Submitter:

Ms. Barbara Neirick Neirick

Organization:

Rush North Shore Medical Center

Category:

Nurse

Issue Areas/Comments

GENERAL

GENERAL

see attachment.

Page 227 of 237

June 05 2006 02:30 PM

Date: 06/02/2006

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter:

Ms. Lyssa Wieland

Organization:

Eden Medical Center

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL.

While your stated goal may be to provide patients with their Medicare rights at discharge the fact is the result will be to increase health care costs, divert needed issue and you will have simply created more bureaucracy.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

II. Comments on the requirement that the notice be given the day before discharge:

Acute hospital patient stays do not have the predictability needed for this process. The patient's medical condition may appear to be improving only to take a turn for the worse. The patient who is doing poorly may make a sudden recovery. Your idea that a patient, especially a senior, will have a predictable consistent course is a clear indication that you have not been involved in the care of these patients. There is also the factor that many of these patients will be transferred to skilled nursing facilities or need home care. There is no guarantee of when these external providers will accept the patient.

III: Collection of information requirements: Comments on the estimation that it would take hospitals 5 minutes to deliver each notice: Several years ago the same time was referenced for issuing a NODMAR. Issuing the letter never took less than 15 minutes AT BEST! To begin with, the letter must be individualized. That alone would take 5 minutes. Secondly, when you enter the patient's room you have to get the patient up in the bed to read it, you need to be sure they can hear and understand English. You then try to go over the letter but the patient wants to discuss problems she had with dietary, the nursing care, the temperature in the room. After you have that settled, you start on the letter. The patient is nervous about signing so now you've been asked to call a family member about it. I wish I could say this is an unusual setting but it is what we experienced with the NODMARs. The other issue is that patients can be discharged 24/7 and there isn't Case Management coverage 24/7. Nursing staff should not be made responsible for explaining benefits.

Comments on the economical impact estimated at \$5200 per provider: At Eden Hospital we 3153 Medicare discharges in 2005. The economic impact on our hospital is well beyond your calculation. It is at least \$40,000 and that is if it only took 15 minutes.

Date: 06/02/2006

Submitter:

Organization:

Category:

Health Care Professional or Association

Issue Areas/Comments

Background

Background

"See Attachment"

GENERAL

GENERAL

"See Attachment"

Provisions of the Proposed Rule

Provisions of the Proposed Rule

"See Attachment"

Regulatory Impact

Regulatory Impact

"See Attachment"

CMS-4105-P-2282-Attach-1.DOC

Date: 06/03/2006



May 26, 2005

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

RE: Proposed Rule Related to Notification Procedures for Hospital Discharges File Code CMS-4105-P

To Whom It May Concern:

We are writing on behalf of the Utilization Management Committee for UNC Hospitals in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. UNC Hospitals is a 708 bed teaching facility that serves all residents of North Carolina. We do not support the proposed rule.

Our current discharge planning practices begin at the time of admission when patients are provided the *Important Notice from Medicare* during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, case managers assess all patients who may need post-acute services or who may be at risk for discharge delays. Patients and their families are involved in discharge planning activities and given a choice of providers for post acute services. Our process also includes ample opportunity for patients and families to consider all options, and if in disagreement with the discharge decision, to appeal the decision to the Carolinas Center for Medical Excellence, the Quality Improvement Organization (QIO) for North Carolina.

We believe the proposed rule will first and foremost erode trust between a patient and his or her provider. For many patients, the notice may give them the impression that they may ask for an extension of stay without any understanding of medical necessity. This has the potential of resulting in an adversarial situation where providers and patients are no longer communicating about care, but rather communicating about the transfer of financial liability from Medicare to its beneficiaries.

The CMS proposed change places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. If a signature is required and the patient is not the decision maker, it can take at least an additional day to obtain the signature of the patient's decision maker. An appeal by a patient would have to await review by our QIO. Currently, the appeal for a HINN can take up to three days. Anticipating an increase in appeals if all beneficiaries are to receive a discharge notice, one would have to question the ability of our QIO to



respond in a timely manner. We surmise the state QIOs are not positioned to respond quickly to the increased workload the proposal will generate.

In addition, a 24 hour discharge notice also poses a risk to patient access. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult for a provider to predict a discharge one day in advance. The proposed rule will prolong the duration of Medicare inpatient stays at a time when our facility is already working aggressively to ensure access to all residents of North Carolina when they require an inpatient admission.

In summary, the proposed rule would place a tremendous burden on hospitals. Many hospitals are challenged by space and personnel shortages. The potential back log of patients in emergency departments and surgical recovery areas in hospitals operating at or near capacity can only have a detrimental effect on patient flow and ultimately, patient care. This is contrary to Joint Commission on Accreditation of Healthcare Organizations, 2006 Hospital Accreditation Standard LD.3.15, that requires leaders to develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.

Several regulations already exist, that if applied appropriately, address this very important aspect of discharge notification to patients in the acute care setting. With the combination of the Hospital Issued Notice of Non-Coverage found in the Beneficiary Notice Initiative, the Discharge Planning regulations, the Utilization Review and Patient's Rights Conditions of Participation, there is adequate regulation about notifying a patient of his/her discharge status. There is no need for an additional regulatory requirement.

We appreciate the role of CMS in safeguarding patient rights. However, we feel compelled to ask you to abandon this proposal and continue to place your efforts into projects that will improve the quality and efficiency of healthcare nationwide.

Sincerely,

Dr. Mitchell Wilson, MD Medical Director Clinical Care Management Chair, Utilization Management Committee

Janet Hadar RN, MSN, MBA Director Clinical Care Management Co-chair, Utilization Management Committee

Submitter:

Mr. Wayne Wasden

Organization:

Saint Agnes Medical Center

Category:

Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The implementation of this proposal will be very detrimental to patients and to the hospitals where they receive care.

LOS will be extended in many cases and patients will be subjected to the risks attendant with being the inpatient setting.

The additional expense of the appeal process and exended LOS will be much much larger than CMS has estimated.

Date: 06/03/2006

Submitter:

Ms. Bonny Sorensen

Organization:

Ms. Bonny Sorensen

Category:

Health Care Professional or Association

Issue Areas/Comments

Background

Background

42 cfr parts 405,412,422 and 489 cms-4105-p rin 0938-an85

GENERAL

GENERAL

this rule will not be cost effective but will be a huge economic burden to smaller hospitals

Provisions of the Proposed Rule

Provisions of the Proposed Rule will have a negative impact on small hospitals

CMS-4105-P-2302-Attach-1.TXT

Date: 06/03/2006



June 5, 2006

Woodward Regional Hospital 900 17th Street Woodward, Ok 73801

Mark McClellan, M.D., Ph.D. Administrator Centers for Medicare & Medicaid 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:

Woodward Regional Hospital in Woodward , OKlahoma 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 one day before their discharge. This new notice would be **in addition to** the following existing communications:

- The" Important Message from Medicare" (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and
- The more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

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.
- The additional costs that hospitals will incur as a result of increased lengths of stay that will come about if this proposed rule is implemented.

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.
- It is virtually impossible to know with certainty the discharge date a day in advance.
- 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
- To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care.
 - Our hospital is paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. We have approximately 79% of our admissions are Medicare hospital admissions, an extra inpatient day for each admission at an approximate cost of \$1,000 per day would increase our cost of care for Medicare patients approximate\$1.9ml_____.
 - Many patients 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.

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 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 language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.
- The estimated cost and burden of the proposal is grossly understated.
 - o CMS has not realistically estimated:
 - the time necessary to prepare and deliver the generic discharge notices,
 - time needed to explain the notice or why it must be signed,
 - the additional time required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent,
 - the manpower and capital costs to maintain hard copy files of the signed copy for our hospital's 1,909 Medicare admissions each year and to retain these hard copies 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). At a conservative estimate of \$1,000 per day, we estimate the cost to our hospital at \$1.9ml per year.
 - Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals.

Woodward Regional Hospital 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.

- 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.

Woodward Regional Hospital appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me at (580) 254-8429 or bonny. Sorensen@triadhospitals.com

Sincerely,

Bonny N-J Sorensen
Chief Financial Officer

Submitter:

Ms.

Date: 06/04/2006

Organization:

Ms.

Category:

Individual

Issue Areas/Comments

GENERAL

GENERAL

I am not in favor of this rule. Patients in acute care settings have frequent changes in their medical status and treatment needs, and often discharge is hard to predict very far in advance of the actual morning of discharge. Under those conditions, how would a hospital know when to issue the notice? I believe that this rule would place an administrave burden on Hospital staff, who would have to issue the notice.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Page 232 of 237

June 05 2006 02:30 PM

Submitter:

Ms. Mary Glamann

Date: 06/04/2006

Organization:

Providence Kodiak Island Med Ctr

Category: Other Health Care Professional Issue Areas/Comments

BackgroundBackground

Patients are currently made aware of their appeal rights with the Important Message from Medicare received at admission and those who refuse to be discharged either already know their rights or are made aware of them immediately. This new process actually encourages the patient to question the ethics and thought process of their physician. There is no need for this change in a process that is currently effective and working. I do not believe that a small hospital should be responsible for the \$7000.00 estimated annual cost of implementing this process when the process currently in place is working. Our small facility currently experiences a LOS of 2.69 days. To place an additional financial burden on our facility would reduce cash flow and become more labor intensive to a small department.

Please reconsider your proposal leave the process in place that is working.

Sincerely,

Mary Glamann, RHIT, CCS

Submitter:

Dr. Edward Reshel

Organization:

Medical Associates.

Category:

Physician

Issue Areas/Comments

GENERAL

GENERAL

The proprosed rule change would not aid but might even hamper the patient discharge process. It would be ludicrous to expect that all discharges times would be predicted within 24 hours. Many patients would like to be dischargesd as soon as they are ready. When lip service is being paid to cost effectiveness in medical care; the additional cost burden this proposed regulation entails is much too onerous. Please do not enact this redundant and costly regulation.

Date: 06/04/2006

Submitter:

Dr. Robert McManus

Date: 06/04/2006

Organization:

CTSG

Category:

Physician

Issue Areas/Comments

GENERAL

GENERAL

As a physician I am completely responsible for all aspects of hospital care for my patients. Hospital discharge is a decision I make jointly with the patient when the time comes that further hospitalization is not in their best interests. Frequently that decision can not reliably be made 24 hours in advance. Any requirement that leads to a patient spending one more minute in a hospital beyond what is medically justified is wrong and is an abrogation of my patients' rights to health care decisions made in their best interests.

Submitter:

Mrs. Judy Rogers, RN

Date: 06/04/2006

Organization:

Providence Kodiak Island Medical Center

Category:

Nurse

Issue Areas/Comments

Background

Background

Providence Kodiak Island Medical Center is a small Critical Access Hospital (the only hospital on the island) serving approximately 15,000 people. As a registered nurse I am opposed to the Proposed Rule: Notification Procedure of Hospital Discharges for the following reasons; this rule would create a hardship for hospital personnel already stretched to their limits; it would add unnecessary costs to our financially burdened critical access hospital; it would create confusion and hardships for the Medicare beneficiaries it is supposedly trying to protect.

The CMS estimated of the time of 5 minutes to issue a notification 24 hours prior to an acute inpatient discharge is flawed. Preparation time alone for the discharge planner or case manager is closer to 10 minutes, delivering the letter another 10 minutes, explaining the letter to the patient perhaps 15 minutes, explaining the letter to a family member who is concerned that their loved one is being discharged too soon another 30 minutes. Nursing staff and physicians in addition to discharge planners and case managers would need to be well versed in the entire process, in order to answer the many questions this seemingly simple peace of paper would create. The frustration of nursing staff having to answer questions about the process after business hours or on weekends (PKIMC does not have discharge planners or case managers evenings or weekends) would stress already overworked professionals who need to concentrate on patient care.

The increased cost in staff training and staff time to issue these notices is an undue burden to a small critical access hospital like PKIMC. PKIMC is a critical access hospital with an average inpatient stay of 2.6 days. Attempting to issue a notice 24 hours prior to discharge would be difficult. Would CMS have us issue a notice upon admit in case the Medicare beneficiary is discharged in 24 hours? Are we to hold the patient an extra few hours or even a day so we can comply with the 24 hour prior to discharge rule? Staff retention in patient care areas is already low; addition of this rule would increase staff turnover and would place a greater financial burden on small hospitals serving an increasingly growing Medicare population.

When a Medicare Beneficiary is admitted to the hospital they are given the Important Message from Medicare, which already provides them with information about their rights. Hospitalized, Medicare Beneficiaries are already stressed as are their family, when this notice is issued. Will the patient and family question the validity of their discharge? Will they demand to stay longer not following the proper appeal process and be burdened with a large hospital bill? Would this not increase the length of stay for the critical access hospital limit of 96 hours and increase the cost of health care overall?

In closing, I appeal to CMS to rethink issuing these notices and to think about the impact this rule would place on small critical access hospitals like PKIMC which are providing health care in rural areas where staffing is difficult, and the cost of providing staff and supplies is costly.

Submitter:

Mrs. Marla Pearson

Organization:

Newman Regional Health

Category:

Social Worker

Issue Areas/Comments

Background

Background

See comments under 'Regulatory Impact'.

GENERAL

GENERAL

As a hospital social worker with discharge planning responsibilities, I wish you could go with me for a month to give out notices such as this. It is just too difficult to explain the impact of these paperwork requirements and the reaction of many of the patients without seeing it yourself. A minority of the patients find it informative and helpful. The MAJORITY of the patients, especially the very elderly, find it upsetting. Those of us who are supposed to be in a position to help patients have instead become people who 'push papers', and the patients don't see that as a helpful or worthwhile service. Some of the patients even get angry at having to sign papers, which then makes it difficult to work with them cooperatively. We're spending more time getting the paperwork right and less time on actual patient care. THIS IS NOT A VALUE-ADDED PROCESS, and has the potential to further increase medical costs and upset patients.

Regulatory Impact

Regulatory Impact

- 1. You SERIOUSLY underestimate the amount of time this will take. Since I already give out SNF HINN letters I can tell you the process would take AT LEAST 30 minutes per patient IF everything goes well. You have to: get the paperwork ready, find the patient in their room and not busy (not getting a bath, working with Physical Therapy, in x-ray, talking with visitors from out of town, sleeping, vomiting, etc.), explain the letter, answer their questions, call their family member if they ask you to and explain it to them or come back later when the family arrives and explain it to them, have the patient sign the letter (some of them struggle with writing, some have been cautioned not to sign anything so they start to not trust you, some of them want their family to sign it when they get off work or get in from out of town), then you need to make and distribute copies. Then there is also the time spent by the organizations who audit the accuracy of the notices. THIS IS A PAPERWORK REQUIREMENT WITH NO PATIENT VALUE ADDED. IN FACT, IT TAKES TIME AWAY FROM DIRECT PATIENT CARE AND CAN CREATE AN UNNECESSARY AND STRESSFUL ADVERSARIAL RELATIONSHIP. And we haven't even talked about what process there would be to 'rescind' the notice if the patient doesn't get dismissed the day they are supposed to.
- 2. There are already processes in place to inform patients of their appeal rights. Medicare patients receive the Important Message From Medicare, and can be issued a HINN letter if the patient and/or physician disagree with a pending dismissal.
- 3. A hospital dismissal is based upon many factors coming together, such as diagnostic test results, improved lab results, etc. Just as we would not be expected to dismiss a patient on a certain day just because they have been told that is when they will probably be dismissed, you can't expect the Dr and hospital to always know a day before dismissal that the patient will be ready for discharge the next day.
- 4. This has the potential for further interference in the doctor/patient relationship.
- 5. The number of letters to be rescinded would be high.
- 6. In some cases this would add a day to the length of stay.
- 7. Discharge planning is already a requirement. Letting patients know about impending dismissal, when we know, is already part of the discharge planning process. But even some patients we've tried to prepare for dismissal 3 to 5 days ahead of time feel that's short notice and that they are 'being kicked out' of the hospital. Giving one days notice, especially when that notice can often be uncertain, is not going to help that process much.
- 8. PAPERWORK REDUCTION ACT! This is SO inconsistent with attempts to REDUCE paperwork. Patients are already overwhelmed with massive amounts of paperwork. This DOES NOT add value to patient care.

Date: 06/04/2006

Submitter:

Mrs. Sonya Mortenson

Date: 06/05/2006

 ${\bf Organization:}$

Providence Kodiak Island Medical Center

Category:

Nurse

Issue Areas/Comments

GENERAL

GENERAL

I do Utilization Review and Discharge Planning in a small CAH on an island in Alaska. Our average length of stay for medicare patient's is 2.6 days in 2005. Do we keep patient's longer to comply with this rule. This regulation is very impractical and difficult to comply with in a small hospital due to short LOS, limited staff, and lack of time. We don't need more PAPERWORK to explain and give to our elderly clients who are often confused and sometimes skeptical when we ask them to sign yet another paper. If you want this information given, add it to the intial notice that is given on admission and require the one signature. This form can be taken to their room and if they disagree with discharge the discharge planner can then review the number to call for an appeal. In all the years(16) that I have worked here, I don't remember a case where a patient has not wanted to be discharged. If anything sometimes, we would like more time to get everything in order for the patient once they are discharged, but they don't want to stay even for that.

Thank you for allowing us to comment on this regulation. I do hope you listen to the people in the field who would find this regulation impractical and not beneficial for improving patient care.

Submitter:

Ms. Diane Paschal

Organization:

SC Hospital Association

Category:

Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-238-Attach-1.DOC

Page 239 of 416

June 07 2006 02:14 PM

Date: 06/05/2006

SCHA Comments CMS 4105 P



SOUTH CAROLINA HOSPITAL ASSOCIATION

1000 CENTER POINT ROAD + COLUMBIA, SC 29210-5802 + P 803 794 3080 + F 803 796 2938 + WWW.SCHA.ORG

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: Comments on Proposed Rule on the Medicare Program: Notification Procedures for Hospital Discharges (CMS-4105-P)

The South Carolina Hospital Association (SCHA) appreciates the opportunity to comment concerning this proposed rule that will negatively impact our member hospitals and the beneficiaries we serve.

SCHA supports proper notification of our seniors related to their healthcare services. Proper notification also relates to the timing of the notices beneficiaries receive and to the process for health care providers of these services. The proposed rule will not serve our seniors or hospitals without burden through repetitious notices and delay in proper discharge that is determined by the patient's attending physician. Not all beneficiaries have valid concerns with hospital discharge.

Unlike home health and skilled nursing facilities, hospitals have always had a process in place to notify patients of the appeals process and a discharge planning condition of participation that begins at the point of admission to the facility. The discharge planners and physicians work together to ensure the patient and their family will be prepared for a safe discharge at the right time. The hospitals do not make the final determination on the date discharge will actually occur; this is the sole responsibility of the patient's attending physician. The proposed rule will adversely impact utilization of inpatient services since the hospital does not have the authority to discharge patients. This means the hospital won't have the ability to always provide the generic notice of discharge on the day prior to discharge without adding another day of utilization since the staff must wait for the physician to order discharge. CMS has always deferred to physician judgment, including the UR or peer review by the QIO. The proposed rule will thus adversely impact the Medicare Trust Fund by adding a required inpatient day for each hospital discharge required through redundant beneficiary notices.

The proposed rule creates a 3-step process for hospitals, not a 2-step process as proposed:

- 1. the Important Message is a generic notice at the time of admission
- 2. the new generic notice of discharge on the day before discharge
- 3. the HINN

SCHA Comments CMS 4105 P

The purpose of providing notice at discharge needs to be clarified. If the purpose is to notify the beneficiary of appeal rights, the current process with the Important Message at admission serves that purpose. If the purpose is to ensure that beneficiaries have advance notice of their expected discharge so they and their families can be ready, that is accomplished by the discharge planning process, already required by Medicare. If the purpose is to notify beneficiaries of financial liability when they stay beyond the point that they need acute inpatient care, the current HINN process serves the purpose.

Other Concerns Identified:

The proposed negatively impacts the current push for an electronic medical record by requiring a paper document, complete with beneficiary signature.

The proposed rule does not offer a plan for short stays or transfers.

The proposed rule does not appropriately address the current Medicare Advantage organizations views on utilization and notices. We have MA plans that state they don't have utilization in their plans and our QIO has not had MA plan contact concerning MA enrollee discharges from our hospitals.

The proposed rule does not address the actual availability of the QIOs for weekend or after 5 p.m. discharge disputes by beneficiaries.

The proposed generic notice contains language that could cause unwarranted concern for beneficiaries on the appropriateness of their physician's decision to discharge.

CMS also states the notice process is 5 minutes. This time frame is understated as the process includes preparation and delivery of the notice. Not all seniors have the mental faculties to understand notices and have appointed a representative to take care of these type matters. That person may not always be present with the patient and must be contacted for notification, again, requiring time for proper notice.

• One of our member hospitals compared the proposed rule to their current process with the following comments:

"We have estimated this proposed process to take at least 30 minutes per notice to issue, maybe up to 60 minutes. When you consider the time spent getting planned D/C date from MD, maybe even multiple MD's, multiple phone calls or contacts will have to be made. Then you must prepare the document for signature and go explain this to the patient or try to find their spokesperson. This will not be an easy process since the beneficiaries have great difficulty understanding even simple explanations of Medicare issues."

Beneficiaries have a difficult time understanding the difference in activities of daily living and clinical, skilled services when it comes to health care concerns. The notice process does nothing to educate our seniors on these matters. This process could promote opportunities for beneficiaries to remain hospitalized for social reasons versus true clinical concerns.

Summary Suggestions:

SCHA would like to work with CMS on developing a sound notification process that will benefit all concerned. We have highly qualified social workers/discharge planners that work with our seniors on a daily basis that are willing to work with the agency to refine the notification process. CMS could begin by further refining the Important Message from Medicare that is given at the point of admission.

SCHA Comments CMS 4105 P

SCHA encourages CMS to reconsider this proposed rule that will not positively impact the information our beneficiaries will receive and will negatively impact hospital staff and the Medicare Trust Fund. Please contact me at 803.408.1014 or dpaschal@scha.org should you have questions concerning these comments or would like to form a workgroup to develop a sound notification process.

Sincerely,

Diane Paschal

Director, Corporate Compliance

Jane R. Paschal

Submitter:

Mrs. Sandra Cook

Date: 06/05/2006

Organization:

Colquitt Regional Medical Center

Category:

Nurse

Issue Areas/Comments

GENERAL

GENERAL

This proposed rule will be a hardship on hospitals. It may mean keeping patients extra days just to satisfy the 24 hours rule. It will confuse patients and cause much extra paperwork.

Submitter:

Ms. Cecelia Wu

Organization:

Partners Healthcare

Category:

Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-240-Attach-1.DOC

Date: 06/05/2006

Partners HealthCare System Boston, MA

Electronically

June 5th, 2006

Mark B. McClellan, MD, PhD Administrator Centers for Medicare and Medicaid Services Department of Health and Human Services Room 443-G Hubert H. Humphrey Building 200 Independence Avenue, SW Washington, DC 20201

Attention: CMS-4105-P

Dear Dr. McClellan:

Partners HealthCare System, Inc. (Partners) is pleased to comment on the Proposed Rule for the Medicare Program: Notification Procedures for Hospital Discharges as published in the April 5, 2006 Federal Register, on behalf of its member hospitals:

<u>Institution</u>	Provider Number
Brigham & Women's Hospital	220110
Faulkner Hospital	220119
Massachusetts General Hospital	220071
McLean Hospital	224007
Newton-Wellesley Hospital	220101
North Shore Medical Center	220035
Rehabilitation Hospital of the Cape and Islands	223032
Shaughnessy-Kaplan Rehabilitation Hospital	222026
Spaulding Rehabilitation Hospital	222035

Overall Concern

CMS seeks to apply policy consistency across all provider types by requiring hospitals to follow the discharge notice process currently in place in the non-hospital post-acute provider

Mark B. McClellan, MD, PhD, Administrator, CMS Comments to Medicare Notification of Procedures for Hospital Discharge, June 5, 2006

setting (Skilled nursing facility (SNF), home health agency (HHA) and certified outpatient rehabilitation facility (CORF)). Having provider representation across nearly all sectors of healthcare continuum, we strongly believe that the discharge planning process in a hospital setting is significantly different from the non-hospital post-acute setting and, as a result, this discharge notice policy that suits the non-hospital provider setting will create significant administrative difficulties in the hospital setting.

We are concerned about the proposed rule's requirements for hospital discharge notice. The proposed 24-hour discharge notice requirement, if implemented, will, at a minimum, disrupt the physician discharge order process and standard discharge planning and will likely cause delays in discharging patients. The additional notice will confuse the beneficiaries unnecessarily and create administrative burdens that are at odds with current CMS' policies to minimize redundancy and encourage efficiency.

Burden on Medicare Beneficiaries

Hospitals are currently required by CMS to issue "Important Message from Medicare" (IMM) upon admission, a detailed notice when there is any disagreement raised about the appropriateness of planned discharge, and a notice of non-coverage when Part A coverage runs out during the hospital stay. Massachusetts' hospitals are also required by the state's Department of Public Health to issue a notice of patient's rights to appeal at the time of discharge. Medicare beneficiaries currently receive at least two of the notices outlined above that address the message in the proposed notice. The added notice will impose more burdens on and create confusions for the beneficiaries and their family at a time when their focus should be devoted to the care of the beneficiaries.

Burden on Hospitals

The current requirements already present significant administrative burden on hospitals. The proposed requirement is redundant and will further add to hospitals' administrative burden. In the cases where beneficiaries have questions about their discharge orders, hospital professionals trained in Medicare coverage currently issue detailed Hospital-Issued Notice of Non-Coverage (HINN) and provide necessary counseling to assure that beneficiaries are informed of their rights. The proposed rule will require hospitals to either (1) Place this additional responsibility of issuing a discharge notice to all beneficiaries on the clinical staff (who will likely require additional training to be able to explain Medicare coverage), at the time when they need to focus on explaining post-discharge care to the beneficiaries, or (2) Increase the number of "discharge planning" staff to process the high volume of these notices, respond to questions, etc.

Partners HealthCare System Boston, MA Page 2 of 4

Mark B. McClellan, MD, PhD, Administrator, CMS Comments to Medicare Notification of Procedures for Hospital Discharge, June 5, 2006

24-Hour Discharge Notice Requirement

It is important to stress that physicians, not hospitals, make discharge decisions. It is often difficult for a physician to project a discharge date and to assume that the patient's condition will progress according to plan. In most cases, the discharge decision is made during the morning rounds, upon determination that the patient has recovered sufficiently to be discharged. The hospital then carries out the discharge order and discharges the patient, generally, on the same day. A 24-hour discharge notice period would increase length of stay by at least one day.

In cases when beneficiaries are transferred to SNFs, discharges must be made within hours of bed availability or the bed will be lost to another patient. The 24-hour requirement will therefore place Medicare beneficiaries at a disadvantage to other (non-Medicare) patients who would not face these administrative delays, potentially creating access problems and extending their stay in the hospital.

Medicare beneficiaries (nor any other patients) do not benefit from extending their hospital stay unnecessarily. The proposed rule finds 2% of all beneficiaries discharged from hospitals disagreed with their discharge decision; 98% of Medicare beneficiaries, therefore, agreed with their discharge decision and preferred to rest and recover at home or in another setting deemed most appropriate by their physician and other caregivers. The proposed policy will delay this preferred setting for Medicare beneficiaries, increase their risk of contracting infection and waste their hospital benefit days.

The 24-hour notice requirement seems counter-effective to CMS' current initiatives to decrease hospital utilization and increase efficiency. For the hospitals, any unnecessarily incurred days create financial burden as well as delay access to beds to Medicare beneficiaries (and all patients).

Regulatory Impact

CMS estimates that the impact of the proposed requirements is an additional 5 minutes to deliver the notice. We believe this estimate grossly underestimates the additional work required. The counseling time required to explain the notice may be 3 times longer than CMS estimated, not to mention the work required for filing and the capital costs associated with storing the notices. CMS also did not consider the impact to hospitals if, on average, each Medicare admission incurs one additional hospital day.

Partners HealthCare System Boston, MA Page 3 of 4

Mark B. McClellan, MD, PhD, Administrator, CMS Comments to Medicare Notification of Procedures for Hospital Discharge, June 5, 2006

Recommendations

We strongly believe that this proposed regulation will inconvenience and confuse Medicare beneficiaries, significantly add to the administrative burden of providers and work in opposition with CMS' initiative to streamline and to promote efficiency in the healthcare system. We urge CMS to withdraw this proposed rule. If CMS feels that the current required notices are insufficient, we further recommend that CMS make changes to the content of current notices rather than creating a new notice.

We appreciate the opportunity to comment on the proposed rule. Should you or your staff have any questions regarding our comments, please contact Cecelia Wu at 617-726-9165.

Sincerely,

Anthony J. Santangelo, Jr. Corporate Manager, Government Revenue

Partners HealthCare System Boston, MA Page 4 of 4

Submitter:

Ms. Marilyn Litka-Klein

Organization:

Michigan Health & Hospital Association

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see our attached comment letter regarding the CMS' proposed discharge notice.

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June 07 2006 02:14 PM

Date: 06/05/2006

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter:

Mr. David Seagraves

Organization:

Sumter Regional Hospital

Category:

Hospital

Issue Areas/Comments

Background

Background

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.

GENERAL

GENERAL

Sumter Regional Hospital 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.

SRH 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, SRH 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.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Date: 06/05/2006

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.

Regulatory Impact

Regulatory Impact

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.

Submitter:

Ms. Ellen Pryga

Organization:

American Hospital Association

Category:

Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-4105-P2-243-Attach-1.DOC

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June 07 2006 02:14 PM

Date: 06/05/2006



Liberty Place, Suite 700 325 Seventh Street, NW Washington, DC 20004-2802 (202) 638-1100 Phone www.aha.org

June 5, 2006

Mark McClellan, M.D., Ph.D. Administrator Centers for Medicare & Medicaid 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 the Centers for Medicare & Medicaid Services (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.

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 2 of 5

• 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.

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 3 of 5

- 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:

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 4 of 5

- 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 hardcopy 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.

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 5 of 5

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.

The AHA appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me or Ellen Pryga, director of policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

Rick Pollack

Executive Vice President

cc: 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

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

Submitter:

Mrs. Holly D'Amico

Organization:

Excela Health

Category:

Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-244-Attach-1.DOC

CMS-4105-P2-244-Attach-2.DOC

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June 07 2006 02:14 PM

EXCELA HEALTH CLINICAL RESOURCE MANAGEMENT 532 W. Pittsburgh Street Greensburg, PA 15601 724-832-4090

June 2, 2006

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

E-mail: http://www.cms.hhs.gov/eRulemaking

To Whom It May Concern:

The following is in response to the proposed rule, Medicare Program: Notification Procedures for Hospital Discharges of the Federal Register / Vol. 71, No. 65 / Wednesday, April 5, 2006 / Proposed Rules:

I. BACKGROUND

In review of the background for the proposed changes, it is noted in the final rule dated 4/04/2003, that notifying Medicare beneficiaries and MA enrollees at least one day before the effective date of discharge would pose a significant administrative burden. Since that time, there have been ever increasing demands on health care providers, the latest being Medication Reconciliation. With these additional demands and a shrinking pool of qualified nurses to meet the staffing needs of acute care nursing, as well as a looming physician shortage in Pennsylvania, the administrative burden now in 2006 would be crippling.

II. PROVISIONS OF THE PROPOSED RULE

The two-step notice process that is in effect for HHAs, SNFs, CORFs and hospices would not be appropriate for Acute Care hospitals. The average Medicare length of stay for most DRGs is 4 days or less. In the settings noted above, the average length of stay can vary from 1-3 weeks or longer. While still a burden to provide and compliance an issue with a two-step notice for beneficiaries receiving services in those alternate provider settings, there is significantly more time to identify patients nearing a discharge and provide the 2-day advance notice. In the acute care setting, discharge decisions are often made in a matter of hours based on response to treatment, toleration of increased oral intake, no fever, normalizing lab results, ability perform certain functions, results of diagnostics, etc. The proposed requirement appears to limit notification of the discharge

to the actual time that the physician concurs with the discharge decision. Physicians are not willing to order a discharge until the patient has met certain criteria. In order to comply with the 24-hour advance discharge notification, patients would stay at least an additional day simply to meet the notice provision, even though the discharge was appropriate and medically indicated 24 hours before. Conversely, another concern with the 24-hour advance notice requirement is the fact that plans for discharge can change depending upon the patient's medical stability. Hospital staff may provide a discharge notification in anticipation of a patient's discharge, but the discharge could be postponed if there is a change in the patient's condition, bed availability at skilled nursing facilities change, etc. The hospital may end up providing several generic notices in order to be compliant.

While the notice of non-coverage is "largely generic", it is proposed to be personalized with the Hospital Logo, the patient's name and Medicare Number, and the date of discharge, as well as the patient's signature at the bottom of the form, acknowledging receipt and understanding. This will require additional man hours not associated with the actual distribution of the notice as well as the need for staff to be present for extended hours since many physicians do not round during normal business hours and are required to see their patients daily, including weekends and holidays, when staff availability to meet this demand is sorely lacking.

Your proposal to require a two-step notice process "is intended only to provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings". I believe you will achieve the same result by reformatting the "Important Message from Medicare" that is given to all Medicare beneficiaries upon admission, to include more detailed information regarding their appeal rights if they feel they are being discharged prematurely or if they disagree with the discharge decision. They would still be afforded the same appeal rights, but without the burden of yet another form that requires a signature and education to patients and/or their representatives to understand what they are signing. An added burden would be placed on the hospital to track down a responsible party in the event the patient is unable to participate in the completion of this process. There will also need to be significant education provided to nursing staff since they will be expected to administer this notice after regular business hours.

If a patient exercises their appeal rights, what time frame can we expect to receive a decision regarding the appeal? The proposal indicates the appeal would be expedited, but what is the availability of the QIO? Again, this process puts additional burden on the healthcare team to provide the more detailed notice (and to have adequate support staff available to prepare the more detailed notice), as well as uncertainty of the availability of QIO staff to respond to the appeal request. Will the acute care hospital be reimbursed additional monies while the appeal is being processed, or will the continued stay (with the potential for no medical necessity during the stay) be incorporated into the DRG payment?

The current proposed method may potentially encourage patients to lengthen their acute care stay since there is no fiscal liability to them during the appeal process. This appeal

process can add 1-2 days minimum to the acute care stay with uncompensated care, while putting the patient at increased risk for falls, infections, and medication errors unnecessarily. At present, the acute care setting is primarily for the sickest of patients with alternate providers and alternate settings utilized to complete the continuum for patients requiring care, albeit at a lesser level, prior to a return to their previous setting when appropriate. The acute care setting should not be utilized as an alternate level of care, which may be the result of requiring a 24-hour advance discharge notice.

Appropriate resource utilization is imperative to avoid holding up bed placement of urgent/emergent admissions, to avoid overcrowding in the Emergency department and to prevent unnecessary ambulance diversions in our community. This proposal has the real potential to add to the already difficulty problem we face with transitioning patients to the appropriate level of care in a timely manner.

Regarding MA organizations, it is unclear if two separate discharge notices may ultimately be required and who would deliver those notices. For those plans that are DRG based, if the admission is denied, when would the notice of non-coverage be required? What happens with per diem based MA organizations that often do not render their determination regarding continued coverage of the acute care stay until the day after care is rendered? This alone would add 1-2 days to the acute stay. It is not reasonable to ask a hospital to explain that the Medicare Advantage plan has determined their hospitalization would no longer be covered when in some instances the hospital may disagree with that determination. In the proposal, you indicate that the MA organization would not be able to shift liability of the notification to the hospital, however, what recourse would there be if they failed to issue timely notification? The patient would still need to be educated on and potentially exercise the same rights as other Medicare beneficiaries. Would the hospital still be required to issue its own two-step discharge notice as well, with potentially conflicting dates, adding to the confusion that already exists with the amount of information that must be conveyed to hospitalized patients during their acute care stay and prior to discharge? What would the expectations be for patients who only require a one-day length of stay in the acute care setting?

III. COLLECTION OF INFORMATION REQUIREMENTS

The estimate of time that it would take to deliver each notice (5 minutes) is grossly underestimated. First, you assume that this notice would be disseminated during the normal course of related business activities. Acute care is not a 9-5 setting and patients can be and are discharged after hours, on evenings, weekends, and holidays. Secondly, the support staff needed to prepare these notices (since they are to be personalized) has not been taken into account. Patients and their families would rightfully expect an explanation of what they are being asked to sign, especially since their signature represents not only receipt but also understanding of the information provided. This is more conservatively a 15-minute process minimally. Additionally, case managers are typically staffed 8-4:30 Monday through Friday, with skeleton crew coverage for off-hours, weekends, and holidays. Nursing would be expected to provide the notices of non-coverage or discharge notices in the off-hours. With the current critical nursing

shortage and the increased burden on healthcare to do more with less, they are ill prepared to take on another "bookkeeping" task. Their precious time is required to provide direct patient care in the form of delivering ordered treatments, medications, and educational instruction as well as keeping physicians, patients and their families informed. There were more than 9,500 Medicare discharges from our health system alone during fiscal year 2005, in addition to over 6,000 MA Advantage enrollees, constituting over 50 % of the patients served on an acute care basis. The task of complying with a two-step notification process would be daunting at best.

The percentage of patients who may request an expedited review (estimated by CMS to be less than 2 percent – an overestimation by your account) may be small initially. As word spreads that patients can extend their hospital stay at least another day (until the review can be conducted) without any financial liability, the percentage of patients requesting an expedited review may grow exponentially.

Other implications that CMS has not accounted for:

- # the costs and time associated with the printing of the forms;
- the time required to assemble the forms with other documents;
- the time required to coordinate with physicians and other health care professionals to establish when the advance notice can be delivered;
- the actual time to explain the form to the Medicare beneficiary and/or Medicare beneficiary's family and to get the form signed by the responsibility party;
- the time to assist the Medicare beneficiary or the family to request an expedited review by the QIO;
- the time required for the filing of the notices in the medical record;
- the costs associated with the copying of the medical records sent for review to the QIO, including the possible need for additional fax machines that allow for transmittal of large volumes of documents, so as to not disrupt the flow of work on the nursing units;
- the upfront costs associated with researching and providing the specific language required to be cited in the detailed notice of explanation;
- the costs associated with having more discharge planners, social workers, and/or case managers available to deliver these notices to Medicare patients or the overtime that will be incurred by hospitals in order to have all the documents delivered to patients or the QIO in the time frames as proposed in this rule;
- the costs associated with training nurses and other health care professionals who would need to deliver the notices during evenings, weekends, and holidays when the Clinical Resource Management staff, utilization management and case managers would be otherwise unavailable; and
- the costs associated with the maintenance and storage of these documents for a period of years.

This CMS proposed rule creates another unfunded mandate for already overburdened hospitals across the country.

Please take the time to review these comments and questions. I realize that a personal response is not possible, but I respectfully implore you to consider what you are asking health care providers to comply with in this proposed rule and carefully seek out an alternate solution that is both manageable and reasonable.

Respectfully submitted by:

Holly J. D'Amico, RN Director, Clinical Resource Management Excela Health

hdamico@excelahealth.org

Submitter:

Mr. Mike Vicario

Organization:

NCHA

Category:

Hospital

Issue Areas/Comments

Background

Background

The North Carolina Hospital Association represents 140 hospitals in our state, and we wish to comment on proposed new regulations affecting the discharge process for hospital inpatients. In general we believe that the rule is duplicative of existing CMS requirements to inform patients of their impending discharge.

NCHA believes that this proposed rule will result in significant costs to hospitals without a demonstrated benefit to patients or improvement to medical necessity, and that it should not be implemented.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The proposed regulation would also require that the standard notice be delivered by hand on the day before discharge, that it be explained to the patient and/or representative, that the patient be capable of understanding and then sign the notice. Estimates from CMS are that this process will take only five minutes per notice. We believe that it will take hospitals much longer to comply with this requirement, especially where patient representative input is required, and that it will result in a costly and unfunded mandate for hospitals.

The proposed regulation does not recognize the physician s role as the decision maker in discharging the patient. This regulation requires a prediction that the patient will be ready for discharge the next day instead of a determination that is based on the patient s current condition. And in the current environment of shortened stays and medically complex patients, it may be more difficult to predict a discharge 24 hours in advance. A patient who may have been unstable could respond to treatment and be ready for discharge the same day, yet have the discharge delayed because the written notification was not received the previous day. The regulation would result in unnecessary days of hospitalization, at the expense of hospitals and without perceivable benefit to patients.

The Conditions of Participation in Discharge Planning and Patients Rights already address notification to patients and their representatives of impending discharge. If CMS believes that the existing process is flawed it should establish workgroups, inclusive of hospital personnel, to evaluate the process and make recommendations. Any recommendations should also include an impact analysis of the expense to hospitals that a third notification requirement could cause.

Regulatory Impact

Regulatory Impact

The proposal describes what it calls a two step process of notification, but it is actually a three step process when the Important Message from Medicare (IMM) notification provided at admission is included. The process is reportedly based upon existing requirements in long term care settings. However, we know that patients in hospitals have substantially shorter stays, more frequent contacts with physicians and other clinicians, and more pronounced changes in their day to day functioning than patients in these other settings. For each of these reasons, and because Medicare patient stays in the hospital average only six days (even less in Critical Access Hospitals), we do not agree that this process should be applied to acute care settings. Furthermore, it is not clear why this regulation is being proposed. We believe that CMS should carefully evaluate the need before adding regulations to the discharge notification process.

CMS projects that 2% of those receiving the generic notice would request an expedited determination. While the generic, three element notification may have been designed to be less burdensome for hospitals, it also lacks the specific information patients need to fully understand the intent of the notification. Also, by generically informing patients that they may appeal the notice without financial consequences, the hospital (and QIO) is placed at risk for additional paperwork. And the hospital is placed at further risk for costs associated with longer patient stays that may have been based on convenience or hesitation and not medical necessity.

Submitter:

Mr. Charles Cataline

Organization:

The Ohio Hospital Association

Category:

Hospital

Issue Areas/Comments

GENERAL.

GENERAL

See Attachment

CMS-4105-P2-246-Attach-1.RTF



June 5, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-4105-P
P.O. Box 8010
Baltimore MD, 21244-1850

Dear Dr. McClellan:

On behalf of its 170+ hospital and health system members, the Ohio Hospital Association is commenting on CMS' proposed rule regarding the *Medicare Program:* Notification Procedures for Hospital Discharges, published in the April 5, 2006, Federal Register.

The proposed rule would create a new notice of Medicare discharge appeal rights that CMS would require hospitals to distribute to all Medicare inpatients the day before their discharge.

OHA strongly opposes the proposed rule and recommends CMS withdraw it. The changes to patient notification requirements proposed are unnecessary, they will be burdensome and expensive to implement and manage, and they are sure to add to the cost of every inpatient hospital admission with no corresponding increase in Medicare payments.

First, the proposed discharge notice is not necessary. The existing Important Message from Medicare and the current Notice of Discharge and Medicare Appeal Rights are sufficient to keep Medicare beneficiaries apprised of their rights and how to get help if they think they are being discharges inappropriately. OHA is not aware of any competent study that suggests hospital patients are routinely discharged too soon, and hospitals are not receiving complaints from patients that they are confused by or dissatisfied with the current procedures. As such, CMS' proposal to unnecessarily add to the number of notices and requirements that already inundate patients is irresponsible.

Second, the proposed new notices and the timelines for their delivery will be difficult for hospitals to implement and manage. Unlike skilled nursing facilities and home health agencies, hospital patients on average do not require long lengths of stay and hospitals are not normally aware of a physician's final decision to discharge a patient until the actual date of discharge. As such, any requirement that a formal predischarge notice be provided the day before the actual discharge will add a day of inpatient care to most stays while hospitals grapple with unnecessary paperwork.



June 5, 2006 Mark McClellan, MD, PHD ATTN: CMS-4105-P Page Two

In addition, the language of the proposed generic notice will lead patients to believe there is something wrong and that they need to appeal, which will cause a rash of requests for expedited reviews and add an unnecessary administrative burden to hospital discharge planners and QIOs who are forced to respond.

Finally, for reasons noted above it is clear that the proposed discharge notice requirements will significantly add to the cost of care for most Medicare beneficiaries, which in a PPS-based system will not be repaid by CMS or the Medicare program.

Hospitals would likely have to add staff to manage the process and the paperwork, to monitor the increased number of appeals, and to remain compliant with CMS' additional recordkeeping requirements and timelines. This does not include the increased cost of the average inpatient stay, which, as OHA has noted, will most likely increase by at least one day per patient in order to deliver a formal notice of discharge the day before the discharge itself.

OHA and its member hospitals and health systems remain committed to the highest quality of care, which includes a process for communication with and comment from patients every step of the way. These activities and notices are already in place and from every indication are working well. OHA is not convinced it is necessary for CMS to significantly add cost and administrative burden at this time, so it strongly recommends CMS revoke the proposed rule and maintain the existing system.

OHA appreciates the opportunity to comment. You may feel free to contact me at any time if you have any questions or concerns at 614.221.7614 or electronically at charlesc@ohanet.org.

Sincerely,

Charles Cataline Senior Director, Health Policy

cc/

Submitter:

Mrs. Naomi Malakoff

 ${\bf Organization:}$

St. Luke's Episcopal Hospital

Category:

Health Care Professional or Association

Issue Areas/Comments

Background

Background

see attachment

GENERAL

GENERAL

see attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attachment

Page 249 of 416

June 07 2006 02:14 PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter:

Ms. Kimberly Littell

 ${\bf Organization:}$

University Hospitals of Cleveland

Category:

Nurse

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see asttachment

CMS-4105-P2-248-Attach-1.DOC

Proposed CMS Ruling

expensive and is virtually guaranteed to add unnecessary days to every Medicare admission.

Medicare: 8,867 Medicare HMO's

Expense:

Obtaining signature

What if that day decides they are ready- we have a bed, give letter for the naxt day- no bed.

Patient not able to understand letter, or read letter or hear letter if read to them - we now send to family member or gaurdain- if need day before will ne d toc ourrier, they may not get, confusion for patient.

Provisions of the Proposed Rule Collection of Information Requirements Regulatory impact

Submitter:

Mr. Mark Joffe

Organization:

Medicare Cost Contractors Alliance

Category:

Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-249-Attach-1.DOC

Page 251 of 416

June 07 2006 02:14 PM



E MEDICARE COST RACTORS ALLIA

1800 K Street, N.W. • Suite 720 • Washington, D.C. 20006 • 202.457-6633 • 202.457-6636 FAX

Arnett Health Plans, Inc. (IN) ♦ Blue Cross Blue Shield of Minnesota ♦ Dean Health Plan, Inc. (WI) ♦ Excellus Health Plan, Inc. (NY) Hawaii Medical Service Association ♦ HealthPartners (MN) ♦ Kaiser Permanente (CA, DC, HI, MD, OH, VA) M. Plan (IN) ♦ Medica Health Plans (MN, ND, SD, WI) ♦ Medical Associates Health Plan, Inc. (IL and IA) Medical Associates Clinic Health Plan of Wisconsin ◆ Regence BlueCross BlueShield of Oregon ◆ Regence Blue Shield of Idaho Rocky Mountain Health Plans (CO, WY) ◆ Scott and White Health Plan (TX)

June 5, 2006

Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services Attention: CMS-4105 -P Room 445-G Hubert Humphrey Building 200 Independence Avenue, SW Washington, DC 20201

Dear Sir or Madam:

I am writing on behalf of the Medicare Cost Contractors Alliance (the Alliance) in response to the April 5, 2006 Notice of Proposed Rulemaking titled: "Medicare Program; Notification Procedures for Hospital Discharges" (71 FR 17052). The Alliance is a coalition of nineteen Medicare cost plans that currently provide services to approximately 289,000 Medicare beneficiaries who are enrolled in their plans.

The Alliance does not support this change because it believes the proposal would not improve beneficiaries' rights concerning appeals but would increase health plans' burden of complying with the notice requirements. However, the Alliance has provided comments below in the event that CMS decides to implement this proposed process.

BACKGROUND

In its final rule implementing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS established a new provision requiring Medicare cost plans to comply with the same procedures for appeals and grievances as Medicare Advantage plans. 42 CFR 417.600(b) states:

> The rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act. In applying those provisions, references to section 1852 of the Act must be read as references to section 1876 of the Act, and references to MA organizations as references to HMOs and CMPs.

The provision became effective on January 1, 2006.

While the regulatory language may sound straightforward, applying the Medicare Advantage appeals requirements to Medicare cost plans has been complicated, and has required a number of clarifications from CMS.

One issue complicating the application of the Medicare Advantage procedures to Medicare cost plans is the fact that most Medicare cost plans do not make payment for Part A services. Medicare cost plans can choose one of two billing options. Under Option 1, CMS (through the intermediary) pays Part A claims (including hospital and SNF claims) on behalf of the Medicare cost plan. Under Option 2, the Medicare cost plan pays Part A claims itself. Only one Alliance plan has chosen Option 2. In addition, Medicare cost plans are not responsible for making payment for services provided by home health agencies or Part B outpatient claims. Medicare makes payment for those services directly.

As a result of these payment arrangements, in many instances Medicare cost plans have minimal or no involvement when a member goes out-of-network to receive these services, and may not have notice that such services have been provided.

To address the challenges faced by Option 1 Medicare cost plans, CMS clarified in the Medicare Managed Care Manual that Medicare cost plans are only responsible for meeting the MA appeals requirements for Part A services furnished under the following circumstances: (1) When the services were furnished by a network facility or provider; (2) when a network provider referred a member to a non-network facility or provider or (3) when an individual received out-of-network emergency services. As noted below, this alignment of responsibilities needs to be reflected in this regulation.

Still, complying with the Medicare Advantage requirements has been a challenge for Medicare cost plans in some instances and a number of issues have yet to be resolved. Meeting the Notice of Discharge and Medicare Appeals Rights (NODMAR) requirements has been particularly difficult in instances when an individual has a short stay at a non-network hospital. The individual may have been discharged before the Medicare cost plan learns of the admission and, because the cost plan does not have a contractual relationship with the hospital, it cannot delegate the NODMAR responsibility.

In addition, meeting the Detailed Explanation of Non-Coverage (DENC) requirements is a challenge when services are provided by a non-network SNF, CORF or HHA because the Medicare cost plan may have had no role in the decision to terminate services, and thus does not have the information necessary to explain the decision. Again, because the cost plan does not have a contractual relationship with the provider or facility, it cannot delegate the DENC responsibility.

GENERAL COMMENTS

As previously noted, Medicare cost plans face a number of challenges in meeting the current appeals requirements. While the plans are putting in place mechanisms to comply when services are furnished by network providers, out-of-network services continue to be a challenge.

The Alliance believes that adding a requirement to provide a DENC in the case of hospital discharges will increase the burden to the plan, without improving the process for beneficiaries. In most instances, the discharge decision is made by the hospital in conjunction with the

treating provider. The Medicare cost plan may not be aware of the basis for the decision and thus will have trouble completing the DENC, particularly in the short timeframes proposed under the rule.

SPECIFIC COMMENTS

Notification Responsibilities (422.622(c)). This provision states that the QIO must notify the MA organization on the date the enrollee files the request for review and that after notification the MA organization must deliver a DENC to the enrollee by the end of the same business day. As an initial matter, the Medicare fee-for-service rules apply to appeals concerning services provided to cost plan members if a non-network provider referred the member to a non-network facility (with the exception of emergency admissions). Thus, CMS should indicate that in those instances, the QIO will notify the hospital, which will be responsible for furnishing the DENC. In addition, we note that the timeframe for providing the DENC is far too short for Medicare cost plans, which may not know of the hospitalization until contacted by the QIO and may not have been involved in the discharge decision. In such cases, the Medicare cost plan will need to contact the hospital and treating provider in order to obtain the information necessary to furnish the DENC. Thus, the Alliance recommends that the timeframe be extended to the close of business on the first business day after the QIO notifies the Medicare cost plan of the appeal.

Financial liability (422.622 (c)(5) and (e)). These provisions specify the time periods for which an MA organization is financially liable for the inpatient stay. In instances where the Medicare cost plan has chosen billing option 1, Medicare FFS will be financially responsible for the Medicare covered portion of these time periods rather than the Medicare cost plan. Thus, we recommend that CMS revise these provisions to except from the provision Medicare cost plans that have chosen billing option 1.

Short lengths of stay (preamble, page 17054). In the preamble, CMS invited comment on whether a different notice requirement should apply for short lengths of stay. CMS gave an alternative arrangement where the standardized general notice would be given by the hospital on the day of discharge. The Alliance agrees that a separate, more easily implemented requirement should be imposed when an individual is discharge within 3 days of admission.

The Medicare Cost Alliance appreciates the opportunity to comment on these proposed rules. If you would like to discuss any of the issues we have raised, please contact me at (202) 457-6633.

Sincerely,

Mark Joffe Executive Director of the Medicare Cost Contractors Alliance

Submitter:

Ms. Patricia Lawson

 ${\bf Organization:}$

Upland Hills Health

Category:

Individual

Issue Areas/Comments

GENERAL

GENERAL

Discharge from the hospital depends on patients individual situation, progress, and needs-- not a set length of stay or number of visits. Although caregivers can predict what tasks need to be met to safely discharge the patient, it is impossible to always predict a day ahead of time when a patient will meet these criteria.

This law represents good intentions gone wrong. It will create undue hardship and costs on the caregivers--while complicating matters with the patient.

Submitter:

Mr. Jerry Wise

Organization:

Hart County Hospital

Category:

Hospital

Issue Areas/Comments

Background

Background

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

7 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.

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

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

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

Regulatory Impact

Regulatory Impact

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.

CMS-4105-P2-251-Attach-1.DOC

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.

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.

Submitter:

Janet Brown

Organization:

Moundview Memorial Hospital & Clinics

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-252-Attach-1.DOC

Page 254 of 416

June 07 2006 02:14 PM

June 5, 2006

Mark McClellan, M.D., Ph.D. Administrator Centers for Medicare & Medicaid 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:

I strongly agree with the Wisconsin Hospital Association's Comments previously submitted. I support the patients' need to be well informed of their rights under Medicare, as well as their right to request an expedited review. I request that you reconsider the necessity, timing and burden of providing this written notice in the less predicable inpatient setting. Wisconsin hospitals are known to be high quality, low cost providers of health care services. Imposing this proposed rule is unnecessary and will create a burden on hospitals for compliance that will only escalate health care costs. I strongly urge CMS to forgo implementation of this rule. The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns.

- 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.

Sincerely,

Janet Brown, CEO

cc: 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

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

Submitter:

Ms. Helen Reed

Organization:

Kent Hospital

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter:

Dr. William Wessinger

Organization: Memorial

Memorial HealthUniversity Medical Center

Category:

Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-254-Attach-1.PDF



June 2, 2006

Mark B. McClellan, MD, PhD Administrator Centers for Medicare & Medicaid Services Department of Health and Human Service Room 445-G Hubert H. Humphrey Building 200 Independence Avenue, SW Washington, DC 20201

Attention: CMS-4105-P

Dear Dr. McClellan:

The proposed rule entitled, "Medicare Program: Notification Procedures for Hospital Discharges" 71 Fed. Reg. 17052 (April 5, 2006), sparked considerable discussion within my department at my hospital. We are a 523 bed community-based teaching hospital. I wish to register our opposition to the proposed rule.

First of all, there has been no demonstrated need for such a rule change. I am unaware of any studies showing pervasive dissatisfaction with the present discharge notification procedure or policy. I am also unaware of any studies that have objectively demonstrated harm to any beneficiaries of Medicare/Medicaid.

The proposed change in notification practice will surely result in an increase in length of stay. Consider the fact that if a decision is made on a Thursday or Friday for discharge the next day, by the time the matter has been reviewed at a state or regional level. I am quite certain that the delay will stretch out until Wednesday thus generating a five-day delay in discharge.

I am a member of the American Case Management Association, Diplomate of the American Board of Quality Assurance and Utilization Review Physicians, and a Certified Physician Executive by the American College of Physician Executives. My wide-ranging networking in this area has failed to demonstrate any need for the proposed rule change. Furthermore, the implementation of such proposed rule changes will result in more harm than good to a program that faces much greater challenges.

Sincerely.

William N. Wessinger, MD. CPE

Medical Director

Clinical Resource Utilization Management

Will A. Wenn

Hosp Oispharge Ltr

Submitter:

Dr. Roger Howard

Organization:

William Beaumont Hospital, Troy

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-255-Attach-1.DOC

June 07 2006 02:14 PM

William Beaumont Hospital, Troy

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

June 5, 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 a Vice President and Associate Medical Director at William Beaumont Hospital, Troy, a 254-bed community hospital located in Troy, Michigan.

As Medical Director of Care Management, I have been directly involved with discharge planning for inpatient population for the past seven years. Our current discharge planning practices begin 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, case managers interview all patients meeting the hospital's screening criteria: patients over age 70, medicare beneficiaries under age 65 and patients at high risk for needing post-acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post-acute services. 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 places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take five minutes to deliver the generic notice and have it signed. If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. My recommendation is to allow telephonic notification of the decision maker when the decision maker is not the patient.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital, the average LOS is 4.0 days. Since lengths of stay are short and patients' conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12 noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00 p.m. that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients are discharged from the hospital in 1-2 days, very soon after the patient has received their medicare rights information during the admission process. My final recommendation is for the generic notice to be required for patients in the hospital for three days or more.

I have read that CMS estimates only 1–2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1–2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expect results, and indeed, the increased costs (administrative and LOS) do not justify the means.

I appreciate the role of CMS in safeguarding patient rights. We believe we must protect patients rights while also stewarding government resources and ensuring patients do not take advantage of an opportunity to unnecessary extend a length of stay adding significant costs to medicare.

Sincerely,

Roger S. Howard, M.D., MBA Vice President & Associate Medical Director William Beaumont Hospital 44201 Dequindre Road Troy, MI 48085

Submitter:

Ms. Elizabeth Hills

Organization:

St. Francis Hospital & Health Center

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-4105-P2-256-Attach-1.DOC



June 6, 2006

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

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)

We are writing in response to the above referenced notice of proposed rulemaking establishing new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs which will introduce a two-step notice process. We are very concerned about the significant administrative and financial burdens this new process would place on the hospital. In addition to the above stated issues we have concerns about patient throughput challenges on our limited resources; causing probable delays in available rooms for treating other patient's who need acute care services. Also we do not see any significant added value to the patient, family or hospital with the implementation of this new burdensome process.

We believe the proposed discharge notice process is inappropriate for an acute care environment. The proposed process will cause unwarranted appeals, longer lengths of stay and much greater consumption of staff resources to work through length of stay issues with patients and family members.

We ask that careful reconsideration be given to the implementation of this process as it is projected to be difficult to implement in the organization and will be very costly to our organization. Currently we are providing the notice "Important Message from Medicare" which outlines the beneficiary's discharge and appeal rights. We believe the implementation of this new process will be redundant.

We appreciate the opportunity you have provided us with in order to comment on this new proposal and we hope that you will reconsider your actions regarding this matter.

Sincerely:

Catherine Brunson Young, MBA, MHA, BA, CPHQ, CPUR, RM, ICP Interim Director Care Management & Elizabeth Hills, Director Patient Financial Services

Submitter:

Marcia Colone

Organization:

Northwestern Memorial Hospital

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-257-Attach-1.DOC

June 5, 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

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 the director of Case Management at **Northwestern Memorial Hospital**, which is a 744 bed hospital in Chicago, IL, I am responsible for ensuring discharge planning to the approximately 45,202 patients who are admitted yearly.

The CMS proposed change places an administrative burden on the hospital coupled with the real possibility that many discharges will be delayed due to procedural issues. Your estimates that the process will take 5 minutes to deliver the generic notice and have it signed is misguided. If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the appropriate signature. My recommendation is to allow telephonic notification to the decision maker when the decision maker is not the patient.

Our current discharge planning practice begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. At Northwestern Memorial, we are committed to involving patients and families in care planning and discharge planning. Patients are kept apprised of the anticipated discharge date and are provided choices regarding post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

Your proposed rule requiring a "day's notice" poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.85 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it sometimes becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients have short stays, I recommend that the generic notice be required only for patients who have been hospitalized for 3 days or more.

Your estimate that approximately 1-2% of beneficiaries will request an expedited appeal is an underestimate of both volume and potential burden. My recommendation would be for CMS to institute this rule only on a temporary basis to judge the actual impact on hospitals. If the percentage is significantly higher, as I would expect from experience, and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expected results, and indeed, the increased costs (administrative and LOS) do not justify the means.

Thank you for this opportunity to comment.

Sincerely,

Marcia Colone, Ph.D., LCSW, ACM

Submitter:

Robert Olsen

Date: 06/05/2006

Organization:

MHA An Assoc of MT Health Care Providers

Category:

Health Care Professional or Association

Issue Areas/Comments

Background

Background

The proposed regulation appears to apply discharge processes crafted for home health or other facility treatment settings to hospitals. Unlike hospitals, home health and skilled nursing facility care is typically implemented and managed by a registered nurse. The care plan is approved by a physician, but not typically subjected to active management by the physician. Further, the course of treatment in these care settings is of longer duration than hospital care. Appeal procedures, and the time to process them, are probably not a major concern.

But acute care provided by a hospital is fundamentally different for other treatment settings. The length of stay for hospital treatment is usually of short duration. Further, a hospital discharge decision is not only whether to terminate care. The decision may be to continue care in a skilled nursing facility, home health agency or other care environment. We question whether a patient would be appealing the decision to discharge them from acute care, or the decision to continue care in an alternative setting.

Net affect of this regulation is to increase treatment cost, make discharge processes more confusing and fail to substantially improve care for the beneficiary.

GENERAL

GENERAL

The proposed regulation should not be adopted in its current form. MHA 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.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Rule requires hospitals adopt a 'two-step' discharge process better suited for home care and other non-acute treatment settings.

Regulatory Impact

Regulatory Impact

The regulation suggests that the hospital makes as decision to discharge the patient. More specifically, the patient s physician makes the decision to discharge the patient. This decision may, or may not, be made with the benefit of input from hospital nurses, family members and others. Unlike home care, the treating physician is not peripheral to the care process they are at the center of it. Patient treatment needs are also protected by Medicare Conditions of Participation and current Medicare discharge regulations. 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.

CMS-4105-P2-258-Attach-1.DOC

CMS-4105-P2-258-Attach-2.DOC

CMS-4105-P2-258-Attach-3.RTF



June 5, 2006

Mark McClellan, M.D., Ph.D. Administrator Centers for Medicare & Medicaid 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:

MHA...An Association of Montana Health Care Providers, appreciates this opportunity to comment on the above referenced proposed regulations pertaining to hospital discharge process. MHA is concerned that this regulation amounts to an unnecessary expansion of administrative work intended to address a problem that may not exist.

There has been no compelling case for the need to implement this change, since hospital patients already receive information about their Medicare benefits, including a right to have their treatment plans reviewed. MHA recommends that CMS withdraw this proposed rule. If evidence emerges that a problem exists with discharge processes, or that the current procedures are failing to meet Medicare beneficiary information needs, a regulation could be proposed to address those concerns.

The proposed regulation appears to apply discharge processes crafted for home health or other facility treatment settings to hospitals. Unlike hospitals, home health and skilled nursing facility care is typically implemented and managed by a registered nurse. The care plan is approved by a physician, but not typically subjected to active management by the physician. Further, the course of treatment in these care settings is of longer duration than hospital care. Appeal procedures, and the time to process them, are probably not a major concern.

But acute care provided by a hospital is fundamentally different for other treatment settings. The length of stay for hospital treatment is usually of short duration. Further, a hospital discharge decision is not only whether to terminate care. The decision may be to continue care in a skilled nursing facility, home health agency or other care environment. We question whether a patient would be appealing the decision to discharge them from acute care, or the decision to continue care in an alternative setting.

By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be putting the hospital at risk of failing to comply with federal requirements. A classic 'catch-22' situation is created. Should the hospital extend the patient stay and incur additional costs with no benefit to the patient, or proceed with the discharge and risk violating federal rules?

The regulation suggests that the "hospital" makes as decision to discharge the patient. More specifically, the patient's physician makes the decision to discharge the patient. This decision may, or may not, be made with the benefit of input from hospital nurses, family members and others. Unlike home care, the treating physician is not peripheral to the care process they are at the center of it. Patient treatment needs are also protected by Medicare Conditions of Participation and current Medicare discharge regulations. 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.

The proposed regulation should not be adopted in its current form. MHA 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.

Please contact me at (406) 442-1911, or by email at bob@mtha.org with any questions.

Sincerely,

Robert W. Olsen Vice President

Submitter:

Mrs. Cheryl Briere

Mt. Ascutney Hospital and Health Center

Organization:
Category:

Critical Access Hospital

Issue Areas/Comments

Background

Background

A day's notice poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 3.5 to 4 days. Since lengths of stay are short and patient s conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12 noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

GENERAL

GENERAL

I have read that CMS estimates only 1 to 2% of beneficiaries will request an expedited appeal. If this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1 2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expected results, and indeed, the increased costs (administrative and LOS) do not justify the means.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The CMS proposed change places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. Our experience in issuing the swing bed Notice of Medicare Provider Non-Coverage has not borne this out. Not only do elderly patients not understand the letter (despite repeated explanation), some patients refuse to even look at it, let alone sign it. This process of repetition can take up to 30 minutes or more in some cases.

If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. My recommendation is to allow telephonic notification of the decision maker when the decision maker is not the patient. In this same circumstance, are we liable for sending the

letter certified? (*and to whom?)

Regulatory Impact

Regulatory Impact

As a Case Manager and Director I have been directly involved with discharge planning for the Medicare population for the past 16 years. Our current discharge planning practice begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, our Case Managers assess the patient s current living situation and needed resources. In addition, case managers interview all patients, acute or skilled. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the OIO.

Submitter:

Dr. Zane Prewitt

Organization:

Dr. Zane Prewitt

Category:

Physician

Issue Areas/Comments

GENERAL

GENERAL

This is poor policy and sill increase the length of hospital stays.

Page 262 of 416

June 07 2006 02:14 PM

Submitter:

Ms. Maureen McNally

Organization:

Froedtert & Community Health

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-261-Attach-1.DOC

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: 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:

I am writing to comment on the proposed rule related to notification procedures for hospital discharges on behalf of Froedtert & Community Health, a system comprised of Froedtert Hospital, an academic medical center in Milwaukee, and Community Memorial Hospital, an acute-care community hospital in Menomonee Falls, Wisconsin. This proposed rule was originally published in the Federal Register, Vol.71, No.65, page 17052.

We take seriously our obligation to keep all patients well-informed about their care, but believe that the procedures outlined in the rule will create a significant burden on providers, will be difficult to operational, and will result in increased costs.

Under the current rules, hospitals issue the "Important Message from Medicare" at the time of admission. This publication advises beneficiaries of their appeal rights. Since more than 50% of inpatient hospitalizations consist of stays between 1 and 3 days, issuing a second notice would be duplicative. However because the patient's length of stay will not be known at the time of admission, under the proposed rule, a separate notice of discharge would be required for a patient even if he or she will only stay 1 day. This will result in significant additional staff time. Under the proposed rule, Medicare Advantage programs may request that a hospital issue a second notice of discharge for a total of three notices if the patient disagrees. This step adds even more staff time and expense to the hospital discharge process.

Under the proposed rule, the notice must be delivered before the close of business on the day prior to discharge. In the acute care setting, patients' conditions often change quickly. This requirement may mean that patients whose conditions worsen will receive a notice of discharge which will have to be revoked and reissued. Conversely, if a patient makes improvements at a faster than anticipated rate, he or she may be required to stay in an inpatient setting longer than needed. This runs counter to current practices, as physicians often review the result of final tests and physical examinations in the morning and write discharge orders for the same day.

Under the proposed rule, the hospital must issue the notice to the patient's representative if the patient is not competent. Again, this will add staff time and may delay the discharge if the representative is not available to receive the notice before the close of business on the day before discharge.

Finally, we believe that the rule does not accurately portray the additional costs providers will bear. The estimated aggregate cost of \$31.2 million for hospitals or an average of \$5,200 for each provider fails to account for the additional staff time spent delivering one or more discharge notices to the patient and his or her representative and the additional costs associated with copying and overnight mailing medical records for review if a beneficiary appeals.

For these reasons, we strongly urge CMS not to implement this rule.

For questions about these comments, please contact me at 414-805-5284 or mmcnally@fmlh.edu Sincerely,

Maureen McNally Director of Government & Community Relations Froedtert & Community Health

Submitter:

Ms. Kathy Poling

Organization:

William Beaumont Hospital - Troy

Category:

Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-262-Attach-1.DOC

William Beaumont Hospital- Troy 44201 Dequindre Road Troy, MI 48085-1198

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

June 2, 2006

To Whom It May Concern:

We are writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. We are the Director of Care Management and the hospital administrator overseeing Care Management at William Beaumont Hospital –Troy, a 254-bed community hospital located in Troy, Michigan.

As the Director of Care Management, I have been directly involved with discharge planning for the past twenty years. Our current discharge planning practices 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, case managers interview all patients meeting the hospital's screening criteria: patients over age 70, Medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. 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 places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. My recommendation is to allow telephonic notification of the decision maker when the decision maker is not the patient.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.04 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM

that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients are discharged from the hospital in 1-2 days, very soon after the patient has received their Medicare rights information during the admission process. My final recommendation is for the generic notice to be required for patients in the hospital for 3 days or more.

I have read that CMS estimates only 1-2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1-2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expect results, and indeed, the increased costs (administrative and LOS) do not justify the means.

I appreciate the role of CMS in safeguarding patient rights. We believe we must protect patients rights while also stewarding government resources and ensuring patients do not take advantage of an opportunity to unnecessary extend a length of stay adding significant costs to Medicare.

Sincerely,

Kathy Poling Director, Care Management William Beaumont Hospital-Troy

Heidi Shepard Associate Hospital Director & Chief Nurse Executive William Beaumont Hospital - Troy

Submitter:

Ms. Joyce Mosier

Organization:

Vanderbilt University Medical Center

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-263-Attach-1.DOC

Page 265 of 416

June 07 2006 02:14 PM

MEMORANDUM

To: CMS

From: Joyce Mosier, Director Utilization Management, Vanderbilt University Medical Center

Date: June 2, 2006

Re: Comments to CMS – 4105 – P

Statement Submitted in Opposition to: CMS-4105-P Notification Procedures for Hospital Discharges

Vanderbilt University Medical Center ("VUMC") appreciates the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services' Proposed Rule, Medicare Program; Notification Procedures for Hospital Discharges (the "Proposed Rule') which proposes to place a requirement on hospitals to comply with a two-step notice process when discharging patients from the hospital level of care.

VUMC has built a strong reputation as a leader in medical education, research and patient care throughout the Southeast and the nation over the course of its 127-year history. Our mission is to bring the full measure of human knowledge, talent, and compassion to bear on the healing of sickness and injury and the advancement of health and wellness through preeminent programs in patient care, education, and research. We do not believe that the Proposed Rule will further our mission or benefit Medicare beneficiaries for two basic reasons:

- 1. The inpatient care setting is significantly different from the long-term care setting. It is not appropriate or necessary to have consistency in discharge notices among these different providers just for the sake of consistency.
- 2. The two-step process poses an extra cost and burden on hospitals that is not justified by any foreseeable benefit to Medicare beneficiaries.

In fact, we respectfully submit that the Proposed Rule would negatively impact VUMC and all other Medicare participating hospitals with very little or no corresponding benefit to Medicare beneficiaries.

Throughout these comments we will refer to acute care hospital patients as "inpatients" and to patients of longer term care facilities such a skilled nursing facility (SNF), home health agency (HHA) and comprehensive outpatient rehabilitation facility (CORF) as subacute or long term care patients.

The proposed two-step process is unnecessary and unworkable in the inpatient setting, which is fundamentally different from HHA, SNF, and CORF settings. Patient stays in these longer-term care facilities generally last for weeks or even months. At our SNF the majority of patient stays are longer than 12 days. Forty percent (40%) of patient stays in the VUMC SNF are longer than two weeks. (See Chart 3 attached) Accordingly, even though patients in our SNF are made aware of their appeal rights at the time of admission, they may forget about those discussions and information when preparing for discharge weeks or months later.

By contrast, the majority inpatient stays at VUMC hospitals are 1-3 days in duration. In fact, over half of our inpatients are discharged within three days or less. (See Charts 1 and 2 attached. Compare to Subacute facility where 50% discharge rate is not reached until day 13.) Each Medicare patient is made aware of his or her appeal rights in the required "Important Message from Medicare" at the time of admission. Because most inpatients receive this information within a day or two of discharge, it is unnecessary to require another notification form in so short a time frame.

It is the nature of acute care hospitals that a stay will be brief, as opposed to longer-term care facilities where the stays are inherently longer. Patients come to hospitals for a particular ailment knowing that when that ailment is stabilized or cured they will be discharged, and are, therefore, already on notice of an impending discharge by the nature of the care sought. A standardized discharge notice is not necessary for purposes of informing hospital patients of an impending discharge. At the time of admission most patients already have a good idea of the timing for discharge due to the nature of the ailment or injury. Otherwise, they are informed and frequently updated through discussions with their physicians, case managers, and discharge planners.

Requiring notification to all patients of their impending discharge at least one day before discharge would impose a significant burden on hospitals that is not outweighed by limited potential benefit to Medicare beneficiaries. We respectfully submit that the time commitment estimated by CMS falls far short of a realistic estimate of the time that would actually be required to comply with the Proposed Rule. Under perfect circumstances, with the form already prepared and readily accessible, it may only take 5 minutes to provide the form to the patient to sign. It will take far longer to lay the groundwork to have that form appropriately prepared, signed and processed, as well as to file, to maintain the files, and to work through the myriad of imperfect circumstances with which staff would have to deal. For example, if the patient is not available to sign the notice at the first attempt, it will take additional time to either wait or come back later for repeated attempts. Inpatients are frequently out of their rooms for tests or procedures. For patients who lack capacity to sign, a significant amount of time could be spent finding their power of attorney or surrogate and arranging for the appropriate patient representative to sign the notice. CMS' estimation overlooks the need to have new policies and procedures written for the hospital, as well as training for the new policies. It is not anticipated that existing staff would be able to handle the increased workload. Hiring new people to perform these tasks will add to the hospitals' permanent overhead costs at significantly more than the \$7000 that CMS estimates as the cost of implementing the Proposed Rule.

It is not always possible to know on the day of admission that the patient will be discharged the next day. More than 15% of VUMC patients have hospital stays of one day or less. In the presence of modern technology a very ill patient may stabilize more quickly than expected. To give an inpatient notice of discharge one day before the discharge should occur would be nearly impossible. It would be an unacceptable waste of resources to require that a patient stay in the hospital overnight just so they can be given a day's notice prior to a medically appropriate discharge.

Frequently, the end of a continued stay in the hospital setting is not known for a full day prior to an appropriate discharge. Often a patient's discharge is dependent on results from a test or on the patient being able to perform a certain bodily function. These results cannot, and should not, be predicted by doctors ahead of time. But when the test result or patient event indicates that a patient is ready to be discharged, the patient should be discharged – perhaps in a few hours or at the end of the day, not after another unnecessary night in the hospital. Under the Proposed Rule, it appears that a patient would be required to stay an additional day beyond their medical need, increasing costs to the patient, hospital, and Medicare.

Another challenge is how to handle patients that request their own discharge. A patient with the capacity to make his or her own health care decisions has the right to refuse care. How will the Proposed Rule apply in this situation?

Because the inpatient care setting is significantly different from the long-term care setting, it is not appropriate or necessary to have consistency in discharge notices among these different providers simply for the sake of consistency. The two-step process poses extra cost and burden on hospitals that is not justified by any foreseeable benefit to Medicare beneficiaries. Accordingly, VUMC strongly opposes the Proposed Rule and urges CMS to forego application of the two-step discharge requirement in the acute care hospital setting.

Chart 1:

Yearly Discharges VUH



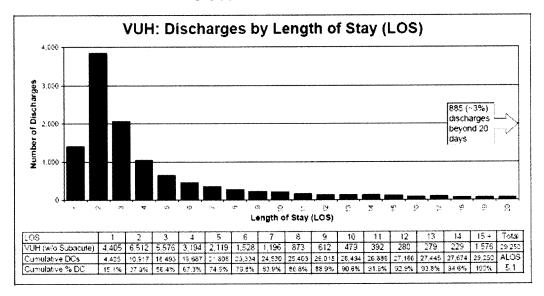


Chart 2:

Yearly Discharges VCH and PHV



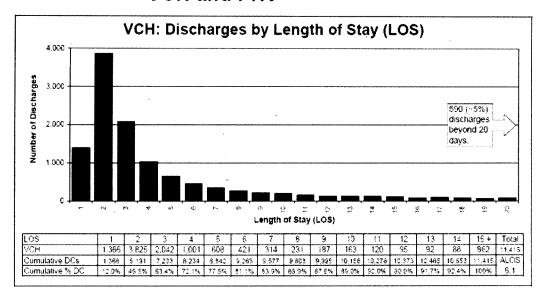
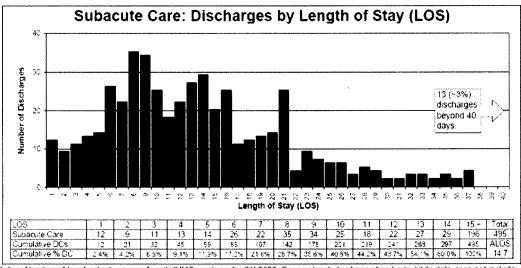


Chart 3:



Notes: Number of Inpatient admissions for all VUMC pavilions for CY 2005. Does not include observation beds. VUH data does not include subacute care (which is housed in VUH).

Source: TSI on EDW (May 25, 2006): Unaudited Inancial data. Provided by Performance Management and Improvement (Phone 6-6198).

Submitter:

Mrs. Jean Holland

Organization:

Sabetha Community Hospital

Category:

Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I have worked in the hospital setting for nineteen years now. I started as the Swing Bed Skilled Care Program came into being. I have experienced first hand how long of a process this can be to notify acute care patients of the explanation of this program. I can say without hesitation that it requires far longer than five minutes to explain this program. It also involves phone contacts to family members and /or guardians. The patient and their family can become very anxious and upset as they attempt to understand their rights while obviously not feeling well. Our Doctors do a good job of keeping their patients informed of their health status but it still is not always possible to be able to give a one day notice for discharge. Please reconsider this move.

Submitter:

Mrs. Karen Porter

Organization:

UHHS Bedford Medical Center

Category:

Nurse

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attached

CMS-4105-P2-265-Attach-1.DOC

Proposed CMS Ruling

Provisions of the Proposed Rule

The proposed rule is will add unnecessary days to Medicare admissions.

The physician often can not anticipate discharge until the day the patient meets discharge criteria, having to give a letter that day will increase days.

The patient may be ready earlier than expected, adding an unnecessary day. The patient may not have met discharge criteria on the expected day, another letter would need to be generated, but the patient may meet criteria one day later. Our physicians' usually only see the patient once a day, if it is in the evening there may be no staff until the following day after a decision to give a letter, increasing hospital days. If the decision is on the weekend we will need to have trained staff available over the hours that physicians see the patients.

MA's will delegate this responsibility to the hospital, since they do not have staff to come on-site to deliver a letter.

Most of our Medicare patients come from a nursing home, and many can't understand a letter. These letters may confuse patients and need to be explained to the patient and often again to a family member. This always takes more than 5 minutes. When a representative needs to receive a letter, this may need to be couriered, and the recipient may not be at home. If they live out of town the letter is sent express mail, this always increases the hospital days, and the cost since the letter is not received until the following day.

Submitter:

Organization:

Lahey Clinic

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-266-Attach-1.TXT

CMS-4105-P2-266-Attach-2.TXT

CMS-4105-P2-266-Attach-3.DOC



wwwl.ahev.org



David M. Barrett, M.D. President Chief Executive Officer Chairman, Board of Governors

June 2, 2006

41 Mall Road Burlington, MA 01805

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

Re: Opposition to CMS proposed rule (CMS-4105-P) that would require hospitals discharging

Medicare patients from hospital level of care to comply with a two-step notice process.

Dear Center for Medicare & Medicaid Services:

I write on behalf of the Lahey Clinic to express our concern regarding the Centers for Medicare & Medicaid Service's ("CMS") proposal to change current hospital inpatient discharge notice procedures to require delivery of a standardized notice to Medicare beneficiaries the day before discharge as well as a detailed notice if the patient requests Quality Improvement Organization review.

By way of background, Lahey Clinic is a tax-exempt charitable organization with multiple campuses in Massachusetts. The Lahey Clinic Medical Center in Burlington, Lahey's largest facility, includes a 303-bed hospital.

As proposed, the CMS notification rule would be logistically incompatible with existing hospital procedures for making appropriate discharge determinations. We recognize that a comparable procedure is already in place for SNFs, HHAs, CORFs and hospices, but the clinical environment within these entities is less intense and more static than that of an acute care facility. Often, in hospitals, a physician decision to discharge a patient is not made until the physician's morning rounds. This practice, which is designed to confirm patient readiness on the day of discharge, makes predicting discharge a day in advance extremely difficult and would likely lead to extended stays that are both medically unnecessary and that would usurp already limited hospital resources.

The proposed rule would also be both confusing and frightening to patients. The proposed generic notice creates uncertainty for the patient as to the appropriateness of discharge which can undermine the trust developed between the patient and physician. It is vital that hospitals do everything they can to ensure that this important component of the healing process is not undermined. For example, as proposed, many patients in situations with the potential for rapid improvement may have to receive notices of discharge each day for an extended period, due to the often unpredictable course of recovery in an acute care environment, in order to account for the possibility that these patients may be ready for discharge the following day. The uncertainty created by such a practice would be confusing to the patients and most likely lead to an increase in requests for unwarranted appeals.

In addition, CMS's estimates of time and resources needed to implement this rule in the hospital setting are flawed in certain respects. For example, the movement by acute care hospitals to electronic medical records is in tension with the proposed rule because the requirement that notices be kept in hard copy form would increase the resources needed to implement this rule. Also, the time estimated to prepare and deliver the paperwork does not account for the time needed for personnel to explain the notices to inquiring patients.

Accordingly, we urge CMS to reconsider the proposed discharge procedures so that hospitals' already limited resources can be better spent towards improving patient care and not towards creating a discharge system that would increase anxiety for patients at the time of discharge.

Sincerely,

David M. Barrett, M.D.

David M. Bant

Submitter:

Organization:

Lahey Clinic

Category:

Hospital

Issue Areas/Comments

GENERAL

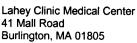
GENERAL

See Attachment

CMS-4105-P2-267-Attach-1.DOC

F 781-744-5767

wwwl.ahey.org





David M. Barrett, M.D. President Chief Executive Officer Chairman, Board of Governors

June 2, 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: Opposition to CMS proposed rule (CMS-4105-P) that would require hospitals discharging

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Accordingly, we urge CMS to reconsider the proposed discharge procedures so that hospitals' already limited resources can be better spent towards improving patient care and not towards creating a discharge system that would increase anxiety for patients at the time of discharge.

Sincerely,

David M. Barrett, M.D.

David M. Bant

Submitter:

Mrs. Rosemary Connor

Organization:

Winchester Medical Center

Category:

Hospital

Issue Areas/Comments

Background

Background

Winchester Medical Center has over 10,000 Medicare discharges per year. Notifying each beneficiary of discharge one day prior will be quite burdensome. Plus I do know that it will in fact take longer than 5 minutes. Giving a HINN takes at a minuimum 10 - 15 minutes. We often spend longer because of numerous questions. What happens if the member has a change in condition after the "generic letter" is given? Do you resend it? Do you then when the beneficiary improves reissue another letter? What happens if the patient can not understand or comprehend the content?

GENERAL

GENERAL

On reading the proposed rule ther are many questions that are unanswered. With the 10,000 plus discharges per year in our facility this would have quite an impact on staff. With contantly changing standards of care many of our patients are short stay. If this proposed rule goes into effect it would mean increasing staff to cover weekend admits & discharges. Issuence of any letter to a Medicare beneficiary is time intensive. Often they do not understand requiring a family member to also hear what the letter has to say or they just have questions. A HINN is issued when the patient no longer requires care at an acute level or SNF level of care so I feel this covers what this proposed rule is trying to do. What happens if a patient is admitted & discharged before the discharge letter can be given? Treatment plans change all the time depending on patient response. If anything this adds more steps than we need. It will hamper efficiency in treating our patients. If you do give a discharge letter what happens when the condition of the patient changes? Do we go & resend that letter? do we reissue another as the patient recovers? Also with any notification letter you will get requests for expedited review? Will the PRO be available on weekends? This certainly will slow the discharge process down thus agin making treatment inefficient.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Winchester Medical Center has over 10,000 Medicare discharges per year. Notifying each beneficiary of discharge one day prior will be quite burdensome. Plus I do know that it will in fact take longer than 5 minutes. Giving a HINN takes at a minuimum 10 - 15 minutes. We often spend longer than 15 minutes just because of questions. What happens if the member has a change in condition after the "generic letter" is given? Do you resend it? Do you then when the beneficiary improves reissue another letter? What happens if the patient can not understand or comprehend the content?

Regulatory Impact

Regulatory Impact

Hospitals do issue HINN to Medicare patients when they no longer require an acute level of care or SNF level of care not "to those Medicare beneficiaries who express dissatisfaction with an impending hospital discharge". The HINN is notifying the patient just as the "generic letter" would plus it does give an appeal process for the beneficiary. this letter is explained in detail so that all understand

Page 270 of 416

June 07 2006 02:14 PM

Submitter:

Organization:

Category:

Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter:

Mrs. Linda Childers

Organization:

North carolina Baptist Hospital

Category:

Social Worker

Issue Areas/Comments

Background

Background

Attachment

GENERAL

GENERAL

Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Attachment

Regulatory Impact

Regulatory Impact

Attachment

CMS-4105-P2-270-Attach-1.DOC

Page 272 of 416

June 07 2006 02:14 PM



AMERICAN CASE MANAGEMENT ASSOCIATION

American Case Management Association North Caroline State Chapter c/o Department of Social Work Services North Carolina Baptist Hospital Medical Center Boulevard Winston-Salem, North Carolina

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

June 5, 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 current president of the North Carolina Chapter of the American Case Management Association, a state chapter of 95 case management professionals who work in hospitals and healthcare systems throughout North Carolina. Our state chapter is a part of the National American Case Management Association (ACMA), a 1377 member national association of nurses, social workers, physicians and leaders who work in the field of case management. Our national association has set goals to: provide innovative professional development services; create networking opportunities; and influence policies, laws, and other issues related to the practice of case management.

As a state chapter of the national case management professional association, we have discussed the proposed rule CMS-4105-P and appreciate this opportunity to share our collective concerns about a new notice of Medicare discharge appeal rights that would be given to all Medicare hospital inpatients the day before their discharge. We also want to comment on the more detailed notice that would be given when a beneficiary is not satisfied with the planned discharge date.

As a state chapter of professionals with extensive experience and leadership responsibilities in many of the hospitals in North Carolina, we share a collective concern that this proposal lacks a fundamental understanding of patient care movement in the hospital environment and how the discharge planning process is individualized for each patient (and family members as appropriate). The proposed rule would impose additional burden on the discharge planning staff as they deliver and explain the discharge notice

letter, obtain signatures on it, and deal with the required follow-up when the beneficiary refuses to sign the letter.

Each of these steps will add significant time to the discharge planning process. The estimated 5 minute timeframe to deliver the notice and have it signed is grossly underestimated. Each patient/family interaction routinely takes much longer than this, especially when the patient/family has questions, wants to review discharge plans, and needs to sign paperwork. The expedited appeal, estimated to involve only 1 - 2 % of beneficiaries, is also a greatly underestimated. This will be both costly and time consuming as it will lengthen the hospital stay and necessitate additional paperwork.

Throughout the patient's hospitalization, the healthcare team provides care to the patient and works to assure that the patient's discharge is timely. Often the discharge is confirmed after physician rounds in the AM, when the patient's medical progress and clinical condition have been reviewed with the patient and team. Requiring that a notice be given "on the day before discharge" but after the discharge decision has been made, is cumbersome. It will mean that the patient remains hospitalized for a day beyond the point of medical necessity and will delay patient flow through all levels of care. Most of our state members cite their continuing need to assure patient discharges each day in order to accommodate the patients in their Emergency Room who are in need of inpatient care. Patient flow will be significantly backlogged by the provisions of the proposed rule, which will necessitate that patients remain in the hospital when they no longer need care, while the Emergency Rooms are crowded with patients needing inpatient care but waiting for an open bed.

The ACMA, North Carolina State Chapter, recommends that CMS withdraw the proposal and continue their current requirements. We urge reconsideration of this proposed rule change and a closer examination of the benefits and costs associated with the rule change as outlined in the current proposal.

Thank you for this opportunity to share our State Chapter's concerns. We would value a dialogue or any initiative working with CMS to further explore these issues. You can reach me at (336) 716-2401 or lchilder@wfubmc.edu.

Sincerely,

Junda Childers, MSW, LCSW

Linda Childers, MSW, LCSW

Chapter President

North Carolina Chapter, of the American Case Management Association

Supervisor, Case Management and Social Work Services North Carolina Baptist Hospital Winston-Salem, North Carolina

Submitter:

Ms. Bernadette Baird

Organization:

Eagleville Hospital

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attached

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter:

Mrs. Cathy Blosch

Organization: Colqu

Colquitt Regional Medical Center

Category:

Nurse

Issue Areas/Comments

GENERAL

GENERAL

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)

I appreciate the opportunity to comment on the proposed rule concening a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. I believe that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting. The changes that you are proposing that hospitals perform would almost be impossible to comply with. With our length of stays for Medicare patients being less than five days on an average and sometimes less, we would have to have two or three days advance notice to be able to comply with this. This would be a formidable task for most hospitals because we usually aren't aware of the patients impending discharge until the night before or the morning of discharge.

I recommend that the current noticesw and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.

Submitter:

Linda Charrier

Organization:

Redington-Fairview General Hospital

Category:

Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

Requiring a discharge notice 1 day prior to discharge would be externely confusing for patinents and an administrative nightmare because:

- *Planned discharges are frequently "contingent" of next day test results. Do we issue a notice if we are not sure of the discharge? How many notices would we have to issue if a planned discharge did not happen?
- *Discharges frequently occur in the late afternoon or early evening due to our diligent efforts to provide efficient care and timely discharges. Do we hold up a discharge in order to issue a notice the day before?
- *Discharge planning begins at admission. The patients and families are involved from the start and know from day to day that a safe discharge is being planned.
- *We already issue "Notices of Non Coverage" when a patient no longer meets criteria or refuses to allow SNF search for discharge.
- *Patients already receive the "Important Message from Medicare" which explains the appeal rights if they feel their discharge is premature.

I feel another notice to issue is redundant. Health care services being provided by acute care hospitals is short term. Everything happens quickly. Requiring a notice be issued the day before discharge can only serve to slow up the process and confuse our patients.

Submitter:

Mr. David McClure

Organization:

Tennessee Hospital Association

Category:

Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-274-Attach-1.DOC



June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid 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 Tennessee Hospital Association (THA), on behalf of our over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments 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 THA 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 THA 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,

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 2 of 5

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,

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 3 of 5

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 THA 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

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 4 of 5

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.

Mark McClellan, M.D., Ph.D. June 5, 2006 Page 5 of 5

• 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 THA 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.

The THA appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me or David McClure, THA vice president of finance, at 615-256-8240.

Sincerely,

Craig Becker, FACHE President

cc: American Hospital Association Ellen Pryga, Director of Policy epryga@aha.org

Submitter:

Ms. susana hall

Organization:

Baystate Medical Center

Category:

Health Care Professional or Association

Issue Areas/Comments

Background

Background

see attachment

GENERAL

GENERAL

see attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

see attachment

Regulatory Impact

Regulatory Impact

see attachment

CMS-4105-P2-275-Attach-1.DOC

Page 277 of 416

June 07 2006 02:14 PM

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:

Baystate Health 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.

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. Also, there has been no compelling case for the need to implement this change. Therefore, we do 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.

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.

- 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, we would have to keep patients when they no longer need inpatient care. As we are paid a set amount for an admission we would not receive any compensation for these additional days. 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 our ED waiting for an open inpatient bed.

We recommend 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.

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. We recommend 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.

Submitter:

Mrs. Kay Gabriel

Organization:

Mitchell County Regional Health Center

Category:

Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

Hospitals are already highly regulated and burdened with paper work. Adding this regulation burdens the nursing staff and takes the nurse further away from caring for the patient.

Submitter:

Organization:

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-281-Attach-1.DOC

CMS-4105-P2-281-Attach-2.DOC

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June 07 2006 02:14 PM

Detailed Comments Regarding the Proposed Medicare Program Notification Procedures for Hospital Discharges

Operational Implications

- The rule is at best unclear as to whether the hospital would still be required to provide the "Important Message from Medicare" at admission. It appears that this requirement would continue to exist under the proposed rule. Hospitals already have a two-step process in place as outlined above, where they are required to provide the "Important Message from Medicare" to patients upon hospital admission and a notice on how to request a review/determination when the patient disagrees with hospital discharge. It is our understanding that under the proposed rule, hospitals would continue to provide the "Important Message for Medicare" at admission, a written advance notice before discharge, and then another detailed notice if the patient requests an expedited review. This three-step process for Medicare beneficiaries where the average length of stay is less than six days is unreasonable. It is even more cumbersome, confusing and burdensome for patients in the hospital 72 hours or less. Congress expressly required the provision of the "Important Message from Medicare" because of concerns related to patient discharge with the implementation of the hospital prospective payment system. We believe that the current process is sufficient. CMS should take appropriate enforcement measures against those hospitals that fail to adhere to the current process rather than mandate more steps in the process.
- Except for a small percent 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 "planned" discharge. 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 team of other physicians. Physicians and members of the hospital team should be discussing the parameters that have to be met to warrant hospital discharge, including acceptable lab values, the ability to tolerate meals without nausea and vomiting, mobility, acceptable radiology studies, normal temperature, clearance from multiple specialty physicians depending on who is managing what aspect of care, etc. Therefore, while patients may be aware of the kinds of issues that must be addressed or under control to warrant discharge, they or their physician often cannot know precisely when those parameters will be met to warrant 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 before discharge. Essentially, the majority of decisions regarding discharge are made the evening before the day of discharge or the morning of discharge, and if hospitals proceed with discharging a patient in a timely manner it would be almost impossible to comply with the proposed requirement of 24-hour notice.
- There are numerous situations when it would be impossible for hospitals to provide the necessary and appropriate care for patients and be in compliance with the proposed rule. For instance, when we, as a general acute care hospital needs to discharge the patient to another acute care hospital, or a small community hospital must discharge a patient to be transferred to us, because we or the academic medical center provides services or higher levels of care than what can be provided in the original hospital of admission. These situations often preclude a 24-hour notice and should be exempted from the provisions in the rule. Another common occurrence is when a patient is awaiting placement in a skilled nursing facility, rehabilitation hospital, and/or psychiatric hospital. As a result of reimbursement and regulatory changes, we often must wait for notification from these health care facilities that a

bed has become available to accept a patient from the our hospital. Under these circumstances, hospitals have to move quickly to discharge the patient in order to secure the bed placement at the other facility. It would not make sense to postpone the discharge in order to provide a 24-hour notice and risk losing the placement, particularly since we have been discussing the placement with the patient and patient's family throughout the discharge planning process.

- Another concern with the 24-hour notice requirement is the fact that plans for discharge can change depending upon a patient's medical stability. This means that hospital staff may provide a discharge notification in anticipation of a patient's discharge, but if the patient deteriorates, the discharge could be postponed. Subsequently, when the patient's discharge is again planned, another 24-hour notice would be required. In essence we may be providing several generic notices in order to be in compliance.
- It is problematic that the proposal requires us to provide a notice of non-coverage on behalf of Medicare Advantage plans. This places us in a position to explain to a patient that the Medicare Advantage plan determined that their hospitalization would no longer be covered when in some instances we may disagree with that determination. It also appears that we would then be required to follow-up with a second generic notice to the same patient when we determine the patient is ready for discharge. The delivery of multiple notices to patients by the same hospital staff would be confusing to patients and families.
- It is likely that majority of the generic written notices could not be provided to patients until after the actual discharge order is written by the patient's attending physician. To comply with the 24-hour notice provision, this would mean that patients would end up staying at least one additional day in the hospital to comply with the rule even though discharge is appropriate and medically indicated. Further, in situations where the attending physician has discharged the patient and a notice has not been given in accordance with the proposed rule, we are not certain if we could legally require a patient to stay in order to be compliant with the proposed rule, particularly if the physician refuses to issue any medical orders since he/she has technically discharged the patient, or the patient wishes to be discharged.
- Increasing the hospital length of stay to comply with the proposed rule will result in delays in
 placement of emergency admissions and overcrowding in our emergency department, as well
 as across the country. This proposal has the potential to add to the already difficult problems
 being faced in our hospital's emergency departments.
- In many cases, the delivery and explanation of the advance notice will fall to nurses because many discharge decisions are made in the evening and on weekends when discharge planners or case managers are not available in the institution. This will undoubtedly create job dissatisfaction among nurses at a time when we are working to decrease such activities by nurses so that they can spend more time in direct patient care. Given the national workforce shortage for nurses, we should be looking at ways to decrease the administrative burden on nurses and not increase it. Even the most diligent nurse may end up failing to give an advance written notice to the patient because of the multitude of other tasks and patients for whom they provide care.

Financial Implications

As previously stated above, the length of stay for many Medicare patients could be extended by at least one day in order to comply with the requirement to provide advance written notice 24-hours before discharge. This will create further financial strain on all hospitals.

- We believe the projection regarding the percentage of patients who would request an expedited review is vastly underestimated. Initially, there may be a small percentage of patients who request an expedited review, but once it becomes common knowledge that the hospital stay can be extended by at least another day until the review can be completed, the percent of patients requesting an expedited review will be well beyond the 1-2 percent of patients estimated by CMS. Anecdotally, home health agencies report that more patients view the request for an expedited review as automatic because the patients know that they will continue to receive health care services while their case is under review and are at no personal financial risk while the review is taking place regardless of the decision rendered.
- The rule fails to accurately estimate the time it will take to deliver the notice to patients and costs associated with the proposed rule. Specifically, the estimated time of five (5) minutes to provide, explain and obtain the patient's signature on the form is a gross underestimation of the time that will be required to provide the advance notice. CMS has failed to account for:
 - the costs and time associated with the printing of the forms, including purchasing duplicate forms or copying the form to demonstrate that all the required information is on the form and that the patient has signed the form;
 - the time required to assemble the forms with other documents;
 - the time required to coordinate with physicians and other care professionals to establish when the advance notice can be delivered;
 - the time required to coordinate with the patient's family in cases where the patient is unable to receive and sign for such a notice;
 - the actual time to explain the form to the Medicare beneficiary and/or Medicare beneficiary's family and to get the form signed;
 - the time to assist the Medicare beneficiary or the family to request an expedited review by the QIO;
 - the time required for the filing of the notices in the medical record;
 - the costs associated with the copying of medical records sent for review to the QIO, including the possible purchase of fax machines that allow for efficient faxing of large volumes of documents;
 - the upfront costs associated with researching and providing the specific language required to be cited in the detailed notice of explanation;
 - the costs associated with having more case managers and utilization review managers available to deliver these notices to Medicare patients or the overtime that will be incurred by hospitals in order to have all the documents delivered to patients, families and/or the QIO in the timeframes as proposed in this rule;
 - The costs associated with training nurses and other health care professionals who would need to deliver the notices during evenings, nights and weekends when the utilization management and case management staff would be otherwise unavailable and the costs associated with the maintenance and storage of these documents for a period of years.
- The detailed explanation must describe any applicable Medicare coverage rule, instruction or Medicare policy, including citations to the applicable Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy. Further, the detailed notice must contain facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case. And finally, the hospital must give the detailed notice to the beneficiary by the close of business on the day that the hospital is informed by the QIO that the QIO has received a request for an expedited determination from the beneficiary. The requirement for the provision of a detailed notice is not something that heretofore has been done routinely by hospitals.

Coverage Determinations versus Discharge

- As previously mentioned, the proposed rule fails to make 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. In §422.620 of the proposed rule, it states, "Before any discharge from the inpatient level of care, the hospitals must deliver valid written notification of non-coverage of the Medicare Advantage organization's or hospital's discharge decision to the enrollee". We would argue that if notification is required to be provided to Medicare Advantage enrollees, that it be the responsibility of the Medicare Advantage plans to provide both the generic notification and the detailed notification. It is the Medicare Advantage plan that is in the position to make a decision regarding non-coverage that could ultimately impact a Medicare patient's financial liability. If the treating physician disagrees with the Medicare Advantage plan's decision of non-coverage, then a patient would continue receiving inpatient treatment and there would be no discharge. Therefore, it is not necessarily the discharge notification that is critical, but the notice of non-coverage which is determined by the Medicare Advantage plans and therefore should be communicated directly by the plan and not hospital personnel.
- Additionally, as proposed, we could be in a position of having to provide a notice of non-coverage on behalf of the managed care plan even though the patient is not being discharged from the hospital, and then be required at the actual time of discharge to give yet another notice. This would be confusing to Medicare patients, especially when both notices would have to be provided by the same hospital staff. Additionally, we may also disagree with the decision made by the Medicare Advantage hospital non-coverage decision and plan to appeal that determination through provider appeal mechanisms. Consequently, we would be placed in an awkward position to have to deliver and explain notices of non-coverage on behalf of Medicare Advantage plans.

Language in the Forms

- We are concerned about being required to place our hospital logo on the "Generic Notice of Non-coverage" and the "Detailed Explanation of Non-coverage", especially in cases of Medicare Advantage plan's determination of non-coverage. We are not making decisions regarding non-coverage; therefore, the notice should not indicate that it comes from the hospital. Specifically, the generic notice states, "Your hospital and/or Medicare Advantage (MA) plan have determined that Medicare probably will not pay" is an inaccurate statement since we do not make determinations regarding Medicare coverage.
- Under the section "You Have the Right to Request a Review," the generic notice states, "if you request an immediate review, you will not have to pay for any services." Again, this appears to be inaccurate since the proposed rule indicates that when a patient requests an immediate review, the patient would not incur any additional financial liability for services received before being notified of the independent reviewer's decision other than regular cost-sharing for which the patient would be liable.

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:

We are writing to comment on the proposed rule in "Medicare Program; Notification Procedures for Hospital Discharges," as published in the April 5, 2006, Federal Register.

We believe CMS, in attempting to improve the hospital discharge planning process, has proposed an unworkable solution. The proposed rule fundamentally ignores how care is delivered in hospitals. First and foremost, we 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.

Additionally, this rule as written will have many unintended consequences for our hospital, and the health care delivery system as a whole. Many critical issues that we are facing today will be worsened, 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 appears to interchange non-coverage decisions with decisions about hospital discharge, which are two separate processes.

Detailed operational, financial and other concerns are included as an attachment to this letter. Based on these identified concerns, we **do not recommend** implementation of the proposed rule. We do recommend the following:

- Maintain current requirements for hospitals and use a consistent approach for oversight and enforcement of these already existing requirements.
- Modify the existing "Important Message from Medicare" to more 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.
- Consider convening a stakeholder group in concert with national hospital associations, key professional groups, and consumer advocacy groups to develop a

Centers for Medicare & Medicaid Services Department of Health and Human Services June 5, 2006

Page 2

better perspective of the various constituency group concerns and how best to address 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 new requirements on what is already in existence.

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, we would encourage the following modifications to the proposed rule for consideration by CMS:

- Modify the Generic Notice and the Detailed Explanation forms to distinguish between decisions made by Medicare Advantage plans for hospital non-coverage and decisions made by hospitals for patient discharge. These are not interchangeable terms, and it is important to make the distinction clear for the patients and families.
- For Medicare Advantage patients, we strongly recommend that it be the Medicare Advantage plans' responsibility for communicating information regarding noncoverage. Specifically, the 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.
- We strongly recommend building flexibility into the requirements for Medicare notification procedures for hospital discharges. We recommend that hospitals are allowed to deliver the generic notice during the course of care as opposed to 24hours in advance. The 24 hour time frame will cause delays in discharges and/or the issuance of multiple letters for many patients during their inpatient hospitalization.
- Further, the 24-hour requirement should be eliminated for patients who have a planned 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.
- At the very least, if the final rule includes the requirement of a 24-nour notice, a provision for exceptions to the notification requirement must be included, such as when a patient requires an emergency discharge to another general acute care hospital for more complex medical/surgical care 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.
- Require the QIO to be available 24 hours a day, 7 days a week so that patients have access to a dispute resolution process.

Centers for Medicare & Medicaid Services Department of Health and Human Services June 5, 2006 Page 3

We 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 our and all hospitals, and result in increased lengths of stay that will negatively impact others' access to patient care. Additionally, we do not feel there has been careful consideration of the financial implications of the proposed rule on hospitals. We also are very concerned about 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.

We strongly 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.

Should you have any questions regarding the comments submitted by our institution, please feel free to contact me at (814) 877-4143 or by email at jim.donnelly@hamot.org, or Theresa Kisiel, Utilization Management Supervisor at (814) 877-2115 or by email at theresa.kisiel@hamot.org.

Sincerely,

Jim Donnelly Vice President, Patient Safety and Quality Hamot Medical Center

Submitter:

Mr. Christopher Palazzolo

Organization:

St. John Hospital & Medical Center

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-282-Attach-1.DOC



June 2, 2006

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

Re: Medicare Proposed Discharge Notice

CMS-4105-P

Dear Dr. McClellan:

St. John Hospital & Medical Center ("SJHMC") appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services ("CMS") regarding the proposed notification procedures for hospital discharges under both original Medicare and the Medicare Advantage program. The proposal would apply to all hospitals and require them to provide Medicare patients with a short, standardized discharge notice on the day before the planned discharge. Since the decision is also made with the patient's physician, frequently during morning rounds, SJHMC believes this proposal would be unnecessarily burdensome for both patients and hospitals and that it is out of sync with standard discharge planning and physician discharge order patterns.

Background

Currently, SJHMC is required to provide patients with the Important Message from Medicare (IMM) that includes generic information upon admission. This required notice provides a general statement of a beneficiary's rights as a hospital patient and their discharge and appeal rights. SJHMC is required to provide a notice of non-coverage to Medicare beneficiaries who express dissatisfaction with an impending discharge. This notice informs the patient that inpatient care is no longer required and that the beneficiary will be financially liable for hospital care beyond the second day following the date of the notice.

Under the recent proposal, the CMS would continue to require hospitals to provide patients with the IMM. However, the proposal would eliminate the current hospital-issued, general notice of non-coverage, replacing it with a two-step patient specific notice process for hospital discharges, similar to the process for post-acute facilities. Under the proposed rule, SJHMC would be required to provide Medicare patients with a standardized discharge notice 24 hours prior to a planned discharge and a more detailed notice if the patient appeals the discharge decision. The proposed notice would be in addition to the Important Message from Medicare (IMM) that hospitals are required to provide to Medicare patients upon admission.

Mark McClellan, M.D., Ph.D. June 2, 2006 Page 2 of 4

SJHMC has several key concerns regarding the proposed discharge notice as summarized below:

Intent of the Proposed Rule

The intent of the proposed rule is not clear. The CMS has not provided evidence to demonstrate that patients of Home Health Agencies, Skilled Nursing Facilities, or other post-acute facilities have benefited from a two-step notice process. The notice also fails to provide evidence that the proposed two-step process will benefit hospital inpatients, hospitals, or the CMS, which is particularly concerning since the policy will have a significant impact on beneficiaries and hospitals. Generally, based on hospital experience in discussing discharge matters with Medicare patients, many Medicare beneficiaries are confused by issuance of multiple documents regarding their rights. As proposed, the discharge notice will further increase confusion and stress experienced by beneficiaries particularly given their state of illness and upcoming transition to a lower level of care. We believe that this proposal would cause consternation among beneficiaries rather than benefit them and create the potential for them to believe their planned discharge date may be inappropriate. This could result in distrust in physicians and hospitals and lead to requests for more detailed notices and appeals than are warranted, resulting in additional burden on both hospitals and Quality Improvement Organizations (QIOs).

Increased Administrative Burden

The proposed policy would create an additional administrative burden for SJHMC to develop a process for determining the discharge date and communicating it to the patient, physicians, and discharge planning staff. In its estimated regulatory impact, the CMS only included the time it would take to deliver a notice to each inpatient, estimating this would take 5 minutes per patient and 60-90 minutes for each patient that appeals the discharge decision. The CMS estimate does not include time required to prepare the notice, explain the notice or why beneficiaries have to sign for it. In addition, it does not reflect the staff time and capital costs incurred by hospitals to maintain hard copy files containing the signed copies for all Medicare admissions. For SJHMC, there are over 13,000 annual Medicare inpatient discharges.

Predictability of Discharge Date

Since patient discharge is often dependent upon specific test results, such as elimination of an infection and its associated fever, it is often difficult to predict when the discharge will occur. The discharge decision is made **solely** by the physician, frequently during morning rounds after reviewing test results, patient medical records, and determining the patient no longer requires inpatient care. The proposed policy would require SJHMC to know the discharge date at least one day in advance of the actual discharge. As a result, in many cases, it would result in hospitals being required to keep the patient an extra day to allow 24 hours after issuing the discharge notice. In addition, the CMS estimates that 2 percent of patients will appeal, which provides them with at least 3 additional days in the hospital. Increasing the length of stay for these patients would result in a significant increase in hospital costs while resulting in bed

Mark McClellan, M.D., Ph.D. June 2, 2006 Page 3 of 4

shortages for hospitals with high occupancy levels. This in turn, would reduce accessibility to inpatient care for beneficiaries who would be required to wait until a bed became available. Although this notice is required in the post-acute setting, SJHMC believes it is inappropriate in for the CMS to require a discharge notice 24 hours prior to discharge. Post acute care providers generally have a longer term relationship with patients, making the discharge notice seem more appropriate. In addition, the medical conditions of patients in the post acute setting is typically much more stable than in the inpatient acute setting.

Discharge Decision

SJHMC believes it is inappropriate for the CMS to penalize hospitals by requiring a discharge notice one day prior to the actual discharge since the discharge decision is made by the physician, not the hospital. As indicated above, the discharge decision is the discharge order, which generally does not get executed until morning rounds on the day of discharge when the physician confirms that the patient's medical condition no longer requires inpatient care. While some patients may know their expected length of stay prior to admission for scheduled procedures, it is adjusted based upon the individual patient's response to treatment and their specific medical conditions. For other admissions such as heart attack, stroke, falls that result in a fracture, or other emergencies, the expected LOS or discharge date is unknown at time of admission.

Timing of Notice

There are a variety of logistical issues related to the timing of the notice, such as when the discharge is postponed due to a fever spike or complication the night before the expected discharge, or when the average stay is one or two days. The CMS' supporting rationale for the 24-hour notice is based entirely on what they have done in the post-acute setting, which differ operationally from the inpatient acute setting. For patients in Diagnosis Related Groups (DRGs) that typically have a length of stay (LOS) of one to two days, the hospital would be required to deliver both the IMM and the standardized discharge at admission. SJHMC believes this would result in further confusion and concern for beneficiaries and increase distrust of the healthcare delivery system and lead them to believe their planned discharge is inappropriate.

Impact on Hospital Length of Stay (LOS)

If SJHMC kept 10 percent of its 13,000 Medicare cases patients an additional day and 2 percent of Medicare patients an additional 3 days due to appeals, the hospital would experience an increase in length of stay of 2,080 days, with no additional Medicare payment. In its proposal, the CMS failed to consider the potential impact on LOS, and additional cost to hospitals, which is a significant concern.

Electronic Health Records

The proposed policy would require manual signatures by Medicare beneficiaries or their representatives, documenting its receipt and their understanding of it. This requirement is contrary to the CMS' desired movement to electronic health records. The paperwork clearance

Mark McClellan, M.D., Ph.D. June 2, 2006 Page 4 of 4

package submitted by the CMS to the Office of Management and Budget (OMB) indicates that it must be provided and maintained in hard copy and that they are not making any provision for electronic alternatives.

Summary

In conclusion, SJHMC strongly opposes this policy due to its significant impact on hospitals and Medicare beneficiaries. As indicated above, SJHMC <u>cannot</u> support the proposed policy due to the:

- impact of increasing hospital length of stay which will have a significant negative financial impact and likely will result in bed shortage issues
- increased administrative burden on hospitals
- inability to predict discharge date 24 hours in advance, prior to having patient test results and monitoring the patient's specific medical condition and response to treatment
- confusion it will cause for Medicare beneficiaries, which will lead to decreased patient satisfaction
- proposal is inconsistent with the CMS' desired movement to electronic health records

If the CMS is concerned about providing patients with a discharge notice, SJHMC suggests that the CMS modify the Important Message from Medicare (IMM) to achieve the CMS objective. This revision could include a highlighted, bolded section explaining discharge appeal rights. We feel that this would be sufficient since for many hospital inpatients, it is impossible to predict the discharge date prior to having test results.

In addition, SJHMC believes it would be helpful if the CMS formed a workgroup, including beneficiaries, to provide input regarding the proposed discharge notice.

Again, we appreciate this opportunity to provide comments to the CMS regarding this proposed discharge notice. We believe that, with the incorporation of our suggested recommendations, Medicare beneficiaries will be able to receive the information they need regarding their discharge from the inpatient hospital setting without undue administrative burden or the potential increase to a patients' length of stay. If you have questions on this comment letter, please contact me at (313) 343-3558 or via e-mail at chris.palazzolo@stjohn.org.

Sincerely,

Christopher J. Palazzolo Vice President & CFO St. John Hospital & Medical Center

Submitter:

Mr. Mark Sblendorio

Organization:

Warren Hospital

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-283-Attach-1.PDF

Page 281 of 416

June 07 2006 02:14 PM



185 Roseberry Street • Phillipsburg, New Jersey 08865 Telephone (908) 859-6700 Fax (908) 859-4546

June 5, 2006

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

Re: Proposed Rule CMS-4105-P

Dear Sirs and Madams:

We are writing on behalf of Warren Hospital in response to Proposed Rule CMS-4105-P (the "Proposed Rule"), published in the Federal Register on April 5, 2006. On behalf of the Hospital, its staff, physicians, and patients, it is our opinion that the Proposed Rule is unnecessarily complex, impractical, and would place a new, significant financial burden on hospitals. It also demonstrates a lack of understanding of the discharge process.

Most significantly, the Proposed Rule would require the Hospital to give the patient a "generie" discharge nonce the day before a discharge occurred. While the Proposed Rule notes that this process is taken from the requirements placed on HHAs, SNFs, and other non-hospital providers, this proposed requirement demonstrates a basic misunderstanding of the discharge process in general acute care hospitals, and how that process differs from other care settings. Unlike in other care settings, the physician's determination of when a patient should be discharged is often a "day-by-day" determination. It is very common for a physician to determine that a patient is ready for discharge on one day, with the patient actually discharged on the very same day. Under the Proposed Rule, the Hospital would be required to, in many cases, guess as to when the date of discharge will be so that it can provide the notice on the day before that assumed date. If the Hospital does not provide the notice at the proper time, it would be required to hold off on discharging the patient for another day.

To require the Hospital to add a day to every Medicare patient's stay would place an unfair financial burden on Hospitals to provide services for that extra day without additional reimbursement. We

Mark Sblenderio, Esq.
Director of Legal Affairs and General Counsel
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¹ For all practical purposes, any "waiting period" between one "day" and the next will likely require a patient to be held for at least twelve (12) additional hours, as patients who may be ready for discharge after the early evening would be required to be kept at the hospital until the next morning.

note that Medicare HMOs are quick to deny payment for any day that a patient is stable, and we noticed that Proposed Rule does not suggest that Medicare will pay Hospitals for the services provided during this "waiting period" before actual discharge.

Further, the financial analyses contained in the "Regulatory Impact" suggesting that the "costs" to the Hospital would be \$5,200 and \$1,875 are grossly off target. To keep a stable person in a hospital bed for an additional day would not only prohibit the Hospital from using that bed for other persons in need. It would also require additional staff and services that the Proposed Rule completely ignores. For example, typical case management personnel and medical records work on 5-day schedules (tied to the normal work week). The Proposed Rule would require the Hospital to have seven (7) days of staff, and in many cases weekend staff are paid at higher rates than weekday staff. Further, all case management, records personnel, and nurses, would have additional duties regardless of when they are scheduled, further stretching the capabilities of the personnel. Simply, every day in the Hospital requires the Hospital to provide food, nursing oversight, security, and other basic needs that very quickly add up. Over the course of a typical year, the Proposed Rule would very likely cost the Hospital hundreds of thousands of dollars, if not more.

Finally, the Proposed Rule does not take into account the wishes of a patient. In almost every situation, the patients are anxious to leave the Hospital, and to require them to stay an additional day when they are no longer in need of the Hospital's services is insulting, unsettling, and, possibly, unlawful. What is a hospital to do if the patient desires to leave, but has not been given the necessary "one day" notice? The process laid out in the Proposed Rule only offers the patient more paperwork to deal with, more chances for misinformation and confusion, and more unhappiness with the Hospital and the health care system in general.

We certainly support every effort by CMS to improve the Medicare system for the benefit of its beneficiaries. However, in a time when hospitals, especially nonprofit hospitals like Warren Hospital, are already stretched to the limit financially, adding significant additional costs to the program must only be in return for some quantifiable and significant additional benefit. Under the Proposed Rule, no such benefits - to the Hospital or the patient - are apparent. As such, we would support the complete withdrawal of the Proposed Rule at this time.

Very truly yours,

WARREN HOSPITAL

Mark Shendorio, Esq.

Director of Legal Affairs and General Counsel

Submitter:

Mr. Val Kraus

Organization:

Boulder Community Hospital

Category:

Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-284-Attach-1.DOC

Page 282 of 416

June 07 2006 02:14 PM

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

Friday, June 02, 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 a director at Boulder Community Hospital, a 210, community Health-care System located in Boulder, Colorado.

As a director I have been directly involved with discharge planning for Boulder for the past year. Our current discharge planning practices 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, case managers interview all patients meeting the hospital's screening criteria: patients over age 70, Medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. 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 places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. My recommendation is to allow telephonic notification of the decision maker when the decision maker is not the patient.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 3.6 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients are discharged from the hospital in 1-2 days, very soon after the patient has received their Medicare rights information during the admission process. My final recommendation is for the generic notice to be required for patients in the hospital for 3 days or more.

I have read that CMS estimates only 1-2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1-2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expected results, and indeed, the increased costs (administrative and LOS) do not justify the means.

I appreciate the role of CMS in safeguarding patient rights. We believe we must protect patients rights while also stewarding government resources and ensuring patients do not take advantage of an opportunity to unnecessary extend a length of stay adding significant costs to Medicare.

Sincerely,

Val Kraus Director, Case Management Boulder Community Hospital PO Box 9019 Boulder, CO 80301-9019 303-440-2124—Office 303-938-5319—Fax

Submitter:

 ${\bf Organization:}$

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter:

Organization:

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-286-Attach-1.DOC

Page 284 of 416

June 07 2006 02:14 PM

Comments to Proposed Rule: Notification Procedures for Hospital Discharges

In response to the proposed Notification Procedures for Hospital Discharges, published in 71 FR 17052, we wish to submit our concerns.

Initially, we note that CMS desires to afford hospital inpatients with the same two-step notice of appeal rights as afforded to other beneficiaries. 71 F.R. 17054. Although standardization between healthcare settings may be conceptually desirable, we believe CMS should reevaluate whether it is warranted. Hospitals differ considerably from their longer-term counterparts regarding the care provided and patient mix. Hospital inpatients generally experience a shorter length of stay than patients in other care settings. Medical care decisions (including alterations to treatment plans and disposition decisions) provided to beneficiaries in acute care settings are fraught with more variability and less predictability than care administered in home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospice settings.

Timing of Notice

In many case, administering the standardized notice on the day prior to the planned discharge is an unrealistic expectation. While this process could probably be implemented with little difficulty in cases that follow a fairly standardized plan of care (i.e. total joint replacement patients) it would be considerably more difficult to implement for most other patients. This is because many patients in acute care have medical conditions that do not follow a predictable course and are not amenable to planning for a next day discharge.

The proposed rule fails to consider the practical implementation of the discharge process, particularly the physician component. Discharge orders are often dependent upon the patient reaching a specified criteria. As hospitals cannot foresee the expediency with which a patient's medical condition improves, the discharge planning process often cannot occur 24 hours in advance. Another factor to consider is that hospitals cannot compel physicians to anticipate patient discharges. The 24-hour requirement would unjustly punish hospital because the hospital would absorb 24 hours of additional, medically unnecessary inpatient stay merely to satisfy the 24-hour notice requirement.

As noted in the Federal Register, CMS specifically seeks comments regarding circumstances under which a hospital should be able to deliver the notice on the day of discharge. 71 F.R. 17054. We have identified several situations CMS should consider:

- Patients with an anticipated length of stay less than 96 hours. It would be unnecessary and potentially confusing to provide the patient with two notices.
- Inter-hospital transfers. Many patients are urgently/emergently transferred from small
 hospitals to tertiary care centers. These patients are technically discharged from one
 hospital and admitted to another. Unfortunately, these situations would not allow time
 for administration of a standardized notice. Instead, patient safety would take precedent
 over compliance with the rule.
- Intra-hospital transfers. Many hospitals perform intra-hospital transfers, such as from the acute, inpatient setting to a skilled nursing setting or to a psychiatric setting. These transfers involve a formal discharge from one unit and a formal admission to the new unit. Patients may be confused if they are presented with a statement that they are being discharged and their stay will no longer be covered. Additionally, there may be

- circumstances in which a transfer must be made urgently, such as from the acute inpatient unit to the psychiatric unit.
- Delays in discharge. The date and time of discharge is dependent upon a multitude of factors, including the physician's rounding schedule, the patient's condition, and the receipt of test results. This raises two questions. First, must the discharge be delayed in order to ensure notice was given within 24 hours? Second, if discharge does not occur within 24 hours of notice, must multiple notices be given?
- Unanticipated early discharges. Patients can rapidly improve and be ready for discharge, as determined by the physician evaluation, on any given day. Should discharge be delayed unnecessarily and the stay be extended by one day so that the standardized notice can be administered? It is not in the best interest of the patient to increase the length of stay for medically unnecessary reasons.
- Patient choice. May patients opt out of the 24-hour delay in discharge (i.e., if the patient is prepared for discharge, but was given notice only 12 hours ago, may the patient opt to be discharged anyway rather than wait the remaining 12 hours)?
- Time at which 24 hours begins. There will be instances in which a patient is not capable of receiving and acknowledging the Notice and the hospital will have to coordinate with a family member or representative to accept the Notice. Many times, the representative will not be available until the end of the business day. In these instances, will the 24-hour period be delayed until the representative signs the Notice or may it begin upon verbal notification and acceptance?

Content of Notice

The proposed rule defines a process that seems only destined to create more confusion in the Medicare population that it seeks to serve. If the goal of the proposed rule is to provide a more consistent approach to communicating appeal rights across provider settings, we think that it could be better accomplished in the following manner: (1) adding a statement to the current "Important Message from Medicare" that Medicare coverage will terminate upon the patient's discharge unless review is requested (2) retaining the current HINN/NODMAR processes for implementation in exception cases. This would lessen the administrative effort for all and diminish the confusion to the Medicare population.

Should CMS implement this proposed rule, we recommend flexibility that hospitals be allowed to handwrite the non-generic information (i.e. name, date of issuance, Medicare number, and effective date). It would be unreasonable and administratively burdensome for hospitals to have to type in the patient-specific information. To do so would consume approximately 5 minutes for the discharge personnel to go to the computer, type in the information, and print the form. Additionally, hospital would have to install a designated computer and printer for discharge notices.

Burden to Hospital

The new rule predicts that it will take an average of 5 minutes to deliver the standardized notice. This may be so, however, the rule also states that "hospitals generally must determine whether a patient is capable of comprehending and signing the notice" and references compliance with State laws and CMS guidance regarding determining appropriate representatives. Additional time will most certainly be required to make the determination and to make contact with and arrangements for signing of the notices by patient representatives. That does not seem to be factored in. This does represent additional burden on small facilities with only one discharge

planner. In addition, it is likely that registered nurses will actually become the staff members administering generic notices after business hours. Given the shortage of nurses, this is not feasible in most hospital settings.

Recommendations

- We believe that an adequate process currently exists in the form of the Important Message from Medicare and the HINN procedure. CMS is relying upon anecdotal, rather than quantitative, evidence that the existing process is deficient. Education and enforcement of the existing rules is all that is necessary to remedy any existing deficiencies.
- We recommend that CMS retract this proposed rule and process, due to the economic, logistic, and administrative burdens. If CMS determines that the current notification process is inadequate, we advise clarifying the current process, rather than creating a duplicative, and potentially confusing new step. If problem lies instead in compliance regarding the existing Important Message from Medicare, we recommend that CMS concentrate its efforts in educating and enforcing this process rather than punishing those who are already compliant.
- If CMS does determine that a duplicative notification process be instituted, we recommend the following:
 - Clarification of the definition of "discharge"
 - Provide exemptions for the Notice, as noted in comments above, under the heading. Timing of Notice.
 - Clarify whether multiple Notices must be given if discharge is delayed.
 - Allow the Notice to be given sooner, such as within 4 hours of discharge.
 - o Allow hospitals to handwrite the patient-specific information on the Notice.

We thank you for the opportunity to comment.

Submitter:

Ms. Terry Lambert

Organization:

Newman Regional Health

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

June 5, 2006

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

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 realize that CMS is trying to provide more information to patients by proposing this rule but it is not practical.

The current process already adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services.

It will be very difficult to provide the proposed notices. From a practical point, just trying to find the patient in the room due to tests and procedures can be almost impossible. A delay in a procedure or communication can cause a delay in discharge. If for some reason we can not talk to the patient because their family might be present, the discharge can again be delayed.

The proposed discharge notice invites or encourages unwarranted appeals and longer lengths of stay.

The true costs associated with this proposed requirement are grossly understated. In addition, it will not add value to the patient.

For the aforementioned reasons, along with others, we encourage you to reject this Discharge Notification Proposal.

Sincerely,

Terry R. Lambert Chief Executive Officer

Submitter:

Mrs. Kathy Cummings

Organization:

Union Hospital

Category:

Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-288-Attach-1.DOC

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June 07 2006 02:14 PM



Kathy Cummings, RN, Director Union Hospital Department of Care Management 659 Boulevard

> Dover, Ohio 44622 Phone: (330) 364-0819

Email: kathyc@unionhospital.org

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

June 5, 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 a Director at Union Hospital, a 140 bed, community Hospital located in Dover, Ohio.

As a Director I have been directly involved with discharge planning for all ages for the past 24 years. Our current discharge planning practices 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, case managers interview all patients. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. 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 places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. My recommendation is to allow telephonic notification of the decision maker when the decision maker is not the patient.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.0 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients are discharged from the hospital in 1-2 days, very soon after the patient has received their Medicare rights information during the admission process. My final recommendation is for the generic notice to be required for patients in the hospital for 3 days or more.

I have read that CMS estimates only 1-2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1-2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expect results, and indeed, the increased costs (administrative and LOS) do not justify the means.

I appreciate the role of CMS in safeguarding patient rights. We believe we must protect patients rights while also stewarding government resources and ensuring patients do not take advantage of an opportunity to unnecessary extend a length of stay adding significant costs to Medicare.

Sincerely,

Kathryn M. Cummings