency patients to inpatient beds once a decision had been made to admit them as hospital patients rather than to treat and release them."

CMS' proposed revisions to the hospital discharge notice process will merely exacerbate this problem. Rather than lead to improved patient care, the proposed rule will be detrimental to patient care.

The Two-Step Notice Process Will Likely Increase Hospitals' ALOS and Result in Increased IPPS Cost Outlier Payments

The proposed rule would require hospitals to issue standardized, generic notices of non-coverage and discharge as early as possible during an admission in an effort to avoid delays in discharge. Where a standardized, generic notice of non-coverage is issued, for example, on a Friday, and a beneficiary requests an expedited review by the following Monday at noon, a beneficiary's covered length of stay would increase. This process could increase a 3-4 day patient stay by over 100%.

Yale New Haven Hospital is concerned that the so-called "expedited review" process will lead to significant increases in a beneficiary's length of stay. To complete the "expedited review" process involves a number of mandated steps:

1. The QIO must contact the hospital as soon as possible to notify the hospital a beneficiary has filed a request for expedited review.

2. The QIO must evaluate whether the generic notice issued by the hospital is valid.

3. The hospital must issue a detailed notice to the beneficiary.

4. The hospital must provide all relevant medical records to the QIO.

5. The QIO must confer with the beneficiary or his/her representative.

6. The QIO must confer with the hospital.

7. The QIO must review all relevant medical records and information.

8. The QIO must issue and provide the beneficiary with a written determination.

As noted previously, under the proposed rule where a discharge date is changed, this process would be required to be repeated.

Regulatory Impact

As noted above, the proposed rule could result in increased cost outlier payments. This cost was not assessed in the regulatory impact statement. CMS also has underestimated the time that will be expended by hospitals in order to comply with the

proposed rule. YNHH experiences approximately 13,000 Medicare discharges a year. Even using CMS' most conservative prediction of 5 minutes per each standardized, generic notice of non-coverage and discharge, and only 2% of patients requesting expedited review with only 90 minutes to prepare a detailed notice and a case file for the QIO, the total annual burden of time associated with the proposed rule for YNHH is approximately 2,557 hours.

Medicare Discharges

13,000	x 5 minutes first notice	= 65,000 minutes
13,000	x 5 minutes second notice	= 65,000 minutes
13,000	x .02 appeals	= 260 appeals
260 appeals	x 90 minutes per appeal	= 23,400 minutes

153,400 minutes or 2,556.66 hours per year

CMS fails to include the additional time that will be required to counsel patients and their families if the proposed rule is adopted. YNHH conservatively estimates it will take at least an additional 30 minutes per patient and family as follows:

Medicare Discharges

13,000	x 30 minutes counseling	= 390,000 minutes or 6500 hours per year.

Thus, the total annual burden of time including counseling associated with the proposed rule for YNHH, would be approximately 9057 hours which is the equivalent of 4.35 full-time employees (FTEs).

In addition, CMS underestimates the additional costs the proposed rule will impose on hospitals. CMS only accounts for a $2.50 cost per standardized, generic notice of non-coverage and discharge and a $45.00 cost per detailed notice, for an estimated total cost per provider of approximately $7,000.00. However, CMS has not considered the additional cost and time associated with copying medical records which may be voluminous or costs for counseling patients and their families which may be significant. Furthermore, CMS has significantly underestimated the costs of implementing the proposed rules by failing to include the costs of hiring 4.35 FTEs as noted above. YNHH estimates the costs of the 4.35 FTEs would be approximately $449,509 per year.

CMS also fails to consider the additional time and cost that will be expended by QIOs in conducting reviews as a result of the proposed rule.

Accordingly, the proposed rule should be reassessed to determine whether it qualifies as a major rule that requires a regulatory impact analysis.

For the foregoing reasons, Yale New Haven Hospital respectfully requests that CMS withdraw the proposed rules. Yale New Haven Hospital thanks you for your consideration of these comments.

Sincerely,

Marna P. Borgstrom
President & Chief Executive Officer

cc: AAMC
AHA
CHA
Senator Christopher J. Dodd
Senator Joe Lieberman
Representative Rosa DeLauro

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 594

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JUNE 24, 2005

Change Request 3903

Transmittal 577, CR 3903, dated June 3, 2005 is rescinded and replaced with Transmittal 594. In chapter 3, Exhibit 1-Hospital Issued Notices of Noncoverage-Ten Letters, was erroneously omitted from the transmittal page. The deletion of this exhibit is now being corrected via this transmittal. All other information remains the same.

SUBJECT: Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare

I. SUMMARY OF CHANGES: This expedited review process, modeled on an existing Medicare managed care process, is effective under regulations July 1, 2005. It allows beneficiaries in specific care settings, home health, hospice, Comprehensive Outpatient Rehabilitation Facility (CORF), Skilled Nursing Facility (SNF) and swing bed, the right to appeal a pending discharge from a period of covered care to a Quality Improvement Organization (QIO). This process is similar to the QIO review of inpatient hospital discharges that has existed for some time.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : July 1, 2005
IMPLEMENTATION DATE : July 1, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/130 - Coordination With the Quality Improvement

	Organization (QIO)
D	3/130.1 - Limitation on Liability Provision
D	3/130.2 - General Responsibilities of Hospitals, Quality Improvement Organizations (QIOs), and FIs
D	3/130.3 - Placeholder for Instructions for FI/QIO Coordination - (Now in Discussion Within CMS)
D	3/130.4 - QIO Monitoring of Hospital Notices for Denial of Continued Stay of Inpatient Care Under PPS
D	3/130.5 - Issuance of Hospital Notices of Noncoverage
D	3/130.5.1 - Content of HINNs
D	3/130.5.2 - QIO Monitoring of HINNs
D	3/130.5.3 - Notices in Investigational/Experimental Procedures Situations
D	3/130.6 - Beneficiary Liability
D	3/130.7 - Provider Liability
D	3/130.8 - Right to a Reconsideration
D	3/130.9 - Model Hospital Issued Letters
D	3/Exhibit 1 - Hospital Issued Notices of Noncoverage-Ten Letters
R	30/20 - Limitation on Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed
R	30/80 - Hospital-Issued Notices of Noncoverage (HINN)
D	30/80.1 - When and to Whom a Hospital ABN Should be Given
D	30/80.1.1 - Admission or Pre-Admission Hospital ABNs
D	30/80.1.2 - Continued Stay Hospitals ABNs
D	30/80.1.2.1 - Attending Physician Concurs
D	30/80.1.2.2 - Attending Physician Does Not Concur
D	30/80.1.2.3 - Advance Continued Stay Hospital ABN
D	30/80.1.3 - Combined Notices in Swing Bed Situations
D	30/80.1.4 - Combined Stay Hospital ABN in Swing Beds Treated as SNF Beds
D	30/80.1.5 - Delivery of Hospital ABN
D	30/80.1.6 - Qualified Recipients of Hospital ABNs
D	30/80.2 - Issuing the Appropriate Hospital ABN
D	30/80.3 - Hospital ABNs (HINNs)
D	30/80.3.1 - Hospital ABN Content Standards

D	30/80.3.2 - Hospital ABNs Model Language
D	30/80.3.3 - Hospital ABN Header Text
D	30/80.3.4 - Hospital ABN End Text
D	30/80.3.5 - Messages for Body of Hospital ABNs 1-9
D	30/80.3.5.1 - Hospital ABN 1 Message - Admission or Preadmission
D	30/80.3.5.2 - Hospital ABN 2 Message - Continued Stay (Attending Physician Concurs)
D	30/80.3.5.3 - Hospital ABN 3 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes from Acute to NF Level of Care)
D	30/80.3.5.4 - Hospital ABN 4 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes from Acute to SNF Level of Care)
D	30/80.3.5.5 - Hospital ABN 5 Message - Continued Stay (QIO Concurs)
D	30/80.3.5.6 - Hospital ABN 6 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to NF Level of Care)
D	30/80.3.5.7 - Hospital ABN 7 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to SNF Level of Care)
D	30/80.3.5.8 - Hospital ABN 8 Message - Continued Stay - Swing Bed Only (Patient Changes From SNF to NF or Custodial Care)
D	30/80.3.5.9 - Hospital ABN 9 Message - Direct Preadmission/Admission to NF Swing Bed
D	30/80.3.6 - Hospital ABN 10 Message - Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization
D	30/80.4 - Signature Requirements
D	30/80.4.1 - Acknowledgement of Receipt
D	30/80.4.2 - Beneficiary Signature Refusal
D	30/80.4.3 - Signature Requirements Under Special Circumstances
D	30/80.5 - QIO Review Authority for Hospital ABNs
D	30/80.6 - QIO Monitoring of Hospital ABNs
D	30/80.6.1 - Ongoing Monitoring
D	30/80.6.2 - Inappropriate Hospital ABN

D	30/80.7 - Notices in Investigational/Experimental Procedures Situations
D	30/80.8 - Beneficiary Liability
D	30/80.8.1 - Preadmission Hospital ABNs
D	30/80.8.2 - Admission Hospital ABNs
D	30/80.8.2.1 - Hospital ABN Issued on the Day of Admission
D	30/80.8.2.2 - Hospital ABN Issued After the Day of Admission
D	30/80.8.3 - Continued Stay Hospital ABNs
D	30/80.8.3.1 - For Hospital ABNs Issued With the Concurrence of the Attending Physician
D	30/80.8.3.2 - For Hospital ABNs Issued With the Concurrence of the QIO, or with the Concurrence of the Attending Physician
D	30/80.8.4 - Grace Days
D	30/80.9 - Provider Liability
D	30/80.10 - Right to a Reconsideration
D	30/80.10.1 - QIO Disagrees with the Hospital's Determination
D	30/80.10.2 - QIO Agrees with the Hospital's Determination
R	30/130.1.1 - Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services
R	30/130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds
R	30/130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Original Medical Benefits: ED Notices and Relation to Other Liability Notices

TRIGGERING EVENT/ SCENARIO	Covered Care Reduction	Covered Care Discharge/ Termination	Covered Care Special Cases	Noncovered[i] Initiation, Reduction, Termination	Not Any Defined Medicare Benefit[ii]
Benefit/Type of Bill (TOB)	**1**	**2**	**3**	**4**	**5**
CORF **75x TOB** **(Part B)**	ABN	**ED Notice(s)** **AND** ABN **if** option to continue noncovered care	None	ABN	None, optional notice[iii]
HH **32x, 33x/ 34x*** **(Part A-B)/(Part B)** *** with therapy plan of care**	HHABN	**ED Notice(s)**, unless special case, **AND** HHABN **if** option to continue noncovered care	End care for HHA business need – HHABN[iv]	HHABN	HHABN; if prior to accepting patient[v], HHABN-- phasing out optional notice
Hospice **81x, 82x** **(Part A)**	ABN, if any	**ED Notice(s)** **AND** ABN **if** option to continue noncovered care	None	ABN	None, optional notice
SNF **21x / 22x** **(Part A)/(Part B)**	Skilled Nursing Liability Notice [vi]	**ED Notice(s)**, unless special case, **AND** Skilled Nursing Liability Notice **if** option to continue noncovered care	At exhaustion of Part A benefits – Skilled Nursing Liability Notice	Skilled Nursing Liability Notice	None, optional notice
Swing Bed **18x** **(Part A)**	Skilled Nursing Liability Notice, if any	**ED Notice(s)**, unless special case, **AND** HINN **if** option to continue noncovered care	At exhaustion of Part A benefits – Skilled Nursing Liability Notice	HINN	None, optional notice

i Meaning specific policy reason for limitation of coverage: care not reasonable/necessary, benefit requirement not met/exhausted.

ii Meaning always excluded from coverage under the original Medicare program by law (i.e., 1862), or not meeting the definition of a Medicare benefit.

iii Optional notices including specific Medicare Notice(s) of Exclusion from Medicare Benefits (NEMB).

iv Special requirement for home health under the Lutwin decision.
v HH COPs require notification if HHA intends charge potential patient for assessment when subsequently deciding not to accept patient.
[VI] Notice found in Publication 100-4, Chapter 30, Section 70.

List of HINN Letters and Applicable Requirements

Letter #/Type	Situation	Statutory Requirement*	Patient Liability Prior to/if no QIO/QIC Review**	Anticipated Result for Patient Care
Letter 1 – Preadmit. (a)	Preadmission: will not admit for covered stay – no concurrence required	1879, 411.404	Entire Part A stay upon receipt of pre-admission notice	No admission or noncovered admission
Letter 1-Admission (b)	Admitted as hospital inpatient, but notice of noncoverage given on or ***before*** 3PM same day – no concurrence required	1879, 411.404	All Part A services after receipt of the notice	Physical discharge or end of covered stay
Letter 1-Admission (c)	Admitted as hospital inpatient, but notice of noncoverage given ***after*** 3PM same day- no concurrence required	1879, 411.404	All Part A services for days following the date of the notice	Physical discharge or end of covered stay
Letter 2 - Cont. Stay	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2), liability does not begin until the day following notice; (2) for IPPS and other hospitals subject to 412.42 ("IPPS+"), liability begins the third day following receipt of the hospital notice	Physical discharge or end of covered stay
Letter 3 - Cont. Stay /Combo	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2), liability does not begin until the day following notice; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	End of covered hospital-level (acute) stay, discharge or start of noncovered swing bed stay (NF)
Letter 4 - Cont. Stay /Combo	End of covered hospital inpatient stay when attending concurs	1154(e), 412.42 (IPPS+), 411.404	N/A for Part A, as long as no insistence on continued hospital level services	Change to covered swing bed stay (SNF-level of care) or discharge
Letter 5 - Cont. Stay	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	All Part A services: (1) Except as in (2) liability begins noon the day after the HINN is given; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	Physical discharge or end of covered stay

Letter #/Type	Situation	Statutory Requirement*	Patient Liability Prior to/if no QIO/QIC Review**	Anticipated Result for Patient Care
Letter 6 - Cont. Stay /Combo	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	All Part services: (1) Except as in (2) liability begins noon the day after the HINN is given; (2) for IPPS+ hospitals, liability begins the third day following receipt of the hospital notice	End of covered hospital-level (acute) stay, discharge or start of noncovered swing bed stay (NF)
Letter 7 - Cont. Stay /Combo	End of covered hospital inpatient stay when QIO concurs	1154(e), 412.42 (IPPS+), 411.404	N/A for Part A, as long as no insistence on continued hospital level services	Change to covered swing bed stay (SNF-level of care) or discharge
Letter 8 Cont. Stay	**DISCONTINUED July 1, 2005 Use expedited determination notices for end of covered swing bed stay**			
Letter 9 Preadmit. (a)	Preadmission: will only admit to noncovered swing bed (NF) – no concurrence required	1879, 411.404	Entire Part A stay upon receipt of pre-admission notice	No admission or noncovered swing bed admission
Letter 9 - Admission (b)	Admitted to NF swing bed ***before*** 3PM same – no concurrence required	1879, 411.404	All Part A services after receipt of hospital notice	Physical discharge or continued noncovered swing bed stay
Letter 9 - Admission (c)	Admitted to NF swing bed ***after*** 3PM same day – no concurrence required	1879, 411.404	All Part A services on days following the date of the hospital notice	Physical discharge or continued noncovered swing bed stay
Letter 10 – Notification of Hospital Request	Informs beneficiary QIO opinion is being sought by hospital on discharge, attending physician has not concurred	1154(e)(2) /405.1208 (b)(1)	N/A; note Letter 10 must precede Letters 5-7	N/A

* For reasons of space, regulation citations have dropped "42 CFR".

** Fills blank for effective date of notice. See E, and F. above in this section for impact of QIO/QIC review. Note that even if review occurs, the provider's notification on coverage in HINN may be upheld, but if the beneficiary requests the review, liability will not start until after

the QIO decisions as per 1154; if hospital requested review, the QIO will specify when liability begins.

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West Jefferson Medical Center

1101 Medical Center Boulevard
Marrero, LA 70072
(504) 347-5511

May 22, 2006

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

Re: Subject: CMS-4105-P Comments

To Whom It May Concern:

I am writing in opposition to CMS-4105-P.

As one of the few hospitals in the New Orleans area, West Jefferson Medical Center remained in operation before, during and after Hurricane Katrina. It's not bad enough that our indigent population is increasing, census is increasing, the complexity of the patients is increasing and the placement difficulties are extremely burdensome, and now CMS wants to propose a rule that would add yet another layer of complexity with no tangible benefit for the patient or the provider. What are you thinking?

Let me make a few notations re: the impact this proposal has on our healthcare system:

- This 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 and case management.
- Would require at least 30 minutes per patient (not the proposed 5 minutes). We cannot just simply deliver a notice and walk away. This is the 65 and over population that we are speaking of. They will get confused and frightened, which could exacerbate their symptoms (possibly requiring additional treatment for chest pain and high blood pressure).
- Require additional time to track, document and audit compliance.
- Would force increased staffing (7 days/week) to be available to serve these notices. These individuals would have to understand the rationale for serving these letters and be an effective communicator to answer questions, while keeping the patient calm. This means you would need someone of a higher pay grade, which will ultimately drive up the price of healthcare.

Given the current healthcare system, with a nursing shortage (especially in the South, post-Katrina) and a baby boom influx, is it necessary to propose a process for a problem that does not exist--a process that will lead to confusion for the elderly and an administrative nightmare for hospitals? Will CMS have a 1-800 hotline that patients can call to get a full explanation of why they were served this letter, a hotline that will be answered timely, 24 hours per day?

Patients are familiar and comfortable with the process we currently use with the Hospital-Issued Notice of Non-coverage for those rare instances of dispute between the patient and hospital regarding discharge. Why confuse them? Hasn't the Prescription Drug—Medicare Part D confused them enough? In fact, Part D alone has resulted in increased resources as we are the ones who are answering their multiple questions.

I strongly oppose CMS-4105-P as it will create negative consumer perceptions, increased hospital staffing, rise in healthcare costs and, more importantly, will lead to an even more confused elderly population. Is this necessary when the current system seems to be working smoothly?

I urge you to dismiss this proposal immediately and focus your attention elsewhere.

Sincerely,

Darlene Gondrella

Darlene Gondrella,
Director, Case Management Dept.
West Jefferson Medical Center

"Whatever you do, do it well™"

Upland Hills Health

www.uplandhillshealth.org

800 Compassion Way
P.O. Box 800
Dodgeville, WI
53533-0800

Phone: (608)930-8000
Fax: (608)930-7250

May 23, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-41050-P
P.O. Box 8010
Baltimore, MD 21244-1850

To Whom It May Concern:

This letter is in response to the proposed New Discharge Notice Requirements. I truly believe this will have a negative impact on the Medicare program itself. This proposal will likely increase Medicare spending.

It is anticipated that this will increase the length of stay, which may hurt many rural hospitals that are Critical Access. Also more hours will be needed to administer these forms to patients.

I believe that discharge intervention does happen within the first 24 hours from date admitted. The additional paperwork may cause increased Patient anxiety.

Please give this serious consideration.

Thank you,

Heidi Kraege

Heidi Kraege, CSW

P.S. If you want to see Medicare spending decrease I suggest changing the length of the qualifying hospital stay, from three nights to two nights.

FRANKLIN MEMORIAL HOSPITAL

One of the Best Hospitals in New England and Nationally Acclaimed as a Healthcare Leader

May 12, 2006

Centers for Medicare & Medicaid Services
Dept. of Health & Human Services
Attn: CMS-4105-P
PO Box 1080
Baltimore, MD 21244-1850

To Whom It May Concern:

This is a response to CMS-4105-P, your proposal of issuance of a "General Denial" to Medicare recipients at an acute care facility.

We fail to see the purpose or advantage of this practice at an acute level of care. Medicare **already** has a denial process in place for inpatient stay. This process **(Hospital Issued Notices of Non-coverage)** covers all possible instances, i.e. admission, continued stay and/or refusal of a skilled bed. They include notification and review by your QIOs to protect the recipients and insure correct Medicare utilization. What you propose is redundant.

Our average length of stay is 3.6 days. Therefore, we would have to issue the notice at admission or the next day. When a patient is acutely ill, the stress and anxiety of the illness or procedure should not be compounded by what is perceived as a threat of [non-payment] financial responsibility for their stay. No matter how eloquent the explanation, experience shows that "hearing" stops with the word **"denial"**. This type of anxiety can prolong the illness or encourage the patient to leave before they are medically stable.

The government has the QIO, C-DAK, PEPPER, JACHO, the Fiscal Intermediary, and state licensing and regulatory agencies monitoring hospital's acute care management and patient outcomes as well as Medicare's fiscal utilization. In this day and age of sky rocketing health care costs, it is irresponsible to require a redundant program that requires an increase use of resources and personnel to manage. We urge you to dismiss CMS-4105-P.

Sincerely,

G. Thomas Marshall

G. Thomas Marshall, M.D.
President of Medical Staff

Pam Brown, RN
Utilization Review/Case Manager

111 Franklin Health Commons Farmington, ME 04938
Tel: 207-778-6031 ME 800-398-6031 TTY: 207-779-2662 Fax: 207-779-2548 www.fchn.org

An Affiliate of Franklin Community Health Network

May 23, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Attention: CMS-4105-P

P.O. Box 8010
Baltimore, MD 21244-1850

PROVISION OF THE PROPOSED RULE

To Whom It May Concern:

I am writing to submit my comment regarding the proposed rule related to written notification to be given to all Medicare hospital discharges at least one day before the effective date of discharge.

All Medicare hospitals provide the Important Message from Medicare notice to all Medicare beneficiaries at the time of admission. This notice contains information explaining the Medicare appeal rights when a beneficiary disagrees with the discharge decision. The above listed proposed regulation provides little additional information to the Medicare patient other than giving them notice of possible date of discharge.

The statement is made in Section II of the proposed rule as follows: We also believe that the new approach we are proposing would not be overly burdensome for providers or MA organizations. Further, because all Medicare beneficiaries who are hospital inpatients have the right to an expedited review, we also believe it is preferable that these beneficiaries have the same notice of appeal rights to which other beneficiaries are entitles. The key words above are "not be overly burdensome". The proposed rule also contains, in Section III, the comment as follows, "Again, we estimate that it would take hospitals 5 minutes to deliver each notice. In 2002 there were approximately 1.6 million MA Inpatient hospital discharges. The total annual burden associated with this proposed requirement is 1,333,333 hours". An additional comment states "We project that 2 percent of affected individuals (that is, 32,000 beneficiaries) will request an expedited determination. We estimate that it will take 5 minutes for an enrollee who chooses to exercise his or her right to an expedited determination to contact the QIO. For those 32,000 cases, the total estimated burden hours is 26,666 hours". This comment demonstrates the lack of experience and understanding of the predominately elderly (over 65 year of age) of those involved in constructing this proposed rule. There is no "five minute rule" in providing these patients the time involved in explaining the notice and explaining the appeal process. While the notice states this information in writing, verbal explanations

are also necessary and simply respectful. The notices would not simply be handed to the patients but would be explained in detail. Any experienced caregiver can relate to the time involved in assuring comprehension on the part of the patient in any health care decision. Your five minutes as mentioned is disrespectful in regards to your own beneficiaries and any facility would be irresponsible in considering this time frame as "workable" as it is not. Your time frame also does not include the clerical time in completing the notices to be distributed as well as overseeing the "process" involved in assuring compliance.

When reviewing the many comments received in regards to this proposed rule, I suggest further review of the average length of stay for Medicare patients in today's hospital environment. I am sure you will discover that this time frame is approximately 4 days. This fact demonstrates the time constraints in completing the required documentation, patient contact, and follow-up as needed. Simply establishing the "proposed discharge date" involves considerable discharge planning team time and effort.

I suggest further consideration of this proposed rule in relation to the extensive staff time involved versus the actual benefit to the beneficiaries. Hospitals have one primary goal, quality medical care for their patients. The Medicare Important Message is already given to all Medicare patients. This proposed rule will only repeat information already given as well as inflict considerable staffing and financial burdens to facilities striving to carry out their primary goal.

Thank you for allowing my response to the above mentioned proposed rule.

Sincerely,

Sherrie A. Russom, CPUM
Utilization Management
Mt. Carmel Reg. Medical Center

Tuality Healthcare
335 SE 8th Avenue
Hillsboro, OR 97123
503-681-1111
Human Resources:
888 SE Baseline St.
Hillsboro, OR 97123
503-681-1158

Tuality Community Hospital
335 SE 8th Avenue
Hillsboro, OR 97123
503-681-1111

Tuality Forest Grove Hospital
1809 Maple Street
Forest Grove, OR 97116
503-357-2173
Center for Geriatric Psychiatry:
503-359-6969
Raines Dialysis Center:
503-359-7972

Tuality Health Alliance
335 SE 8th Avenue
Hillsboro, OR 97123
503-681-1817

Tuality Health Education Center
334 SE 8th Avenue
Hillsboro, OR 97123
503-681-1700

Tuality Health Information Resource Center
334 SE 8th Avenue
Hillsboro, OR 97123
503-681-1702

Tuality Healthcare Foundation
335 SE 8th Avenue
Hillsboro, OR 97123
503-681-1170

Tuality HealthPlace
1200 NE 48th Avenue, Suite 700
Hillsboro, OR 97124
503-640-6064

Tuality Home Health
1809 Maple Street
Forest Grove, OR 97116
503-357-2737

Tuality Medical Equipment & Supply
333 SE 7th Avenue, Suite 1200
Hillsboro, OR 97123
503-681-1658

Tuality/OHSU Cancer Center
299 SE 9th Avenue
Hillsboro, OR 97123
503-681-4200

Tuality Urgent Care
17175 SW Tualatin Valley Hwy.
Suite A
Aloha, OR 97006
503-681-4223

Tuality Healthcare

Building a healthier community.

May 17, 2006

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

RE: File Code CMS-4105-P
Proposed Rule for Medicare Program Notification Procedures for Hospital Discharges
42 CFR Parts 405, 412, 422, and 489

Dear Rule makers:

We would like to identify the following concerns regarding the proposed rules for the Medicare program regarding the notification procedures for hospital discharges as identified in the Federal Register Volume 71, #65, Wednesday, April 5, 2006.

1. It is believed your cost for implementation of this rule is greatly under estimated. In our experience trying to provide a letter to a patient will require significant more time than 5 minutes per patient to help them understand the contents of the letter and obtain a signature. Often times the patient will not only desire a discussion to understand but will want to have it repeated when a family member is available. For the hospital to implement this type of program, because of the time required, will require additional personnel. Additional reimbursement needs to be provided through Medicare if something like this is desired to be implemented.

2. This can potentially result in a financial burden for the patient as they could be staying beyond an approved stay at their own cost after receiving the discharge notification.

3. What happens if the discharge letter is delivered to the patient and then the physician changes his/her mind and does not write a discharge order or the patient's condition changes such that the physician does not feel they are appropriate for discharge? Will the provision of the letter to the patient need to be repeated? This could occur on several successive days which could be very misleading and confusing to the patient.

4. Physicians do not always know a day in advance that the patient will be discharged the next day, particularly when they are waiting for test results or for some type of assessment to make their decision. What happens if the physician does not provide an indication of discharge the day prior, and then discharges a patient so that the 2 day notification cannot be provided?

5. If a patient decides to appeal their discharge, the PRO has not readily had a local source available for the appeal, particularly as a weekend approaches, or on a weekend. How will this be resolved as this discharge letter will generate a significant increase in the need for this type of response?

6. Some Medicare patients are admitted as Observation Patients. Within 48 hours they can convert to an Inpatient and then are discharged. How would the discharge letter be handled in this case as there would not be a day prior notification opportunity?

As you can see from these issues there are considerable complications with implementing this type of program. It is our request that these issues either be resolved prior to implementing a rule and inclusion of them with the implementation rule, or the Centers for Medicare & Medicaid Services reconsider and do not proceed with implementing this proposal.

Thank you very much for your consideration of these concerns.

Very truly yours,

Manuel S. Berman, FACHE
Administrator/Chief Operating Officer

MSB/sa

ASANTE®
HEALTH SYSTEM

File Code - CMS – 4105-P
Medicare Program
Notification Procedures for Hospital Discharges

May 5, 2006

Proposed Rule Comment:

Once again, CMS is preparing to impose another unnecessary and burdensome requirement on hospitals, with their proposal to notify all Medicare beneficiaries in writing of impending discharge within 24 hours. To suggest that this process would only require 5 minutes per patient shows a complete lack of understanding of hospital operations. In addition, patients already receive the "Important Message from Medicare" on admission, which gives a detailed explanation of their right to appeal if they feel they are being asked to leave too soon. And it is inconceivable that preparation for the detailed termination notice would require 60 to 90 minutes. Is the QIO going to be available on weekends for case review?

CMS must understand that this action would require dedicated staff to follow up with each physician on a daily basis for an estimate of when he/she plans to discharge the patient. Since this function would likely fall to Case Management staff, just tracking alone would require additional FTE's, for the weekday and weekend. It isn't as though they are dealing with only a few physicians. There are hundreds of physicians on the medical staff that would require hounding on a daily basis. Actually, with complex cases where there is intense involvement by the hospital discharge planner, there is more predictability than on straightforward cases, where there is rapid response to treatment.

The suggestion that this hospital requirement would level the playing field, since Home Care Agencies and Skilled Nursing Facilities have similar notification requirements is completely absurd. Those agencies and facilities generally have a more predictable patient population and longer lengths of stay. When removing outliers, our Medicare inpatient length of stay is approximately 4 days. What about "inpatient only" procedures that only remain overnight or patients who meet InterQual acute criteria on admission but respond quickly to treatment? Why should they be given a 24-hour notice, when they meet InterQual discharge screen criteria? What happens when the anticipated discharge does not occur on that day? Does the patient get another 24 hour notice?

Instead of implementing a new and redundant process, it would seem prudent for CMS to pay attention to some other glaring Medicare problems, such as Observation Services, which cost hospitals an enormous amount to monitor for compliance. Fifty percent of the Utilization Management staff's time involves Observation tracking. Every time CMS issues a clarification of rules, the process gets worse, i.e., Condition Code 44. Before adding yet another barrier to efficient movement along the continuum of care, it would seem prudent to finally put this one to rest. That can be done by designating all admissions of 24 hours or less as Outpatient/Observation. Another murky area needing attention is self-administered drugs in the Outpatient/Observation setting. Part D didn't help Medicare beneficiaries in this instance.

It's incredible that CMS is proposing to add more red tape to already over-regulated/over-burdened hospitals. Physicians decide discharge, not hospital staff. As with Observation vs. Inpatient, the physician will have no financial incentive to comply. In addition to requiring additional staff to administer, this proposed rule will increase length of stay and inevitably lead to an increase in the cost of healthcare. Furthermore, it's preposterous to believe that hospitals would have the ability to comply with this requirement even a majority of the time.

Today's Medicare population is the most entitled and protected population in the nation. Please consider the ramifications of this proposal.

Very sincerely,

Cam Christensen

Cam Christensen, RN, BS, CPUR
Director of Resource Management

Banner Health®

1441 North 12th Street, Phoenix, AZ 85006
602-495-4000
BannerHealth.com

May 31, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4105–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Comments on Proposed Rule CMS–4105–P, Notification Procedures for Hospital Discharges

On April 5, 2006, CMS published proposed rule CMS-4105-P, which would require hospitals to comply with a two-step notice process when discharging patients. The proposal would require hospitals to deliver a standardized notice of non-coverage to each Medicare beneficiary one day prior to the anticipated day of discharge for any inpatient hospital stay. The beneficiary would be instructed to contact the QIO to request an expedited review if he or she wishes to dispute the planned discharge day, at which point the beneficiary would receive a second, more detailed notice.

Please accept the following comments with respect to the captioned sections of CMS-4105-P, noted below, on behalf of Banner Health.

Provisions of the Proposed Rule

Adverse Financial Impact

Additional cost related to the implementation of the proposed two-step notification process for hospital discharges would be significant for the Banner Health, which operates 20 hospitals in 7 states. Some specific elements of those additional costs:

1. Staffing Costs: Using an estimate of 20 minutes to deliver and explain the notice to each affected Medicare patient, Banner Health will need to employ an additional 10 full time equivalents (FTEs) to handle the proposed notification procedure during normal working hours (Monday through Friday, 8 hours daily). If the same coverage is required during evenings and weekends (which appears to be the case), the FTEs required roughly doubles and the cost is $634,000.

2. Extended Length of Stay: Requests for expedited appeals would be expected to increase with the implementation of the second notice step and would increase the length of stay for these patients. If, for instance, 10% of Medicare patients took advantage of this option, an additional 6,480 hospital days would be used by these patients at an estimated cost of $8.1 million. This increase would result in 18 inpatient beds being filled with patients who would, under current requirements, be discharged. Our hospitals are currently experiencing significant capacity constraints and long ED wait time due primarily to insufficient availability of inpatient beds. This proposal needlessly adds to the capacity challenge.

3. Appeal Related Costs: We expect additional costs associated with the expected increase in appeals activity related to the proposed rule, including, but not limited to photocopy charges of 50 cents per page of the affected medical records as well as fees for courier services to the QIO, Health Services Advisory Group. Furthermore, to prevent delays and unnecessary hospital costs, QIO staff responsible for expedited review would need to be available evenings and weekends, requesting overtime and premium shift pay.

Negative Impact on Patients

The two-step notice process was implemented at our 60-bed Transitional Care Unit in Arizona in January 2006. This experience revealed that patients and families often do not understand the intent of the notice and it serves to generate distrust between the caregivers and the family members.

The decision to discharge is complex. The overwhelming majority of patients and their families are ill-equipped to understand the use/application of medical criteria in making the discharge decision. In addition, it is unreasonable to expect patients to understand the scope and limits of acute hospital care as defined by CMS and other payers. Typically, the only definition provided regarding coverage of inpatient services is "reasonable and necessary".

Unreasonableness of 24 Hour Notice

For patients who are admitted with a medical (versus surgical) diagnosis, it is often very difficult to determine when "24 hours from discharge" will occur:

- In order to determine that the patient is clinically stable for discharge, diagnostic work-up often continues through the last day of the patient's hospitalization, and time must be allotted for receipt of test results to verify the patient's clinical status prior to discharge. In addition, the discharge decision is often a function of gaining the consensus of several treating and consulting physicians, making timing of the discharge very unpredictable with any degree of certainty.

- Physicians are not generally in the habit of providing firm discharge times for their patients even if they have a date in mind (see prior comment). Without this information, it is virtually impossible to comply with the provisions of this proposal.

- A significant number of beneficiaries are incapacitated and have a designated medical power of attorney. Often decisions regarding care are conducted by telephone and may involve family in another state. The logistics of issuing letters are difficult at best in these situations and it is quite possible hospitals will experience unnecessary delays in discharge as a result.

Thank you for providing an opportunity to respond to the proposed changes. Should you need any clarifications or further information, please feel free to contact Paul Dzurinda, System Director of Reimbursement, at 602-495-4157.

Sincerely,

Dennis Dahlen
Senior Vice President Finance

cc: Paul Dzurinda, System Director, Reimbursement
David Bixby, Senior Vice President and General Counsel
John Hensing, Chief Medical Officer

Rush North Shore Medical Center
9600 Gross Point Rd
Skokie, Il 60076

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

June2, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am the Director of Care Management at Rush North Shore Medical Center, a 265 bed, community hospital located in Skokie, Illinois. The number of Medicare discharges from our hospital in CY05 was 6339.

For nearly 7 years I have supervised a team of over 20 employees responsible for discharge planning, bed placement, utilization management and traditional social work. There are five-six Social Workers present M-F, two present on Saturdays, and one on-call on Sundays. Their primary responsibility is for discharge planning, and they execute that responsibility with great ability and comprehensiveness.

The discharge planning process at our hospital begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, a Care Manager (RN) from my department screens every patient for potential discharge needs. This screening occurs within the first 24-48 hours. The Care Manager then refers any patient who passes the screening (more than 80% of our patients do) to a Social Worker who performs a comprehensive assessment of the patient, including focus on such areas as: caregiver issues, living arrangements, financial need (to name just a few). Patients and their families are involved in this assessment process and any subsequent discharge planning activities. The physician, patient and family participate in the selection of any aftercare services that are required or desired. The Social Worker identifies resources/agencies and offers guidance to the patient and family, but the final choice is the patient's. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

The CMS proposed change seems mostly unnecessary since we seem to already have a more than adequate process currently. Implementation of the proposed change would

impact our hospital negatively and I fail to see how it could improve the patient's experience or better address patient's rights. Additionally the proposed change would place a considerable administrative and financial burden to the hospital. We have estimated that the annual administrative cost to deliver the "generic notice" to be $79,237. The cost burden for delivery of the "detailed notice" would range from a $188,268 (conservatively) to $456,408 (a more realistic estimate). These costs would be in addition to the significant financial impact of expected longer lengths of stay as a result of the CMS proposed change.

It has been my experience that the current process for informing Medicare beneficiaries of their appeal rights, and the current process of utilizing Hospital Issued Notices of Noncoverage (HINN) when conflict about discharge exists, encourages appropriate use of hospital services and adequately meets the information and appeal rights of patients. Furthermore, the proposed discharge notice is inconsistent with the timing of physician decision-making, and the hardcopy signature requirements and recordkeeping are at direct odds with CMS efforts to encourage hospitals to adopt electronic health record systems.

I hope that CMS and related agencies will attend to the concerns of clinicians such as myself who have spent their careers caring for patients, putting patients" and their families" needs over all else, while at the same time creating and managing processes for improving quality and efficiency of that care. The proposed CMS change's burdensomeness to hospitals seems to greatly outweigh any potential benefit (if even necessary to exist. I am grateful for the opportunity to express my concerns with you and your time in considering them.

Sincerely,

Barbara Lott Neirick, RN
Director, Care Management
Rush North Shore Medical Center

45

ADVENTIST
HEALTH SYSTEM

June 1, 2006

Mark B. McClellan, M.D. Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, MD 21244-1850

RE: Proposed Rule Code CMS-4105-P

Dear Dr. McClellen:

The referenced proposed rule will have a negative impact upon the hospitals operated by Adventist Health System and most other hospitals. As we note in our attached detailed comments, this rule is duplicative and does not enhance the care or rights of the Medicare beneficiary. There are already existing regulations that are more than adequate to meet the issues raised by CMS. Financially this impact will be much greater than estimated by CMS. What has not been factored by CMS is the additional cost of unnecessary days of care that will be caused by this rule. Using the CMS estimate that 2% of the patients will appeal their discharge under this rule, Adventist Health System Hospitals will incur up to 6939 more days of care at an estimated non reimbursed cost of over $3.4 million dollars. Beyond the monetary impact for busy hospitals, the impact upon patient flow will be significant. Patients are already waiting too long in the emergency department for a bed to become available. This new rule will only add to the problem by artificially increasing length of stay.

This proposed rule is unnecessary, costly and will disrupt the efficiencies of many hospitals. It should be withdrawn.

Sincerely,

Richard E Morrison

Richard E. Morrison
Vice President Government Affairs

111 NORTH ORLANDO AVENUE ■ WINTER PARK, FL 32789-3675 ■ PHONE: 407-647-4400

CMS-4105-P2

Proposed Rule: Notification Procedures for Hospital Discharges

Section 1: Background and Provisions		Review/Comments
I. Background:	In the November 26, 2004 final rule, we left largely unchanged our longstanding requirement that, consistent with § 12.42(c)(3), a hospital must provide a hospital-issued notice of noncoverage (HINN) to any original Medicare beneficiary that expresses dissatisfaction with an impending hospital discharge. Hospitals also continue to be required to deliver the Important Message from Medicare to all Medicare beneficiaries at or about the time of admission.	In addition to the HINN reference, and the reference to the 'Important Message From Medicare' in the background to this proposed rule, there should also be a reference to the existing and long standing rules for Discharge Planning. Social Security Act § 1861 (ee) has been in existence since at least 1988. The Discharge Planning regulations are critical to safety and effectiveness of the transition of patients from one level of care to another. The DCP regulations adequately address the involvement of patients and persons involved in their care in the discharge planning process. The existing standards for Utilization Review also address the issue of patient discharge adequately: §482.30 Condition of Participation: Utilization Review The hospital UR plan should include a delineation of the responsibilities and authority for those involved in the performance of UR activities. It should also establish procedures for the review of the medical necessity of admissions, the appropriateness of the setting, the medical necessity of extended stays, and the medical necessity of professional services. Another existing standard is that of Patient's Rights. The JCAHO standards also contain specific requirements regarding discharge. 2006 JCAHO Provision of Care.15.20 **Comment: There already exists several regulations, that are operational today, that address this very important part of the delivery of care to patients in the acute care setting. The combination of the HINN, found in the Beneficiary Notice Initiative, the Discharge Planning Regulations, Utilization Review, Patient's rights, and the JCAHO standards there is adequate regulation about notifying a patient of his/her discharge status. There is NO need for an additional regulatory requirement.**

II. Provisions of the Proposed Rule	FR pages 17053-17056 Proposed Two-Step Notice Process For these reasons, we are proposing to require hospitals to deliver, prior to discharge, a standardized, largely generic notice of non-coverage to each Medicare beneficiary whose physician concurs with the discharge decision. Timing of delivery: Given the greater volatility of hospital discharge patterns, we propose that hospitals be required to provide the standardized notice on the day before the planned discharge from any inpatient hospital stay.	There is a long standing rule within the Social Security Act § 1961 (ee) – Discharge Planning: (E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative). In The Conditions of Participation (COP-DP) for Discharge Planning (§482.43) there already exists specific references to notification of patients and individuals acting on their behalf. Examples include the following excerpts. *(b) Standard: Discharge planning evaluation .....(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge, and* *(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.* ***c) Standard: Discharge plan.:** (3) The hospital must arrange for the initial implementation of the patient's discharge plan.* *(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.* *(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.* There also already exists in the Section on Patient's rights a requirement that patients have a right to participate in their plan of care: *Patient's Rights: The Patients' Rights CoP (§482.13) does provide the patient the right to participate in the development of their plan of care. Discharge planning is considered a part of the plan of care.* **Comment: Regulations already exist that address the issue of notification of pending discharge to patients and to individuals acting on their behalf.**

		No additional requirement is needed. JCAHO currently monitors compliance with the discharge planning standards in their routine hospital surveys.. **Hospitals actively work with patients/families to ensure that the appropriate resource is available to them at the time of discharge. Capacity constraints require that the patient is cared for at the right level of care, to allow hospitals to continue to care for patients in need of acute medical services.** **<u>Regarding the timing of a notice</u>**: In the 10-1-1987 version of the COP, at that time in Subpart C, Basic Hospital Functions for Quality Assurance in which the new requirements for 'discharge planning' were issued, there is an entry about 'timing'. The rules state that 'discharge planning must be initiated in a timely manner'. *(a) Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.* *(b) Standard: Discharge planning evaluation.* In the Interpretive Guidelines is the statement that reads: *There is no set time frame for identification of patients requiring a discharge planning evaluation other than it must be done as early as possible. The timing is left up to the hospital, its staff, and attending MD/DO.* **Comment:** **Imposing the strict 'timing' of any regulation can cause problems for patients and hospital staff. Short stay patients as well as patients whose physician determines that the patient is ready for discharge that day would not be able to meet the standard of the day before a planned discharge. Also, frequently the attending physician will write an order: "OK to discharge, if OK with --, --, -- consultants". The timing requirement would be a difficult to operationalize due to the many variables of the actual discharge order. Within the existing regulations there is recognition that 'timing' of the application of rules is dependent on what is <u>appropriate</u> for the individual patient.**

Proposed Sec. 405.1205	To implement the changes we are proposing, we would add a new Sec. 405.1205, to require hospitals to deliver a standardized, largely generic notice to original Medicare beneficiaries.	**Comment:** **Based on comments above regarding the numerous regulations already dealing with the topic of notice of discharge, this additional regulation is NOT needed.** **The term 'standardized, largely generic notice' poses an undo burden on both the hospital, the physician and the patient and family. Language barriers, limited English Proficiency, a list of providers to facilitate patient choice of discharge provider, written discharge instructions, a reconciled list of medications (JCAHO safety standard), etc will make the time of discharge even more complicated than it already is. The already overcrowded emergency rooms throughout the country will become more clogged, as hospitals struggle to comply with this day before discharge regulation and any associated appeal process. In addition, more nurses will be required to move into a monitoring role and away from the bedside. In this era of critical nursing shortages, this is not the direction to go.**
Proposed Sec. 405.1206	Proposed Sec. 405.1206 contains the responsibilities of the hospitals, QIOs, and beneficiaries relative to the expedited determination process.	
Proposed Definitions Pertaining to Sec. 405.1206 and Sec. 405.1206 [sic]	Definitions	**Comment:** **The definition of the term 'discharge' in this proposed rule is confusing. Since 'discharge' of a patient from acute care is so highly regulated the term should only be applied to the process of discharging of patients.** **Throughout this proposed rule the phrase: "For any discharge from the inpatient hospital level of care, the hospital must notify the beneficiary in writing of the impending non-coverage and discharge" is used. These are two distinct processes.**

Proposed Sec. 422.620 and Sec. 422.622	To implement these changes for MA enrollees, we propose to replace the existing NODMAR notice and review regulations in Sec. 422.620 and Sec. 422.622 with new regulations substantially similar to the notice and review requirements for HHAs, SNFs, and CORFs under Sec. 422.624 and Sec. 422.626.	**Comment:** **The average length of stay for a Medicare patient in this hospital system was 5.11 days in 2005. The Important Message from Medicare given at admission already addresses how the Medicare beneficiary may access the QIO to question any issue.** **The requirement of an additional letter to the beneficiary 4 days later, on average, would be confusing to the beneficiary as it provides information that they have already received. It also has the potential to interfer with the physician/patient relationship.**
Conforming Changes Proposed to Sec. 489.27 and Sec. 412.42	Thus, proposed Sec. 489.27(b) would specify that delivery of the hospital discharge notices consistent with proposed Sec. 405.1205 and Sec. 422.620 is required as part of the Medicare provider agreement.	

References:

1. Social Security Act § 1861 (ee), Discharge Planning
http://www.ssa.gov/OP_Home/ssact/title18/1861.htm

2. State Operations Manual- Interpretive Guidelines [Discharge Planning- pages 238-250], [Utilization Review- pages 212-220]
http://new.cms.hhs.gov/manuals/downloads/som107ap_a_hospitals.pdf

3. Conditions of Participation for Discharge Planning [Title 42, Volume 3] [Revised as of October 1, 2004]
http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/42cfr482.43.htm

4. Medicare Claims Processing Manual: Chapter 30 - Financial Liability Protections: (Rev. 594, 06-24-05) [HINN}
http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf

MHA

Maryland
Hospital
Association

2006 JUN -5 PM 6:08

June 2, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
200 Independence Avenue SW
Room #314 G
Washington, DC 20201

RE: Medicare Program: Notification Procedures for Hospital Discharges Proposed Notice of Rule Making, CMS-4105-P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)

Dear Dr. McClellan:

On behalf of the 69 members of the Maryland Hospital Association, this letter is written to share our comments and express our strong concerns regarding the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge.

The rule proposes that hospitals deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hard copy of the signed or annotated notice indefinitely.

This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

We believe that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. Further, no compelling case has been made for the need to implement this change. Therefore, the MHA does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process.

6820 Deerpath Road
Elkridge, Maryland
21075-6234
410-379-6200
FAX 410-379-8239

- more -

Our specific concerns with the proposed rule are outlined below:

Physicians, not hospitals, make discharge decisions—

The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation and, for all Maryland hospitals, by the Joint Commission on Accreditation of Healthcare Organizations standards. In both cases, those standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.

It is virtually impossible to know with certainty the discharge date a day in advance—

Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. That determination is based on test results and clinical indicators, such as whether a patient is free of fever. Patients generally know their expected day of discharge (often from before admission in the case of elective admissions), which is then adjusted as necessary to reflect their condition during the discharge planning process. There may be an expected discharge date of Thursday for example, but if the patient develops a fever the evening before, the discharge date will be postponed until that fever is gone.

By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequence—

The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. In some cases, the discharge order might be written the night before, but CMS' proposal requires that the notice be delivered "by the close of business" which is defined as the end of the administrative day. An evening discharge order would not enable a discharge notice to meet that standard, even if staff were available to prepare and deliver it.

To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. With almost 13 million hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would impose a significant burden on hospitals. And for many patients, they would be compelled to stay in the hospital when they want to and are medically able to go home. For patients

awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless—

The proposal would require that the beneficiary or a representative sign a copy of the discharge notice documenting its receipt and their understanding of it. The paperwork clearance package submitted by CMS to the OMB indicates that it must be provided and maintained in hard copy, with no provision for electronic alternatives. Since care and discharge plans must be documented in the patient's medical record, this requirement is unnecessary and counterproductive.

The alarmist language of the proposed generic discharge notice (which was included in the paperwork clearance package) could cause a beneficiary to doubt whether the planned discharge is appropriate—

The notice never mentions that the discharge decision would be based on whether the beneficiary requires hospital-level care, could safely go home, or needs to receive post-acute care in another setting. The notice could lead to requests for more detailed and unnecessary notices and appeals which hospitals and the QIOs would then have to review. The notice focuses solely on a termination of Medicare payment and financial liability for the beneficiary if they do not appeal by noon the day after the notice is received. Also, by repeatedly stressing that the beneficiary can stay in the hospital during an appeal without any financial liability – no matter the outcome of the QIO review – the notice would likely encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based on medical necessity.

The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions—

The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons why services are no longer reasonable or no longer covered by Medicare, and specifically cite the relevant Medicare rule or policy that applies to the beneficiary's case. Direct input from the physician, a resident, or a hospitalist would be required to complete this notice, but they likely would not be able to cite specific applicable Medicare coverage policies — hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria.

The estimated cost and burden of the proposal is grossly understate—

CMS believes to prepare and deliver the generic discharge notice to a patient will take five minutes, but this does not include the time needed to explain the notice or why it must be signed. It also does not reflect the additional time and effort required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent. Nor does it reflect the manpower and capital costs to maintain hard copy files of the signed copy for 13 million or more admissions a year for an indefinite period of time. The most significant cost, however, is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge (as explained above). Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals for the reasons cited above.

For the above reasons MHA is requesting that CMS withdraw the proposal and retain the current requirements. If there are specific issues with the discharge planning process that need to be addressed, we recommend that CMS convene a national work group comprised of hospital, physician, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures affect the various parties, and ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights.

The MHA appreciates the opportunity to comment on this proposed rule. To discuss any questions or reactions to our comments, please do not hesitate to contact me at 410-379-6200.

Sincerely,

Pegeen A. Townsend

Pegeen A. Townsend
Sr. Vice President, Legislative Policy

cc: Melissa Musotto, Centers for Medicare and Medicaid Services
Carolyn Lovett, Centers for Medicare and Medicaid Services

June 5, 2006

Office of Information and Regulatory Affairs
Office of Management and Budget
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P
Room 10235
New Executive Office Building
Washington, DC 20503

To whom it may concern:

I am writing in response to the proposed rule CMS-4105-P Medicare Program, Notification Procedures for Hospital Discharges.

As Director of Social Services at Mary Lanning Memorial Hospital in Hastings, NE for the past 20 years, I have been directly involved with the discharge planning process.

I have serious concerns with the proposed rule, chiefly among them, the significant administrative and financial burdens this would place on hospitals. I believe CMS has completely underestimated the information collection costs and has failed to recognize the financial impact of the proposal on the overall health care delivery system. It is my belief providing a patient specific discharge notice to every Medicare beneficiary will lead to unnecessary and longer hospital stays.

In our hospital the average length of stay is 4.7 days. Since the lengths of stay is short and the patients condition can stabilize quickly, it becomes difficult to predict a discharge one day in advance. Physicians make the decision on discharges not the hospital.

Other issues of concern include:

- The current process adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services.
- The proposed discharge notice used for SNF"s, HHA's and Hospice is not appropriate in an acute care hospital setting.

- The proposed discharge notice is inconsistent with timing of physician decision making and with hospital operations.

- The proposed generic discharge notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources.

- The cost estimates for delivering generic and detailed hospital discharge notices are grossly understated. We would ultimately have to hire more staff to carry out the regulations.

I recommend that these issues be taken into consideration and that any outstanding questions be fully considered prior to making a change of any kind to current hospital discharge notice procedures.

Sincerely,

Pat Kern, MSW
Director Social Services
Mary Lanning Memorial Hospital

June 2, 2006

TO: Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850
Submitted electronically: http://www.cms.hhs.gov/eRulemaking

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted by email: Paperwork@cms.hhs.gov

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P
Submitted by email to: carolyn_lovett@omb.eop.gov

RE: File Code: **CMS-4105-P**
Medicare Program: Notification Procedures for Hospital Discharges
Proposed Notice published in the *Federal Register* of April 5, 2006
(71 FR 17052 – 17062)

These comments are written by Little Company of Mary Hospital in Evergreen Park, Illinois in response to the referenced notice of proposed rulemaking which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process currently used by other service providers, specifically non-acute care.

These proposed changes would place significant administrative and financial burdens on hospitals and beneficiaries. Providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary longer lengths of stays creating additional patient throughput challenges for patients that are in need of acute care hospital services.

Kindly consider the following in regard to this proposed rule:

- There is an already existing process that already informs beneficiaries of their Medicare appeal rights. ("Important Message from Medicare") as well as the Hospital Notice of Non-Coverage (HINN) for patient-specific notices to patients when inpatient criteria is no longer met.
- The proposed discharge notice process used for Skilled Nursing Facilities, Home Health agencies and Rehabilitation facilities is not appropriate for use in an acute hospital setting.
- A generic discharge notice will invite unwarranted appeals as well as longer and unnecessary lengths of stay.
- Generic and detailed hospital discharge notices are delivered hard-copy. The administrative costs to deliver such notices to all Medicare beneficiaries would be substantial. (refer to below for specifics)

The estimate for this hospital to deliver the proposed notices using fiscal year 2005 data, would be as follows:

Annual cost to deliver generic notice	= $ 85,112
Conservative annual cost to deliver detailed notice	= $202,227
Realistic annual cost to deliver detailed notice	= $490,248

There will also be expected longer lengths of stay which are estimated as follows, again using fiscal year 2005 data:

Conservative estimate for expected longer LOS	= $11,999,160
Realistic estimate for expected longer LOS	= $16,239,465

Finally, the issuing of these letters requires staff to witness, document and discuss with patients and families at level of detail that is time-intensive. Additional staffing will be required weekdays and weekends in order to ensure timely delivery of the required notices and adequate explanation of its implications

We thank you for your consideration of these comments as well as the opportunity to respond to this proposed rule. If you need any additional information or have any questions regarding the issues raised in these comments, please contact me at 708-229-5710, e-mail jshere@lcmh.org.

Sincerely,

Joann Shere
Director, Case Management
Little Company of Mary Hospital

June 5, 2006

Centers for Medicare and Medicaid Services
Departments of Health and Human Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850
Submitted electronically: http://www.cms.hhs.gov/eRulemaking

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-41-5-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted by email: Paperwork@cms.hhs.gov

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P
Submitted by email to: Carolyn_lovett@omb.eop.gov

RE: File Code: CMS-4105-P
Medicare program: Notification Procedures for Hospital Discharges
Proposed Notice published in the Federal Register of April 5, 2006
(71 FR 17052 – 17062)

I am writing to express my concerns regarding the above referenced notice of proposed rulemaking, which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process similar to what is currently in place for other Part A providers.

I am currently the Director of Case Management and Social Work Services at Hancock Medical Center; a 25-bed Critical Access Hospital in Bay St. Louis, MS. I have worked in this capacity, at this facility, for twenty-two years. Our facility only recently became licensed as a Critical Access Hospital as a result of significant population changes and damage to our Hurricane Katrina devastated community. Prior to the storm we were a 104 bed acute care facility with an average daily census of 55 patients, average length of stay 4.5 days. Approximately 65% of our patients are Medicare and/or Medicaid

recipients. The majority of them are currently living in FEMA trailers or homes under some form of reconstruction.

After reviewing the proposed rulemaking with our staff we have identified a number of serious concerns including: the administrative and financial burdens this would place on hospitals and the negative impact that would result for both Medicare beneficiaries and non-Medicare patients. It is our belief that providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary and longer hospital stays, thus creating significant throughput issues for hospitals by challenging their capacity limitations and threatening their ability to treat other patients who need acute care services.

We currently deliver the "Important Message from Medicare" to all Medicare beneficiaries at the time of admission, and we provide a hospital-issued notice of non-coverage (HINN) to beneficiaries in the original Medicare program who are dissatisfied with a pending discharge. We believe the current process is a "two-step" process that adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services.

Individual patient discharge decisions are made by the attending physician responsible for the patient's care. The hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharge timely, collaborates with the physician to expedite the discharge process. This inpatient criterion is based on severity of illness, intensity of service, and discharge appropriateness. This clinical criteria is outlined by Interqual or Milliman.

Occasionally, the physician is reluctant to discharge a patient, or the beneficiary or the beneficiary's family, is reluctant to make a decision regarding post-acute care. Beneficiaries and their families have an inherent financial interest in delaying pos-discharge decisions since their out-of-pocket costs are generally greater in a nonacute setting. Our patients have an additional incentive – our patient rooms and services are generally roomier and more comfortable than living in a FEMA trailer. The HINN is an effective vehicle for prompting action by both the physician and the patient/family.

The proposed "two-step" process would require hospitals to deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date where the patient's physician agrees with the discharge. This "generic" notice erroneously indicates that the **hospital** determines that Medicare will not pay for the hospital stay; the **hospital** has determined that Medicare coverage for the hospitalization "should end". The beneficiary would be instructed to contact the QIO if the discharge is disputed. This type of language does not accurately recognize the role of the physician, and it creates an unwarranted barrier in the hospital/patient relationship. Discharge decisions are made by physicians, not hospitals – and they are made based on clinical indicators, not financial.
Although the hospital is working closely with the physician and patient to monitor care and a pending discharge throughout the patient's stay, it is not possible to accurately

identify the date of discharge one day in advance for every Medicare patient. We are also concerned with inadequate staff available at hospitals to deliver the notice. Ideally the notice should be delivered by trained case management staff that are familiar with Medicare regulations regarding notice delivery, appeal rights, and clinical implications. Weekend and holiday staffing would be required to appropriately meet Medicare's proposed one-day notice requirement. Although hospitals understand their responsibilities to be adequately staffed, this is a tremendous challenge when faced with shortages of trained case management staff and limited personnel budgets. The proposed discharge notice process will add at least one additional day to every Medicare stay.

We believe the proposed notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources and jeopardizing the ability of hospitals to meet the acute care needs of other patients. The language of the notice, particularly the repeated references to "an immediate review," will raise doubt in the beneficiary's mind with respect to whether the discharge is appropriate. It basically invites beneficiaries to appeal. Hospitals find that families of some Medicare beneficiaries will take advantage of every opportunity to appeal a discharge decision, especially when there is no financial penalty to do so. It is our belief that the vast majority of the proposed generic notices will be appealed. The reality is that many Medicare patients do not want to leave the hospital, not because they are not medically ready to be discharged, but because the acute hospital setting offers a more emotionally secure and comfortable environment than they will find at home or in a post-acute healthcare setting. Other beneficiaries resist discharge because a bed has not become available in a non-acute setting of their choice (although beds are available elsewhere). Unfortunately the families of some Medicare patients deliberately avoid contact with the hospital during the patient's stay. It could take several hours or days to locate the beneficiary's family. We also anticipate that as a result of Post Katrina stress syndrome many patients will be reluctant to leave the perceived safety of the hospital; particularly if there is a storm in the Gulf.

Finally, we believe that the hardcopy signature and recordkeeping requirements are at odds with federal efforts to encourage electronic medical records. This short-sighted approach fails to recognize the current steps hospitals are taking to implement cost-effective electronic health information record keeping formats and the strong commitment that the current Administration has made to electronic health records.

We recommend that CMS not implement the proposed discharge notice procedures. We believe the current process (providing the "Important Message from Medicare" to all Medicare beneficiaries at the time of admission, and providing a hospital-issued notice of non-coverage (HINN) to beneficiaries in the original Medicare program who are dissatisfied with a pending discharge) meets CMS's intent to keep patient's informed of their rights.

Thank you for the opportunity to review CMS' proposal and to offer comments.

Susan Stevens, Director
Quality Resources Department

Hancock Medical Center
Bay St. Louis, MS 39521-2790

(228)467-8739

GOOD SAMARITAN
HEALTH SYSTEM
The Good Samaritan Hospital

June 5, 2006

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

RE: CMS-4105-P

Dear Sir/Madame:

The Good Samaritan Hospital is in agreement with The Hospital & Healthsystem Association of Pennsylvania (HAP) and the Delaware Valley Healthcare Council of HAP (DVHC) in their position on this matter as follows:

On behalf of Pennsylvania's 225 member hospitals and health care systems, The Hospital & Healthsystem Association of Pennsylvania (HAP) and the Delaware Valley Healthcare Council of HAP (DVHC) welcome this opportunity to comment on the proposed rule in **"Medicare Program; Notification Procedures for Hospital Discharges,"** as published in the April 5, 2006, *Federal Register.*

As published, the proposed rule requires general acute care hospitals, long-term acute care hospitals, rehabilitation hospitals, and other specialty hospitals to provide written notice to Medicare patients (beneficiaries and Medicare Advantage enrollees) of hospital non-coverage decisions and/or hospital discharge on the day before coverage ends and/or the planned hospital discharge. Additionally, the rule provides for an expedited review process through the state's Quality Improvement Organization (QIO). If the patient decides to exercise the expedited review, the hospital and/or Medicare Advantage plan must provide the beneficiary/enrollee with a detailed explanation for the reasons for non-coverage and/or hospital discharge decision. The published rule states that the Centers for Medicare & Medicaid Services (CMS) is proposing these revisions to existing requirements to match the notification and review requirements required of home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and in some circumstances, hospices.

In response to a final rule promulgated under the Benefits, Improvements, and Protection Act (BIPA) for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospices, HAP submitted a comment letter that outlined the burden and operational requirements associated with home health agencies providing advance written notice to Medicare Advantage enrollees and Medicare beneficiaries and detailed notices to Medicare beneficiaries when an expedited review is filed with the state's QIO. It is evident in both this rule and those already promulgated for other service settings

that there is a fundamental lack of understanding on how care is delivered in these settings. HAP's recommendation to CMS in our previous comment letter was that CMS consider implementing the same provisions currently used in hospitals in these other settings—namely to provide a notice at the time of admission for services similar to the "Important Message from Medicare" and to provide information regarding the right for an expedited

review/determination to those Medicare beneficiaries who disagree with discharge from or termination of health care services.

HAP and DVHC, again, believe CMS has proposed an unworkable solution in its attempts to improve the hospital discharge planning process and that the proposed rule fundamentally ignores how care is delivered in hospitals. Hospitals do not differentiate care provided to patients based on financial class. To require a 24-hour notice only for Medicare patients requires these patients to be treated differently during the course of rendering care to all patients on a unit. This is in opposition to other existing federal regulations.

While CMS was well intentioned in proposing this rule in response to concerns raised by consumer advocacy groups with respect to hospital discharge planning processes, this rule will have many unintended consequences for the health care delivery system as a whole and will complicate other critical issues including patient flow, hospital capacity, emergency department crowding, emergency department diversions, and additional dissatisfaction for frontline nurses who will be burdened with more paperwork rather than providing care to patients. Additionally, the proposed rule serves to confuse the terms non-coverage with decisions about hospital discharge.

Detailed operational, financial and other concerns are included as an attachment to this letter. Based on these identified concerns, we recommend the following:

- CMS should maintain its current requirements for hospitals and use a consistent approach for oversight and enforcement of these already existing requirements, including penalties for those facilities that fail to consistently comply with current law and regulation.

- CMS should modify the existing "Important Message from Medicare" to clearly delineate procedures available to patients who disagree with planned discharge from the hospital or a decision made by a Medicare Advantage plan for hospital non-coverage.

- CMS should consider convening a stakeholder group in concert with national hospital associations, key professional groups, and consumer advocacy groups to develop a better perspective of the various constituency group concerns and how best to address these concerns about discharge planning. A review and revision of current hospital discharge planning provisions in the Medicare hospital Conditions of Participation and surveyor interpretative guidelines would be more productive than overlaying these requirements on what is already in existence.

- CMS should establish a pilot/demonstration project to assess the ability for hospitals to comply with the plan for providing critical information regarding discharge and patient rights and responsibilities to Medicare patients.

In the event that CMS decides to proceed with enforcing a process for Medicare Notification Procedures for Hospital Discharges, HAP and DVHC offer the following modifications to the proposed rule for consideration by CMS:

- For Medicare Advantage patients, HAP and DVHC strongly recommend that it be the Medicare Advantage plans' responsibility for communicating information regarding non-coverage. Specifically, we think that Medicare Advantage plans should be responsible for preparing both the Generic Notice and the Detailed Explanation (when necessary) and should deliver such notices to patients. Further, CMS should consider modifying the forms to distinguish between decisions made by Medicare Advantage plans for hospital non-coverage and decisions made by hospitals for patient discharge.

- In light of the workflow in hospitals, HAP and DVHC urge CMS to build flexibility into the requirements for Medicare notification procedures for hospital discharges. We recommend that CMS allow hospitals to deliver the generic notice during the course of care as opposed to 24-hours in advance.

- HAP and DVHC recommend the elimination of the 24-hour requirement for patients who have a length of stay of three days or less. The "Important Message from Medicare" could be revised to make patient rights and pertinent discharge information more visible as previously recommended.

- If CMS' final rule includes the requirement of a 24-nour notice, we recommend that CMS provide for exceptions to the notification requirement such as when a patient requires an emergency discharge to another general acute care hospital for more complex medical/surgical care; emergency transfer from a psychiatric facility to a general acute care hospital for an acute medical problem; and discharge from acute care to a rehabilitation, psychiatric or skilled nursing facility when the general acute care hospital has been waiting for an available bed in one of those facilities.

- CMS also must require the QIO to be available 24 hours a day, 7 days a week so that patients have access to a dispute resolution process.

HAP and DVHC appreciate the interest that CMS has in receiving comments on this proposed rule and believe that CMS has a legitimate interest in ensuring that Medicare beneficiaries have access to an expedited determination review process when they disagree with hospital discharge, termination of hospital services, or when a Medicare Advantage plan determines that the plan will not cover the hospital stay. However, the rule as proposed would create operational problems for hospitals and result in increased lengths of stay that will negatively impact others' access to patient care. Additionally, CMS has not carefully

considered the financial implications of what it is proposing on hospitals or the potentially confusing aspects of mingling decisions made by Medicare Advantage plans about hospital non-coverage versus hospital decisions to discharge the patient in this rule.

HAP and DVHC recommend that the current process should be retained with consideration given to modifying the current "Important Message from Medicare" to make it much more explicit about procedures available to patients who disagree with planned discharge from the hospital or a decision made by a Medicare Advantage plan for hospital non-coverage. HAP and DVHC strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Once again, we are in complete agreement with the views of the aforementioned organizations, and hope that you will give serious consideration to their recommendations concerning this matter.

Sincerely,

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Emerson Hospital

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June 2, 2006

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

Comment to proposed rule change for discharge process: CMS-41050-P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)

The purpose of this letter is to add to concerns expressed by the American Hospital Association. As a patient advocate, having practiced the vocation of nursing for more than 30 years in many different settings, I can see nothing positive in the proposed rule change, and in fact can see extreme hardship both to the providers of care, but more importantly to Medicare beneficiaries.

The stated purpose of this change is standardization of the discharge process, making discharge from the acute hospital setting the same as discharge from the skilled nursing facility or from home care services. However, care delivered in the acute hospital setting varies widely from the other two areas mentioned. Hospitals have been under great pressure to provide continued access to care in light of a great loss of hospital beds over the past 10 years, and increased pressure from consumer driven health care initiatives that have greatly reduced operating margins therefore also reducing available resources. Identifying the appropriate level of care and appropriate utilization of resource management for patients comprises a large commitment by hospitals and on-going, daily challenges to balance the varying needs of very sick patients.

Hospitals are committed to having patients and families participate in their acute care plan and assist in the plan for post discharge needs. These needs may be acute rehabilitation level of care, short term rehabilitation in a skilled nursing facility, on-going acute care delivered in a long-term acute facility, or home with services from a home care agency and/or community services that may be available. Discharge to hospice care is also an important component of discharge planning for appropriate patients.

All of these decisions and choices relate to safe discharge planning as well as facilitating timely and appropriate care during the acute phase of illness in a hospital setting. This requires an enormous amount of patience and skill by physicians, nurses, rehabilitation specialists and social workers, and staff serving in the role of discharge planning or care coordination. This is a population already burdened with forms and paperwork, which they can not understand. Medicare Part D is a perfect example. Now to add to that burden by introducing another form that will need to be explained in detail and add to an already complex process is neither advantageous for the beneficiary or in any way helpful to the hospitals attempting to provide the best quality care available.

Estimating the time of 5 minutes per form is totally unrealistic. Many patients do not have family members available to act as Health Care Proxies and many of these same patients are not able to make decisions on their own. The added burden and time of using faxes and/or return receipt mail to obtain needed signatures is horrifying at best.

The added Length of Stay that hospitals will experience will result in both hospitals unable to provide adequate access for patient care, and those with minimal margins no doubt will be forced to close, again negatively impacting much needed access to care for the ever growing Medicare population. There will no doubt be an increase in Emergency Department overcrowding and need to be on diversion. Most importantly, this new proposal will force Medicare beneficiaries to utilize their benefit for administrative purposes rather than the medical necessity for which it was originally designed.

I fully support the AHA recommendations that the current notices and procedures be retained until need for revisions are clearly established and more workable, and less burdensome approaches are developed.

Mary Lou Cunningham, RN, MS, CCM
Director, Social Work and Care Coordination
Emerson Hospital/Emerson PHO
133 ORNAC
Concord, MA 01742

June 5, 2006

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

RE: Medicare Program: Notification Procedures for Hospital Discharges Proposed Notice of Rule Making, CMS-4105-P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,800 member hospitals and health care systems, and 35,000 individual members, appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

The AHA believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. Also, there has been no compelling case for the need to implement this change. Therefore, the AHA does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process.

This letter includes our specific comments on the proposed rule and addresses several issues.

- The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns.

- The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.

- The hardcopy signature and recordkeeping requirements are counter to hospitals' movement to electronic medical records and federal efforts that encourage an even faster conversion.

Background

The notice states that CMS developed the current two-step notice process for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices largely in response to litigation involving Medicare managed care enrollees who were unaware of benefit and coverage limitations in these settings. The notice also states that CMS wishes to implement the same two-step process for Medicare hospital inpatients.

Hospitals already follow a two-step process for notifying Medicare beneficiaries of their appeal rights by providing the IMM at admission and a detailed notice when a beneficiary believes he or she is being asked to leave the hospital too soon. This new notice would create a three-step process. For an average Medicare length of stay of six days, a three-step process is unreasonable. Congress required the IMM so that beneficiaries would know their discharge rights at admission and in anticipation of "quicker and sicker" discharges under the inpatient prospective payment system (IPPS) – an expectation that did not materialize. Furthermore, the timing for hospital discharges and, therefore, the potential subject of an appeal or Quality Improvement Organization (QIO) review, generally concerns the length of the beneficiary's stay related to medical necessity, not availability of hospital benefits.

Provisions of the Proposed Rule

The rule proposes that hospitals deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hardcopy of the signed or annotated notice indefinitely.

There are several problems with the proposed approach.

- *Physicians, not hospitals, make discharge decisions.* The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation and, for most hospitals, by the Joint Commission on Accreditation of Healthcare Organizations standards. In both cases, those standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.

- *It is virtually impossible to know with certainty the discharge date a day in advance.* Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. That determination is based on test results and clinical indicators, such as whether a patient is free of fever. Patients generally know their expected day of discharge (often from before admission in the case of elective admissions), which is then adjusted as necessary to reflect their condition during the discharge planning process. There may be an expected discharge date of Thursday for example, but if the patient develops a fever the evening before, the discharge date will be postponed until that fever is gone.

- *By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences.* The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. In some cases, the discharge order might be written the night before, but CMS' proposal requires that the notice be delivered "by the close of business" which is defined as the end of the administrative day. An evening discharge order would not enable a discharge notice to meet that standard, even if staff were available to prepare and deliver it.

  To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost 13 million hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would impose a significant burden on hospitals. And for many patients, they would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased

emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

The AHA recommends that CMS withdraw the proposal and retain the current requirements. If there are specific issues with the discharge planning process that need to be addressed, we recommend that CMS convene a national workgroup comprised of hospital, physician, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures affect the various parties, and ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights.

Collection of Information and Recordkeeping Requirements
The notice's language and the process for preparing, delivering and documenting receipt are problematic. Some of the troubling requirements are spelled out in the proposed regulation and others in the paperwork clearance package sent by CMS to the Office of Management and Budget (OMB). Those issues include:

- *At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless.* The proposal would require that the beneficiary or a representative sign a copy of the discharge notice documenting its receipt and their understanding of it. The paperwork clearance package submitted by CMS to the OMB indicates that it must be provided and maintained in hard copy, with no provision for electronic alternatives. Since care and discharge plans must be documented in the patient's medical record, this requirement is unnecessary and counterproductive.

- *The alarmist language of the proposed generic discharge notice (which was included in the paperwork clearance package) could cause a beneficiary to doubt whether the planned discharge is appropriate.* The notice never mentions that the discharge decision would be based on whether the beneficiary requires hospital-level care, could safely go home, or needs to receive post-acute care in another setting. The notice could lead to requests for more detailed and unnecessary notices and appeals which hospitals and the QIOs would then have to review. The notice focuses solely on a termination of Medicare payment and financial liability for the beneficiary if they do not appeal by noon the day after the notice is received. Also, by repeatedly stressing that the beneficiary can stay in the hospital during an appeal without any financial liability – no matter the outcome of the QIO review – the notice would likely encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based on medical necessity.

- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the

hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons why services are no longer reasonable or no longer covered by Medicare, and specifically cite the relevant Medicare rule or policy that applies to the beneficiary's case. Direct input from the physician, a resident, or a hospitalist would be required to complete this notice, but they likely would not be able to cite specific applicable Medicare coverage policies; hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria.

- *The estimated cost and burden of the proposal is grossly understated.* CMS believes to prepare and deliver the generic discharge notice to a patient will take five minutes, but this does not include the time needed to explain the notice or why it must be signed. It also does not reflect the additional time and effort required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent. Nor does it reflect the manpower and capital costs to maintain hard copy files of the signed copy for 13 million or more admissions a year for an indefinite period of time. The most significant cost, however, is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge (as explained above). Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals for the reasons cited above.

We believe this price is too high just to ensure consistency with requirements designed for very different operating environments. If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice. If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. More paperwork does nothing to improve care – it simply consumes resources that would be better devoted to direct patient care. **The AHA recommends that the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.**

June 1, 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

RE: CMS-4105-P

Dear Sir/Madame:

As Director, Care Coordination/Utilization Management for Chambersburg Hospital, I welcome this opportunity to comment on the proposed rule in "**Medicare Program: Notification Procedures for Hospital Discharges**," as published in the April 5, 2006, *Federal Register*.

As published, the proposed rule requires that hospitals provide written notice to Medicare patients (beneficiaries and Medicare Advantage enrollees) of hospital non-coverage decisions and/or hospital discharge on the day before coverage ends and/or the planned hospital discharge. Additionally, the rule provides for an expedited review process through the state's Quality Improvement Organization (QIO).

I believe that this proposal is an unworkable solution in its attempt to improve the hospital discharge planning process and that the proposed rule does not account for the actual process by which the care is delivered in hospitals. In our facility, provision of care is not differentiated based on the financial class or status of the patient. To require that only patients with Medicare/Medicare Advantage be given a 24-hour notice prior to discharge constitutes their being treated differently during their course of treatment as compared to all of the other patients on their unit. This would be in opposition to other existing federal regulations.

This rule will have numerous "domino" effects and consequences for the entire health care system as a whole, and will cause other issues to arise to a critical nature, which as a sytem, we have been trying to address and resolve. This would include:

- the delay in patient flow, due to possible filling of Medical/Surgical beds with patients who, due to the appeal process, would stay unnecessarily an additional day (or possibly longer based on the QIO turnaround time and available staff); the domino effect would occur with more patients being held in the post-critical care units, intensive/cardiac care units, or emergency departments, possible delays in elective surgeries, etc.
- emergency department crowding and overflow, with potentially unnecessary emergency department diversions
- additional manpower needed to ensure compliance due to the large amount (47%) of Medicare eligible patients that we admit, as well as, additional supplies and

material resources needed to care for the patients if the length of stay is increased due to the 24-hour requirement and possible appeal process.

- additional dissatisfaction for frontline nurses, especially on the "after-normal working hours" shift, who will be burdened with more paperwork rather than providing care to the patients
- confusion regarding terms of "non-coverage" with decisions related to hospital discharge, as would occur with the Medicare Advantage population
- confusion in receiving the additional discharge notice, along with the notice at time of admission, if the patient has a short length of stay, or receipt of more than one discharge notice if the patient's condition changed and additional length of stay was medically necessary
- problems in compliance of the 24-hour rule based on the impromptu bed availability notice by a tertiary facility, psychiatric or rehabilitative facility, or skilled care facility; if the bed is not accepted when offered, the bed may not be held for that patient, so the patient's ability to receive the care needed may be affected or delayed even longer, which could be detrimental to the patients' well-being and recovery

The following options are recommended:

- CMS should maintain its current requirements for hospitals and use a consistent approach for oversight and enforcement of these existing requirements.

- CMS could modify the existing "Important Message from Medicare" to clearly delineate procedures available to patients who disagree with their planned discharge from the hospital or as a result of a decision made by a Medicare Advantage plan, especially if the patient's stay is 3 days or less.

- If it is deemed essential for any changes to be made, the time frame for the generic notice to be delivered should be during the course of the hospitalization, as opposed to 24-hours in advance.

In summary, the rule proposed would have a negative impact on patient care, patient access and appropriate bed utilization, as well as, affecting numerous operational issues, related to distribution of the notice and all aspects involved with the completion of the appeal process, as well as, the increased length of stay and resulting consequences affecting manpower, materials and supplies, etc. Additionally, the potential confusion that this additional notice may cause when different decisions occur between the Medicare Advantage plan versus the hospital's decision to discharge the patient must be considered.

Thank you again for this opportunity to comment on the proposed rule.

Sincerely,
Patricia McCulloh RN, MSN
Patricia McCulloh, RN, MSN

Temple University Health System

Howard R. Grant, J.D., M.D.

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June 1, 2006

Mark B. McClellan, M.D., Ph.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-4105-P; Notification Procedures for Hospital Discharges; Provisions of the Proposed Rule

Dear Dr. McClellan:

On behalf of the Temple University Health System, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule covering Notification Procedures for Hospital Discharges, as published in the April 5, 2006 Federal Register.

We agree with CMS that a standardized, generic notice of non-coverage is helpful to Medicare Beneficiaries and Medicare Advantage enrollees (collectively "Beneficiaries"), and that all Beneficiaries who are hospital inpatients should be afforded the same notice, expedited review and appeal rights as other Beneficiaries receiving treatment from non-hospital providers. Nonetheless, we believe the proposed rule underestimates the administrative burden on hospital providers.

CMS estimates that it would take hospitals 5 minutes to deliver each notice of non-coverage to Beneficiaries. While this might be sufficient time to deliver the notice, it is far more time consuming to communicate the determination to the patient, answer questions, ensure that the patient understands his or her rights, and have the patient sign the notice. Given the language barriers, age of the population, dependency on children or significant others to support decision making and other factors representative of the patients we serve, we estimate that the actual time could range from 15 to 30 minutes.

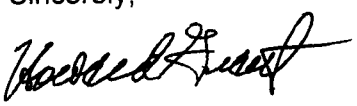
Moreover, the delivery of this notice prior to discharge is placing the discussion at the wrong time in the discharge planning process. Unless the patient has a length of stay of less than 3 days, we recommend that hospitals deliver the notice within 48 hours of admission. This will enable open communication for discharge planning, and assist in the understanding their rights as Beneficiaries. The early notice will enable discussion at both the patient level with their family and at the hospital level in establishing the plan of care for discharge. This timeframe would foster a more open dialogue and help avoid miscommunication and misunderstanding.

Furthermore, we believe that the proposed rule, with its 24-hour notice provision could lead to increased length-of-stay. By providing discharge notice at an earlier stage, providers are better able to manage discharge discussions and avoid unnecessarily extended patient stays.

CMS also projects that 2% of Beneficiaries will request an expedited review of the discharge determination, and that it would take hospital providers and Medicaid plans 60-90 minutes to prepare a case file for the Quality Improvement Organization (QIO). Given that hospitals and physicians bear the burden of showing that services are no longer reasonable or necessary, we believe that it would take 90-120 minutes to organize the medical record and accurately dictate and transcribe physician summaries. In addition to the increased time to prepare the files, providers must also incur the cost of record duplication, courier services and tracking of outcomes from the QIO.

For these reasons, we urge the Centers for Medicare and Medicaid Services to reconsider its proposed Notification Procedures for Hospital Discharges, and to incorporate our concerns into the final rule. Again, thank you for the opportunity to comment.

Sincerely,



Howard Grant, J.D., M.D.
Chief Medical Officer

CC: Melissa Musotto, CMS Regulations Development Group
Carolyn Lovett, CMS Desk Officer

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June 2, 2006

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Department of Health and Human Services
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Baltimore, MD 21244-1850

Centers for Medicare and Medicaid Services
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Office of Information and Regulatory Affairs
Office of Management and Budget
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Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

RE: File Code: **CMS-4105-P**
Medicare Program: Notification Procedures for Hospital Discharges
Proposed Notice published in the *Federal Register* of April 5, 2006
(71 FR 17052 – 17062)

Summary of Comments

Mt. Sinai Hospital in Chicago is a safety net hospital that serves an extremely impoverished community. Many members of our patient population have overwhelming social issues, which include: broken and disconnected families; transience of housing and lack of telephone numbers (which we use to try to find family members); and the sheer poverty of the families which itself creates an incentive for prolonging a stay in a situation where care, food and shelter have no cost to the patient.

A large number of our Medicare patients come from nursing homes with all of the medical issues common in that population, especially dementia. Because of this, we apply for many more guardianships than does the typical hospital, and that is only done after exhaustive attempts which take many days are made to find family members. The whole process prolongs the stay of patients. We also issue more HINN letters (or the equivalent document for other payers), as we find that substantial

numbers of our patients desire to prolong their stays beyond the time of medical necessity, probably because the hospital environment makes them feel more secure than the environment from which they came.

We also have a large number of recent immigrants in our population. Most of these patients are either non-English speakers or are so insufficiently fluent in English that extensive explanation time and/or translation services are mandatory. Delving a Part I notice to such a patient takes far longer than the 5 minutes estimated in the proposed regulation.

The wording of the Part 1 document makes it most attractive for the patient to appeal and prolong his or her stay. Combine this wording with the incentives previously described which the patients already have to artificially prolong their stays produces a situation where we anticipate that a very large percentage of the patients will exercise this appeal right. The proposed regulations estimate of 2% is extremely understated.

We already have many processes in place to notify patients of their progress through their stay and of their nearing discharge date. All Medicare patients are given the "Important Message from Medicare" on admission. Physicians are given a form as a part of the admission packet and asked to project the patient's discharge date at the time of admission. Illinois has a law and our physicians have been informed that they need to give Medicare patients 24 hours notice of the intent to discharge (assuming all the last minute pieces fall into place) and to document this conversation in the medical chart. They are also directed to have this discussion with family members, in the case of a frail older person or one who is not mentally competent, and this occurs when the family can be found and they return telephone messages left for them.

There is already an effective, two-part process in place relating to discharges. The process described in the proposed regulation involves may factors that are outside of the hospital's (or physician's) control, will be both operationally and financially difficult to implement, and will not be any more effective in granting patient's their lawful protections that the processes currently in place. Getting signatures from hard-to-find family members is difficult and expensive; guardianships a time consuming and expensive.

We estimate, with our patient population, that the Part 1 process will take 30 minutes on the average (a very conservative estimate considering that many of these cases will need translator services). The estimate in the proposed regulation was 5 minutes. At $12.50 per case this would mean an unreimbursed financial burden to Mt Sinai Hospital of at least $37,500 per year based on our approximately 3000 Medicare admissions per year.

The detailed notice would cost at least $89,100 - $216,000 based on 33% - 80% of the patients using the opportunity to prolong the stay at no cost to them by requesting an appeal; local experience with HINN letters suggests the higher number is the more probable estimate.

But the biggest cost by far, and will hit our safety net hospital disproportionately to suburban hospitals, is the cost of the unreimbursed prolonged stays while the hospital tries to find a family member and get them to return a call and show up at the hospital to sign the notice on behalf of the elderly Medicare patients with dementia. Or in the case where this responsible person cannot be found after diligent search, to then start the application for guardianship (at the cost of about $5,000 per case) in order to

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have someone to sign the Part 1 discharge notice. If the 33%-80% of the patients appeal and add only one day to their length of stay, the cost in unreimbursed additional length of stay (based on $1000 cost per day) of the additional one day for our population would be between $3.9 – 5.4 million dollars. However, given the unusual circumstances of our Medicare inpatient population, the search to find families and do guardianships would add much more than a single day to a significant portion of our Medicare discharges (perhaps 20% of the total). The resultant cost would double or triple the above estimate.

We urge you to allow the processes that are currently in place, described above, to remain in place for the Medicare population, and to keep in place the existing HINN letter structure in order both to protect the rights of the patients and to allow the hospital a means of accomplishing a timely discharge when the hospitalization needs of the patient have been fully met.

Sincerely,

Larry E. Volkmar
President,
Hospital Divisions

LEV:js

Cc: Kathryn Stewart, M.D.