Submitter : **Paul Stimmel** **Date: 06/05/2006**

Organization : **UPMC**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:
On behalf of the University of Pittsburgh Medical Center (UPMC) we are submitting our comments and concerns regarding the Center for Medicare and Medicaid Services (CMS)proposed rule (71 FR 17052,4/5/2006) 'Medicare Program; Notification Procedures for Hospital Discharges.' UPMC comprises 19 hospitals and a network of other care sites across a 29-county service area: doctors' offices, cancer centers, outpatient treatment centers, specialized imaging and surgery facilities, in-home care, rehabilitation sites, behavioral health care, and nursing homes. All care management activities within UPMC are coordinated by the corporate care management department to ensure consistent policies and procedures are in place.

Our Directors of Care Management and Physician Advisors have serious concerns about this proposed rule and request that it be withdrawn. We believe that the impact of this proposed rule is not minimal to acute care facilities, but instead places additional administrative and financial burdens on healthcare staff, requires unnecessary extensions of patient stays and is redundant to current notification requirements. (See attachment for full text of comments.)

Submitter : Mr. Fred Kagarise

Date: 06/05/2006

Organization : MidMichigan Health

Category : Health Care Industry

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached comments

CMS-4105-P2-290-Attach-1.DOC

MidMichigan
Health

June 2, 2006

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

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

On behalf of MidMichigan Health and MidMichigan Medical Center – Midland, MidMichigan Medical Center – Gladwin, MidMichigan Medical Center – Clare, and Gratiot Medical Center, providers of inpatient hospital services to Medicare Beneficiaries, I am submitting these comments on the proposed rule.

Our general comments are:

- The rigid process of this Notice will lead to longer than necessary stays for patients
- The Notice will be used to extend stays to meet Skilled Nursing three day rule
- The Two-Step Notice process does not fit Short-Term Hospital processes
- The required signature and storage of forms is unnecessary
- The Notice process is too rigid for changing patient's condition
- The Notice will increase cost or divert services worth approximately $125,000

Our specific comments follow below.

Provisions of the Proposed Rule

We do not support the requirements of the two-step discharge notification process for all Medicare patients as proposed in this rule.

Our primary concern with this required notice is that it would be turned into a mechanism to increase the stays of patients that no longer need acute levels of care. The determination that a patient no longer needs an acute level of care can happen at any time of the day. Often, that determination is made once test results are known or the patient's condition changes as the day progresses. The patient is then safely ready at that time for discharge. But, there will have been no way to know that the situation will be such twelve to twenty-four hours earlier so as to have given the patient this Discharge Notice. So, the result is likely to be that most patients will be ready to be discharged, but the notice will not have been given on the prior day. So, we

will have to hold the patient until the next day only so as not to violate this notice requirement. We think this will be the resulting standard and not medically necessary for the patient. We believe this Notice process should not be a requirement that keeps patients in the hospital beyond what is medically required, but as proposed would do just that.

We are concerned the Notice will encourage patients to extend their stay to meet the required three-day acute stay criteria prior to Medicare coverage of Skilled Nursing care. Many times a patient is no longer in need of acute care, but Medicare will not pay for the care at a Skilled Care facility because the three-day acute stay minimum has not been met. The patient tries to extend the acute stay just for that purpose. CMS should review the need for the three-day minimum given the changes in medical care since this standard was adopted and the expansion of "transfer" criteria on the acute DRG payment method.

The proposed two-step process may work in situations where the care treatment is not continuous, such as is the case for Home Care or CORF. In these cases no additional costs are incurred by the providers as the notice process unfolds. In the case of hospital patients, there are incremental costs that are not incurred now if we have to keep patients over to the next day. The patient may not receive additional medical care, but will need to be provided additional meals, being checked on by staff, added visitors requiring staff assistance, and other non-medically necessary services.

Another difference in the care that allows the two-step process to work in HHAs, hospices, CORFs or SNFs is the length of time the care takes place over. Acute Care in our hospitals takes place over one, two, up to four days in the majority of cases. Each patient has just received the Important Message from Medicare information when admitted. Then, we will be giving them another Notice that covers the same information very soon after that. This is unnecessary in the short stays we generally see. Another Notice may be more appropriate in the case of a Long-Term Care Hospital or Rehabilitation Hospital or Unit where the length of stay is so much longer. Many days will have passed since admission in these types of settings. We see it being reasonable that another Generic Notice be given to the patient for long length of stays, like those that last beyond seven days, when necessary. We do not see a need to provide additional Generic Notices for shorter-stay patients.

We disagree with the need to require a signature by the patient or a representative that a Generic Notice was provided and that the signed Notice be retained in the Medical Record of the patient. Only in circumstances where the patient will incur additional costs has the Program required signatures and the storing of the document for later proof. As stated in the Proposed Rule, the vast majority of patients will not incur additional costs or challenge the discharge timing. In this majority of cases, the Generic Notice and signature step is unnecessary then. We do not believe that any additional burden is justified just so the process is the same as that of other providers.

We are concerned this process would be too restrictive and possibly confusing for a patient when their condition changes once the Notice is given and we are not able to go through with the discharge. If we give a patient the Notice in anticipation of being able to discharge them and the patient's condition is such that we cannot discharge them as notified, we believe this

rule requires another Two-Step process to be preformed once the patient is ready. This places everyone in a confusing situation. The patient may believe they are going to have to pay for the added day because they have been notified as such or they may start a discharge appeal unnecessarily. Our Staff may believe the patient was notified correctly, when the patient didn't get the second Notice. We will have to file multiple sets of the form and some may get discarded as being duplicates. This Notice Rule does not improve the patient's treatment and shouldn't be adopted.

We are concerned about the need to increase knowledgeable staff on weekends to comply with filling out the Detailed Explanation of Hospital Non-Coverage form. Identifying medical reasons for no longer needing inpatient care for a patient is not overly burdensome, but filling out this form wouldn't be normally taken into account when assigning staffing levels. The time estimate for completing the form would be incremental to normal operations and require additional costs. This incremental time would have to be covered through overtime by nursing staff that are already short in many places. Next the requirement that individualized Medicare policy and coverage guidelines are required to be included, is not the normal concern of nursing staff. This would mean having additional knowledgeable staff on site or on-call and at additional costs as well. We will need to either add staffing cost or divert the current efforts of staff of approximately $125,000 between direct and indirect costs for this Two-Step process. We believe any additional burden, even if not viewed as "significantly impacted" to the hospital by the CMS staff, should be taken only when a compelling need justifies it since there is no way to recover the added costs fully through the Medicare Program. This Rule would require additional services to Medicare beneficiaries that are not the same as those for other patients and the added cost will not be recoverable from the Medicare Program. This is shifting the burden to pay for these added services to other patients inappropriately, either as added costs or reducing staff availability diverted for this process.

Summary Comments

We believe in the ideal situation each and every patient will be fully informed by the treating physician and hospital staff as a patient is care for. The exact timing of a patient's condition to allow discharge from care is not so ideal. Requiring a prior day's notice of discharge will undoubtedly add to the length of some patient stays and place providers at risk for unnecessary costs.

We believe the Proposed Rule requiring an additional Two-Step Notification Process for Medicare patients is an unnecessary burden by requiring patient signatures and storage of unnecessary papers as the vast majority of patients will not challenge their discharge.

We believe there may be a need to re-notify a patient of their right to appeal a discharge after a long length of medical care as is the case generally for HHAs or LTCHs care, but in General Short Term hospitals it is an unnecessary compliance procedure.

Submitted on behalf of MidMichigan Health,

Fred Kagarise

Fred Kagarise
Manager of Corporate Reimbursement

Submitter : Mr. Mike Whitehair

Date: 06/05/2006

Organization : Sutter Delta Medical Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-291-Attach-1.DOC

Attachment #291

Sutter Delta Medical Center

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 Case Manager at Sutter Delta Medical Center, a 141 bed, community Hospital/Heatlhcare System located in Antioch, California.

As a Case Manager I have been directly involved with discharge planning for Medicare Population for the past 9 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 <x> 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,

Mike Whitehair MSN, RN
Case Manager

Submitter : Ms. Jennifer Fennell

Date: 06/05/2006

Organization : St. John Oakland Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-4105-P2-292-Attach-1.DOC

Attachment #292

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:

On behalf of St. John Oakland Hospital (SJOH), one of the St. John Health hospitals located in Southeast Michigan, SJOH appreciates this 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, SJOH 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, SJOH 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. SJOH 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, SJOH hospital 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.

SJOH 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 hospitals 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 SJOH, there are over 3,600 Medicare inpatient discharges annually.

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 that SJOH 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 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, SJOH 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

SJOH 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. SJOH 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 SJOH hospital kept 10 percent of our 3,600 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 576 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 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, SJOH strongly opposes this policy due to its significant impact on hospitals and Medicare beneficiaries. As indicated above, **SJOH cannot support the proposed policy due to the:**

- impact of increasing hospital length of stay which will have a negative financial impact for SJOH and will result in bed shortage issues.
- increased administrative burden on SJOH
- 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, **SJOH 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, SJOH **believes it would be helpful if the CMS formed a workgroup, including beneficiaries, to provide input regarding the proposed discharge notice.**

Again, the SJOH appreciates 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 via e-mail at jennifer.fennell@stjohn.org.

Sincerely,

Jennifer O. Fennell
Vice President of Finance
St. John Oakland Hospital

Submitter : Lisa Croce

Date: 06/05/2006

Organization : American Health Quality Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-4105-P2-293-Attach-1.DOC

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. Len Preslar **Date:** 06/05/2006

Organization : North Carolina Baptist Hospital

Category : Hospital

Issue Areas/Comments

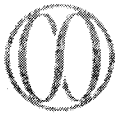
GENERAL

GENERAL

See attachment.

CMS-4105-P2-294-Attach-1.PDF

Attachment #
294



Wake Forest University Baptist
MEDICAL CENTER

Len B. Preslar, Jr.
President and Chief Executive Officer
North Carolina Baptist Hospital
Telephone: (336) 716-4750
Fax: (336) 716-2067

June 5, 2006

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

Dear Dr. McClellan:

North Carolina Baptist Hospital (NCBH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled, "Medicare Program; Notification Procedures for Hospital Discharges." 71 Fed. Reg. 17052 (April 5, 2006). NCBH is the acute care hospital of Wake Forest University Baptist Medical Center, an academic health system comprised of 1,106 acute care, psychiatric, rehabilitation and long-term care beds located in the northwestern section of North Carolina, the region's main tertiary referral center.

NCBH believes the proposed discharge notice process would be overly burdensome because it would be out of sync with standard hospital discharge planning and physician discharge order patterns, would result in unwarranted extensions to length of stay, and would impose an unnecessary financial burden on our hospital.

Background:

In the Notice of Proposed Rulemaking (NPRM), CMS states it developed the current two-step notice process for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices in response to litigation involving Medicare+Choice (now Advantage) enrollees who were unaware of coverage and benefit limitations in hospital settings. CMS now proposes to implement the same two-step notice process for all Medicare hospital inpatients.

Through the NPRM CMS proposes that prior to discharging any Medicare beneficiary, hospitals, such as ours, would be required to deliver "on the day before the planned discharge" a standardized notice to each Medicare beneficiary whose physician agrees with the discharge decision. The notice would inform each beneficiary when Medicare coverage ends and beneficiary financial liability for continued services begins, and it would explain the beneficiary's rights of appeal. The appeal would be triggered if the beneficiary disagrees with the discharge decision. In such a case, NCBH would be required to deliver a detailed notice providing specific information about the decision discharge. The NPRM further states that this first notice would take only about five minutes to complete and up to 90 minutes to complete, deliver and explain the appeal notice.

Problems with the Proposed Rule:

1. Notice "One-Day Prior" to Discharge

It is often impossible for NCBH to know a day in advance whether a patient will be discharged. Our physicians determine when a patient is to be discharged based on the patient's clinical status, not NCBH. NCBH cares for the most complex and severely ill patients, whose health status can change very quickly. The discharge determination of these patients often requires the agreement of multiple physicians. Many times this decision is made on the morning of the day of discharge. Hospital staff do keep the patient informed of progress toward discharge, however, the physician makes the discharge decision - which is the predominant discharge practice for acute care hospitals.

The proposed "one-day prior" notice requirement would result in hospitals, including NCBH, providing an extra day of inpatient care when the Medicare beneficiaries would no longer need it, thereby adding significant financial costs, and creating significant deleterious operational and patient care consequences.

2. Personnel Time:

NCBH also believes that it will take much longer than CMS's five minute estimate to deliver the first notice, and longer than 90 minutes to complete, deliver and explain the appeal notice. It is not an accurate estimate of the amount of time that would be required to explain the notice to the beneficiary or explain why he/she has to sign it. In addition, if the beneficiary cannot understand the notice or is unable to sign, our staff would need to deliver the notice(s) to the patient's representative and obtain a signature.

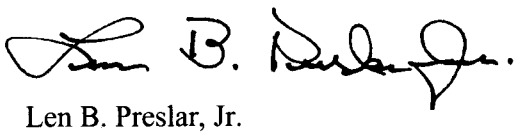
Either additional staff will be required or if no additional staff is available the proposed notice procedure would reduce the amount of time the staff is able to devote to other important aspects of the coordination of the beneficiary's care, which we believe is counterproductive to CMS's philosophy.

Recommendations

NCBH respectfully requests that CMS withdraw the proposed rule and retain the current discharge requirements. If CMS nevertheless believes there are specific problems associated with the discharge planning process in hospitals that need to be addressed, we support the recommendations of the American Hospital Association (AHA) and the Association of American Medical Colleges (AAMC) that CMS convene a national work group comprised of hospital, physician, beneficiary, CMS, and Quality Improvement Organization representatives to ensure full understanding of how current and proposed procedures will affect the various parties, and to ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights.

If you have any questions concerning these comments, please contact Joanne C. Ruhland, NCBH Vice President Government Relations, at jruhland@wfubmc.edu or 336-716-4772.

Sincerely,



Len B. Preslar, Jr.

LBP:jcr

Submitter : **Ms. Rosarian Clemons** **Date: 06/05/2006**

Organization : **Saint Anthony Medical Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

The proposed rule requiring healthcare providers to give patients written noticem of their impending discharge at least 1 day in advance will add unnecessary hospital lengh-of-stays. Clinicians CANNOT accurately predict, in the large majority of cases, the optimal moment when everything comes together for discharge. Frequently, you must wait for lab results, x-ray results, home care or SNF approval, etc. also, patients' conditions may improve from one day to the next-they may not have been ready for discharge the day before but now their condition is such that they may be discharged home safely (their lungs have cleared, temperature is down, etc.).

Also, I feel you're grossly under-estimating the time it will take to deliver the letters. Try going into an elderly patients room, giving them a sheet of paper, explaining it to them, and being able to leave in 5 minutes. Each patient will take at least 20 minutes!

If we are not able to deliver the notice 1 day prior to dischare, will the patient be able to stay an "extra" day when they don't meet medical necessity? This goes against what CMS has been trying to accomplish. this why HINN letters are normally issued.

Submitter : Mrs. Christine Wagner **Date:** 06/05/2006

Organization : Southwest General Health Care Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

The proposed rule would add unnecessary days to the hospital and cause financial hardship on the hospital to comply. Particularly when under pressure to meet the DRG expected length of stay.
Getting the physician to communicate to the staff the exact date anticipated for discharge can be difficult. We are a community hospital and the physicians are private practitioners who make rounds at all times of the day and evening, making speaking directly with them on a daily basis difficult at times. The staff in the Utilization Review department do not work 7 days a week or 24 hours a day. Their role is to work with the physician staff around medical necessity and discharge planning. The weekend Social Work staff would be unable to do anything but serve letters and answer questions for patients and families. I would estimate each encounter would take about 30 min. This would be a hardship on the staffing and budget for the hospital.
The physicians often have difficulty anticipating the exact date of discharge, every patients case is individual and needs careful consideration. This would prolong the length of stay and add unnecessary days if the patient became ready for discharge before the anticipated discharge date.
If the patient does not meet discharge criteria on the anticipated date another letter would need to be generated. This will add unnecessary days to the stay.
There may not be an appropriate bed in the post acute area.
This will only confuse patients, who may then want an explanation to a family member or members. This will take significant time for the staff to spend explaining the letter, instead of focusing on medical necessity.
If the patient has a POA they will have to be reached, they may not be available or even live in the state. If they are unreachable by phone,they will need a registered letter.

Submitter : Ms. Andrea Werner **Date:** 06/05/2006

Organization : Bellin Health Hospital Center

Category : Hospital

Issue Areas/Comments

Background

Background

Our hospital is working very hard to eliminate waits and delays for our patients as they traverse the continuum of care. If this notification process becomes a regulation, it will add another step in the process of procuring a timely discharge.

There are many methods for which to procure a timely discharge. Our health system uses the Milliman Guidelines to help us moniter the patient progress, and we have insituted things like scheduled discharges in order to synchronize all necessary services to support discharge on time. This regulation would be duplicative to the innovative steps we already have in place, and wasteful.

It is also important to note that this regulation takes the staff such as social workers and discharge planners, and also admission reps and billers, to do a paper work oriented task. Thus, it is the patient in the end who suffers as a result of less face time with the healh care professionals.

Finially, I feel that this is a negative financially on hospitals if passed, as it would be costing us money to do this redundant work.

Submitter : Ms. Michele Moran **Date:** 06/05/2006

Organization : Marquette General Health System

Category : Hospital

Issue Areas/Comments

Background

Background

See below in general comments.

GENERAL

GENERAL

As a Utilization Management professional with 30 years experience in the field, I join my state hospital association(Michigan)in opposing the policy of notifying Medicare beneficiaries 24 hours prior to discharge that their coverage will end the next day.
First of all, this is impossible in some situations as numerous legitimate inpatient hospitalizations are shorter than 24 hours. And in lengthier hospitalizations, the physician cannot always predict 24 hours in advance when his/her patient will be ready for discharge.
This would be stressful for a patient who receives this notice in anticipation of discharge the following day,and then subsequently experiences an event that prolongs his hospitalization. Having received a NODMAR, he might be more focused on potential liability than on following his doctor's advice to remain in the hospital. With such a possibility always existing, this would also mean more monitoring once a notice is delivered, rescinding the notice, and then reissuing it at a later date.
This proposed policy also infringes on the patient/physician relationship, which has always been promoted by CMS as sacrosanct. I have administered hundreds of HINN's in my career, but we always stress that discharge date and time is between patient and physician.
I predict that notification for some patients would necessarily fall on the day of discharge, which, for some patients would allow them technically an extra day. This would be costly for the Medicare program and the hospital. And of course, should those records be reviewed by the state QIO, it would be obvious that the day was non-acute.
CMS notes that the cost of this program will not impact any individual hospital to a great degree. I probably speak for most hospitals when I say that the estimate of $1875 per provider is impossibly low. We have +6000 inpatient Medicare discharges/year and it is in no way possible to do this task for $.31/patient. CMS estimates that each notice would require about 5 minutes per patient. The logistics of filling out the generic notice with the patient's information alone would take a few minutes; there is also the trip to the patient's room, explaining the content of the notice, and then documenting the delivery of the notice. In the best case scenario, that being an alert, agreeable patient, we would expect this to take at least ten minutes, at least for the first hospitalization after this becomes law. In other cases locating a relative, making a phone call, and mailing the letter would add up.
But even using this low estimate this would be, according to CMS calculations a total of over eleven million dollars. In a time when 46 million of our population has no health care coverage it is a travesty to consider spending health care dollars in this way. Add to that CMS's cost to monitor this program, and it is obscene.
I feel that even the requirement of issuing the 'Important Message from Medicare' is inappropriately delegated to providers. I believe that this information would better be distributed to beneficiaries at the time of enrollment in the Medicare program. This should be handled by either the Social Security Administration or the QIO in the state where the beneficiary resides. With less that 1/2 of hospital inpatient admissions qualifying as scheduled or planned, the time of admission is not the most practical time for patients to learn about their rights as a Medicare patient. The average beneficiary does not understand level of care, medical necessity, or any of the terms of their health care coverage that we, as providers, must comply with under conditions of participation.
Beneficiaries would be better served if CMS took this $11 million plus and invested it in outreach programs to educate recipients about their coverage.
Please do not burden hospitals with this task. There is absolutely no benefit for the patient or the physician, nor is there any return on investment for hospitals.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS-4105-P REQUIREMENTS FOR HOSPITAL DISCHARGE NOTICES TO ALL PATIENTS 24 HOURS PRIOR TO DISCHARGE FROM AN ACUTE CARE HOSPITAL. NOTICE TO INFORM PATIENTS THAT THEY WILL BE LIABLE FOR FURTHER CARE AFTER IT IS DETERMINED THAT THEY ARE READY FOR DISCHARGE. NOTICE TO BE GIVEN THE DAY BEFORE.

Regulatory Impact

Regulatory Impact

1993 class action lawsuit involving a Medicare managed care organization.

Submitter : Ms. Jill Squiers **Date:** 06/05/2006

Organization : New Jersey Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-299-Attach-1.DOC

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

Attachment #299

May 31, 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

The New Jersey Hospital Association, on behalf of its member hospitals and health systems, appreciates the opportunity to comment on amendments to the hospital discharge notice requirements proposed at 42 CFR Parts 405, 412, and 422. For several years we have lobbied CMS through meetings with the American Hospital Association and via regulatory comments for greater clarity in the process of providing notice of noncoverage to enrollees. While this current proposal brings consistency to the processes among healthcare settings, and between traditional and managed Medicare, NJHA believes that additional changes would close any ambiguities related to the Medicare Advantage plans' requirement for delivering the notice and their obligation to continue coverage for services during an appeal. NJHA's support, as well as a request for greater clarification, is explained in detail below.

Provisions of the Proposed Rule

NJHA is generally supportive of the proposal, which requires hospitals to issue a standardized discharge notice similar to the one provided at admission while retaining the requirement that, for Medicare Advantage beneficiaries, the MA plan must issue the more detailed denial explanation. We have long believed that it is the plan's responsibility to notify the patient regarding any decision to deny or reduce a service. Placing this responsibility on the provider, as had been proposed on previous occasions, is not only administratively burdensome for physicians and hospitals, but absolves plans from accountability for their utilization management determinations.

However, we are concerned about the timing of the notice that hospitals must deliver. In addition, we request that, upon adoption, CMS provide clarification on the role that physician concurrence plays in an MA plans' discharge decision:

- **Section 422.620(b)(1) – Timing of the notice/financial responsibility for services**

  NJHA is concerned about hospitals' obligation to provide notice under this section. The reality is that hospitals are told either by a faxed authorization log or during their daily concurrent review session with a payer's utilization management staff that the plan will no longer cover acute care services for that day. Hospitals rarely receive advance notice from a payer that it will cease coverage of inpatient care the next day. Under the proposal, hospitals will be notifying patients of the pending discharge <u>on the same day</u> the plan is discontinuing coverage.

760 Alexander Road ■ PO Box 1 ■ Princeton, New Jersey 08543-0001
Tel 609-275-4000

NJHA seeks CMS' confirmation that despite not having advance notice of a plan's intent to terminate coverage or change the level of authorized care, patients would still have until noon of the day following issuance of the notice to make a decision about filing an appeal. For example, if a plan tells a hospital on Tuesday that it will no longer cover acute care services, and a hospital notifies the patient that same day of the discontinuation of coverage, the plan must cover services at the acute care level until noon Wednesday. This policy is reflected in the current rules at § 422.620(a)(2), which specifically state that an enrollee is entitled to coverage until at least noon of the day after a notice of noncoverage is provided. However, the new proposed section removes this explicit language entirely.

It is not clear whether the removal of this coverage obligation was an oversight or if CMS intended to change which party is responsible for covering the hospital stay until the discharge notice is effective. CMS' assurance that MA plans will continue to be responsible for covering inpatient hospital services at the same level as previously authorized until the effective date of the discharge notice is appreciated.

- **Section 422.620(c) – Physician concurrence**

NJHA supported changes CMS made in 2005, eliminating the requirement that plans obtain the treating physician's concurrence with the discharge decision prior to delivering the notice. The requirement to obtain concurrence resulted in a delay in issuing the notice, which prevented enrollees from appealing a decision that had been made already by the plan but simply not communicated to the enrollee. The change adopted last year more accurately reflects the way healthcare is practiced today, in that health plans may determine that they will no longer pay for acute care services but the physician does not agree with that decision.

However, CMS is retaining in this proposal a similar requirement, which is that plans obtain the physician's concurrence before discharging a patient or changing the level of care. This requirement still sets up obstacles to moving the discharge and/or appeal process along. The practical effect of the requirement is that when a plan cannot obtain a physician's concurrence with its discharge decision, the effective date of a patient's discharge cannot be established.

NJHA requests CMS' confirmation that if the discharge date cannot be established because the physician does not agree with the plan's decision, hospitals' obligation to deliver the standard notice of noncoverage is not triggered. Moreover, CMS should confirm that because a discharge date cannot be determined and a notice delivered, plans will continue to be financially liable for hospital services until at least noon the day following delivery, despite the plan's previous decision to discontinue coverage.

Thank you for your consideration of our concerns and requests for clarification. Should you have questions or would like more information, please contact me at jsquiers@njha.com or 609-275-4252.

Sincerely,

Jill A. Squiers

Jill Squiers
Assistant Vice President, Health Planning

K:\MANAGED CARE\Medicare MC\NODMAR\Comments to Notice Proposal 4-5-06.doc

Submitter : Ms. Charleeda Redman **Date:** 06/05/2006

Organization : UPMC|University of Pittsburgh Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-300-Attach-1.PDF

CMS-4105-P2-300-Attach-2.PDF

Attachment
300

UPMC University of Pittsburgh Medical Center

Corporate Care Management/Resource Center

Quantum One Building
Fourth Floor
2 Hot Metal Street
Pittsburgh, PA 15203

June 5, 2006

VIA Electronic Submission

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

Dear Sir or Madam:

On behalf of the University of Pittsburgh Medical Center (UPMC) we are submitting our comments and concerns regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (71 FR 17052, 4/5/2006) "Medicare Program; Notification Procedures for Hospital Discharges." UPMC comprises 19 hospitals and a network of other care sites across a 29-county service area: doctors' offices, cancer centers, outpatient treatment centers, specialized imaging and surgery facilities, in-home care, rehabilitation sites, behavioral health care, and nursing homes. All care management activities within UPMC are coordinated by the corporate care management department to ensure consistent policies and procedures are in place.

Our Directors of Care Management and Physician Advisors have serious concerns about this proposed rule and request that it be withdrawn. We believe that the impact of this proposed rule is not minimal to acute care facilities, but instead places additional administrative and financial burdens on healthcare staff, requires unnecessary extensions of patient stays and is redundant to current notification requirements. Within our organization issuance of Hospital Notices of Non-coverage (HNN) and Notice of Discharge and Medicare Appeal Rights (NODMAR) falls within the scope of the care management department at each of our facilities and contrary to CMS position on the minimal impact to acute care facilities, we recognize that adding the issuance of the two-step discharge notification for acute care hospitals would require expenditure of additional resources and be an administrative burden to all involved. Staffing would need to be adjusted to have resources available on weekends and after hours. Turnover rates within care management nationally are extremely high as case loads are increasing but FTEs are not. Adding additional administrative burden to an already taxed workforce will contribute to the unnecessary loss of advanced practice staff. Feedback from UPMC professionals that have had experience with this requirement in both the home health care and skilled nursing environments agree that to mandate this process within acute care facilities is not reasonable.

The estimation of 60-95 minutes for the two-step process to be completed is a gross underestimation of the resources that will need to be allocated to this process. Given the numerous changes with Medicare and the recent confusion surrounding patients passively enrolled in Medicare Advantage Plans, this additional change will add to the chaos that currently exists for the Medicare population.

Given the rapidly aging population and challenges faced by acute care hospitals to care for this population, it is not practical to expect that hospitals can be compliant with the requirement to provide the discharge notice 24-hours prior to discharge. In the event of a 1 day length of stay the

notification would need to be provided at the time of admission. For patients with longer lengths of stay the physician decision to discharge the patient will depend on test results and response to treatment; therefore, the predictability within 24 hours will be difficult to assess in many cases.

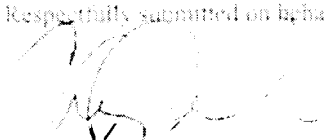
Furthermore, in the event that a decision has been made to discharge the patient, but the 24-hour notification has not been given, is it the expectation that facilities will need to increase the overall length of stay to comply with this regulation? These additional 24-hours in the hospital may place the patient at risk for infection and/or an adverse event.

Lastly, there has been no guidance as to how patients with altered level of consciousness, decreased mental capacity, and/or language barriers should be addressed. In these situations the estimated time to comply will significantly increase. Additional education and resources to ensure patients are adequately informed and understand these forms will need to be put in place.

The content of the documents that will be required for this notice is not significantly different than what is currently contented in HNN or NODMAR documents. It is not clear what the added value to the beneficiary would be in the new process. Medicare beneficiaries and their families are already under a significant amount of stress and have had difficulty understanding the changes in Medicare coverage in the last several years. Implementation of this proposal will only add to the state of confusion that already exists as it will not be possible to accurately predict discharge given the amount of clinical variables that ultimately determine the patient's stability for discharge.

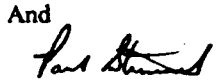
We strongly believe that the process that is currently in place to issue a HNN or NODMAR is appropriate. The proposal does not provide justification to do away with an already efficient process to add to the administrative burden and increased resource utilization for Medicare beneficiaries. The cost to implement this rule and resource that would need to be allocated to comply with this regulation can be better spent in enhancing services for Medicare and Medicare Advantage members and/or in addressing the many underinsured or uninsured Americans.

Respectfully submitted on behalf of UPMC and UPMC Care Management,



Charlpeda Redman RN, MSN
Director, Corporate Care Management
UPMC| University of Pittsburgh Medical Center

And



Paul Stimmel
Sr. Special Projects Manager, UPMC

Submitter : **Mrs. Marci Bennett** **Date: 06/05/2006**

Organization : **St. Francis Hospital and Health Centers**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-4105-P2-301-Attach-1.DOC

June 5, 2006

Department of Health and Human Services
Centers for Medicare & Medicaid Services
File Code: CMS-4105-P

To whom it may concern,

This letter is in response to the proposed new ruling, CMS-4105-P, which would replace the acute hospital's obligation of a general notice of non-coverage with a two-step process for hospital discharges. The new proposal would require hospitals to notify every Medicare recipient of their prospective discharge date, their right to appeal, and the date that financial liability for continued services would begin. This process would instill undue hardship and costs to hospitals to meet this standard for a variety of reasons discussed within this letter.

The greatest impracticality of this process would be for the departments responsible for issuing these letters and to do so in a timely manner. The majority of acute care hospitals have case management programs but few are staffed to a level that every patient is seen each day and few if any could accommodate this new process on weekends and holidays. The nursing staffs are already immersed with the day to day care of patients, do not have the expertise to address the patients and their families' questions, and should not be asked to add this to their list of duties. In providing this information to patients, the case management staff with expertise in the Medicare rules should be the one to do so in order to answer questions or facilitate an appeal if requested.

Many patients have anticipated dates of discharge that are changed based upon clinical complications or changes that occur prior to the anticipated date of release. This would entail more than one notice with a corrected date to the beneficiary, which would further increase time commitments and costs to the case management departments.

The concern of the hospital's time and cost to provide this process is only one factor. One has to consider the reaction of the patients to such a letter. The elderly patient population has difficulty understanding their Medicare benefits that this would further compound their confusion and increase their anxiety. This would also impact the time spent with patients for each of the case managers/social workers.

The potential concern with not being able to meet the standard set by CMS could be a significant impact to the acute care hospital system. While we appreciate the attempts by CMS to impact the financial reimbursements from Medicare, the financial ramifications to the acute care hospital systems could potentially be overwhelming. We as a three acute care hospital system and a Division of the Sisters of St. Francis Health Services, Inc., appreciate the leadership of CMS and respectively request the CMS-4105-P proposal be denied. Thank you.

Sincerely,

Marci Bennett RN, BSN, CPHQ, LNC
Director of Healthcare Quality/Case Management
St. Francis Hospital and Health Centers
(317) 783-8746
marci.bennett@ssfhs.org

Submitter : **Mrs. Lisa Kattelmann** **Date: 06/05/2006**

Organization : **Northeast Georgia Health System**

Category : **Hospital**

Issue Areas/Comments

Background

Background

We feel implementation of CMS-4105-P will cause increased administrative burden on hospitals. Northeast Georgia Health system had 9,531 Medicare inpatient discharges in FY05. Per CMS calculations of 5 minutes per letter this would be 794 hrs. of personnel time. At $30/hr the cost to our organization would be $23,820. This is another example of significant administrative overhead and additional annual cost with no reimbursement

If CMS goals are to "select regulatory apropaches that maximize net benefits: this proposed rule does not. We debate the suggestion that issuance of the discharge notice will take 5 minutes per patient. It is our experience that discussion of potential noncoverage issues prompts many questions and frustrations from patients and families and 10-15 minutes per patient is a more realistic time frame.

GENERAL

GENERAL

See attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Identifying the day before discharge is challenging with acute care patients. the patients are acutely ill and it is difficult to anticipate when response to treatment will allow discharge. If the letter is issued and the patient needs to stay longer do hospitals issue a reinstatement letter only to go through the process again? This is time intensive and an administrative burden on hospitals.

We feel the proposed process will cause confusion with Medicare beneficiaries and frustration towards the hospital staff as the bearer of information. Our experience has shown that patients often become frustrated when discussing coverage information during an acute hospitalization. Discussion between the patient and physician regarding readiness to DC is usually successful. If the patient agrees with the medical decision making regarding discharge why does discontinuation of coverage need to be brought up with every patient? We feel it is more prudent to allow medical decision making to continue to drive the process vs. benefits entering into every discharge.

Regulatory Impact

Regulatory Impact

It appears the primary rationale for implementation of CMS-4105-P is to provide consistency with a two-step notification process currently in place with SNF, HHA, CORF and Hospice Services. It is our opinion that these areas have a much longer length of stay in which the discharge date is anticipated further in advance than acute care. These areas often set discharge dates one week in advance with ample opportunity for notification. Acute care stays are most often 3 to 4 days, with identification of the day prior to discharge being difficult. Often the medical decision regarding readiness for discharge is done the day of discharge following evaluation of current clinical status and testing and/or labwork. We believe the current one step process of HINN is more appropriate in the acute care stay and gives the patient appropriate appeal opportunity and grace days if the disagree with the disharge decision.

CMS-4105-P2-302-Attach-1.DOC

Attachment #302

Northeast Georgia Health System, Inc.
743 Spring St. NE Gainesville, GA 30501

June 2, 2006

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

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 RN Manager of Case Management Services at Northeast Georgia Health System, which includes 461 acute care beds in Gainesville, GA.

As an RN Case Manager I have been directly involved with discharge planning for the past 15 years. Our current discharge planning practices begin at the time of admission and involve regular on-going communication with patients and families regarding their readiness for discharge and their discharge plan. The current process includes ample opportunity for patients to change their minds regarding discharge plans, question the process or disagree with the discharge and request an appeal to the QIO.

BACKGROUND: It appears the rationale for implementation of CMS-4105-P is to provide consistency with a two-step notification process currently in place with SNF, HHA, CORF and Hospice Services. It is our opinion that these areas have a much longer length of stay in which the discharge date is anticipated further in advance than acute care. These areas often set discharge dates one week in advance with ample opportunity for notification. Acute care stays are most often 3 to 4 days, with identification of the day prior to discharge being difficult. Often the medical decision regarding readiness for discharge is done the day of discharge following evaluation of current clinical status and testing and/or labwork. We believe the current one step process of HINN is more appropriate in the acute care stay and gives the patient appropriate appeal opportunity and grace days if they disagree with the discharge decision.

PROVISIONS OF THE PROPOSED RULE:
Again, identifying the day before discharge is challenging with acute care patients. The patients are acutely ill and it is difficult to anticipate when response to treatment will allow discharge. If the letter is issued and the patient needs to stay longer do hospitals

issue a reinstatement letter only to go through the process again? This is time intensive and an administrative burden on hospitals.

We feel the proposed process will cause confusion with Medicare beneficiaries and frustration towards the hospital staff as the bearer of information. Our experience has shown that patients often become frustrated when discussing coverage information during an acute hospitalization. Discussion between the patient and physician regarding readiness to DC is usually successful. If the patient agrees with the medical decision making regarding discharge why does discontinuation of coverage need to be brought up with every patient? We feel it is more prudent to allow medical decision making to continue to drive the process vs. benefits entering into every discharge.

REGULATORY IMPACT: We feel implementation of CMS-4105-P will cause increased administrative burden on hospitals. Northeast Georgia Health System had 9,531 Medicare inpatient discharges in FY05. Per CMS calculations of 5 minutes per letter this would be 794 hrs. of personnel time. At $30/hr the cost to our organization would be $23,820. This is another example of significant administrative overhead and additional annual cost with no reimbursement.

If CMS goals are to "select regulatory approaches that maximize net benefits" this proposed rule does not. We debate the suggestion that issuance of the discharge notice will take 5 minutes per patient. It is our experience that discussion of potential noncoverage issues prompts many questions and frustrations from patients and families and 10-15 minutes per patient is a more realistic time frame.

Our organization appreciates the role of CMS in safeguarding patient rights. We believe we must protect patient rights while also maintaining excellence in care, exceptionally responsive customer service, and appropriate stewardship regarding use of Medicare funds. If new processes are to be put in place we would hope there would be a significantly positive patient impact vs. the desire to have conformity across various services at a significant administrative burden to hospitals.

Sincerely,

Lisa Kattelmann, RN, BSN
Manager-Case Management
Northeast Georgia Medical Center

Submitter : **Mrs. Joanne Fletcher** **Date: 06/05/2006**

Organization : **Bayhealth Medical Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-303-Attach-1.DOC

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 06, 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 Bayhealth Medical Center which consists of Kent General Hospital, a 231 bed, community Hospital/Healthcare System located in Dover, DE and Milford Memorial Hospital, a 168 bed, community Hospital/Healthcare System located in Milford, DE.

As a director, I have been directly involved with discharge planning for the past 3 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, care 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 5.4 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 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,

Joanne Fletcher, RN, MSN
Director of Care Management
Bayhealth Medical Center

Submitter : **Mrs. Elizabeth Reffitt** **Date: 06/05/2006**

Organization : **St. Claire Regional Medical Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-304-Attach-1.DOC

St. Claire Regional Medical Center
222 Medical Circle Drive
Morehead, Ky. 40351

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 4, 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 Registered Nurse at St. Claire Regional Medical Center, a 139 bed Hospital located in Morehead, Ky. I respectfully request CMS to postpone implementation of these changes and to allow a group of hospital discharge planners to work with CMS to identify problem areas or concerns and develop a solution that will be satisfactory for all.

As a Case Manager I have been directly involved with discharge planning for patients in our facility for the past several 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, the case management team interviews patients meeting the hospital's screening criteria, including Medicare beneficiaries and patients at high risk for needing post acute services, etc. 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.
I have read that CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal and expect the process would take only five minutes. My experience has been that it often takes much longer to explain the Medicare regulations. I am also concerned that this may be a gross underestimate of time consumption as patients become more aware of how easy it is to continue their hospital stay.

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. The physician makes the decision when to discharge a patient. Physicians usually do not issue a discharge order until the morning of the day of discharge. The discharge order is written after they have seen the patient, evaluated their status, determined the patient has not developed a fever or other complication and is stable for discharge. Should a patient recover and cease to need acute services more rapidly than anticipated, will an additional day of hospitalization be mandated to allow for the delivery of the "day's notice"? If so it would seem that CMS is requiring hospitals to provide an extra day of inpatient care that is unnecessary.

I respectfully request CMS postpone making these proposed regulatory changes. I would also suggest that a task force of hospital discharge planners be convened to address issues or concerns with the discharge planning process.

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,
Elizabeth Reffitt, R.N.
Manager, Case Management
St. Claire Regional Medical Center
Morehead, Ky. 40351

Submitter : G. Richard **Date:** 06/05/2006

Organization : Hastings

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-305-Attach-1.DOC

June 5, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Dear. Dr. McClellan:

RE: CMS-4105-P

I write to you today on behalf of Saint Luke's Health System (SLHS) in Kansas City, Missouri. SLHS is made up of eleven hospitals, several physician groups, and other medical services organizations. Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule, "Medicare Program; Notification Procedures for Hospital Discharges" appearing in the Federal Register, Vol. 71, NO. 65, on Wednesday, April 5, 2006.

We have many concerns about this proposed rule. Most important, it will affect the quality of care for outpatients, by potentially and unnecessarily extending their length of stay. It will also place an administrative burden on our hospitals that greatly outweighs the would-be benefits reported in the proposed rule.

Provisions of the Proposed Rule
We understand CMS's intent to standardize the discharge process for Medicare beneficiaries, but the requirement to give patients (or their representatives) one-day notice is not always practical. For example, the decision to discharge a patient often is not made until the morning after an uneventful night and it is determined that the patient no longer requires inpatient care. This is not an exceptional circumstance, but standard practice in today's world of healthcare. If it is then required that the patient be given one-day notice of discharge, the result would be an additional day of stay, increased costs for that stay, and a reduction of efficiency for the hospital and physician.

In our largest facility, Saint Luke's Hospital of Kansas City, a tertiary care facility, our average length of stay is 5.4 days. Since lengths of stay are short and patient conditions can stabilize quickly, it is very difficult to predict a discharge one day in advance. As an alternative, we recommend that patients be notified by noon on the day of expected discharge, with a deadline of 5:00 PM if the patient wishes to appeal the discharge. This provides the patient ample time to consider the discharge and notify the Quality Improvement Organization if they decide to seek an expedited appeal. Furthermore,

many patients are discharged from the hospital in 1 or 2 days, shortly after the patient has received their "Important Message from Medicare" (IMM) information during the admission process. In these very common situations, the requirement that a patient receive one-day notice before discharge would increase the length of stay by 50 to 100 percent.

In addition, we believe the proposed rule will add redundancy to the current requirements and create an unnecessary burden on hospitals. The current process (providing the IMM, followed by the "hospital-issued notice of noncoverage (HINN)" if concern or disapproval of the discharge is expressed by the Medicare beneficiary) is more than sufficient to protect the rights of the patient. Because the average length of stay at Saint Luke's Hospital is just over 5 days, the patient will receive an individual form communicating virtually the same information just received only a few days earlier, only serving to duplicate documents and increase the burden on the providers.

Collection of Information Requirements

Section 405.1205 Notifying Beneficiaries of Discharge From Inpatient Hospital Level of Care

In this section, CMS estimates, "that it would take hospitals 5 minutes to deliver each notice" of impending discharge. We feel this estimation is inaccurate and does not take into consideration the level of explanation that may be necessary for patients to fully understand what it entails. Also, if the patient is not the official representative responsible for making decisions, the amount of time it could take to reach that person and obtain an approval signature may be an additional day.

Conclusion

We value and understand the efforts of CMS to provide a consistent approach to the discharge and appeal process for Medicare beneficiaries from various types of healthcare providers. Likewise, we take very seriously our obligation to provide the highest quality of care and consideration for our patients. However, the proposed rule will have serious negative impacts for hospitals and beneficiaries. We respectfully urge CMS to maintain the current process which already provides notification to Medicare beneficiaries by means of the IMM, and a further detailed notice if the beneficiary expresses disapproval of the discharge decision. We support the American Hospital Association and the Association of American Medical Colleges recommendation that a national workgroup of affected parties be convened if CMS desires to further examine discharge planning issues.

If you have questions concerning these comments, please do not hesitate to contact me or Jodi Faustlin at rfaustlin@saint-lukes.org, or 816-932-8160.

Sincerely,

G. Richard Hastings, FACHE

Submitter : Mrs. Marilyn Heitlinger **Date:** 06/05/2006

Organization : Good Shepherd Specialty Hospital

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 : Dr. Steven Strongwater

Date: 06/05/2006

Organization : UConn Health Center/John Dempsey Hospital

Category : Hospital

Issue Areas/Comments

Background

Background

We believe that the current process to provide the IMM followed by a hospital-issued notice of noncoverage (HINN) if a beneficiary expresses dissatisfaction with an impending discharge sufficiently protects the rights of Medicare beneficiaries. As the proposed rule acknowledges, the IMM provides much of the same information about appeal rights as the proposed standardized discharge notice. (71 Fed. Reg. at 17054). The only real difference between the notice being proposed and the IMM is that the IMM is provided earlier in the stay and not in an individualized form. However, unlike stays in post-acute facilities, Medicare patients generally are in the hospital for slightly over 5 days, on average (MedPAC June 2005 Data Book, Chart 8-6). Thus a need for beneficiaries to receive a second notice only days after receiving the IMM is unnecessary and could be confusing to patients.

We also respectfully disagree with the Agency s five minute estimate of the time associated with delivering the notice. This estimate does not reflect the time that would be required to explain the notice to the beneficiary or explain why they have to sign for it. In addition, if the patient is not capable of understanding and signing the notice, the hospital would need to deliver the notice to the patient s representative and obtain a signature. This undoubtedly would add time and effort that is not reflected in CMS s estimate.

GENERAL

GENERAL

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Notification Procedures for Hospital Discharges 71 Fed. Reg. 17052 (April 5, 2006). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; and the nation s medical students and residents.

We have serious concerns about this proposed rule. It is redundant to current requirements, would result in unnecessary extensions to length of stay, and would be unduly burdensome on hospitals. We respectfully urge the Agency to maintain the current process which already provides beneficiary notification procedures by means of the Important Message from Medicare (IMM) notice and a detailed notice if the beneficiary expresses dissatisfaction with the discharge decision. We support the recommendation of the American Hospital Association (AHA) that if discharge planning issues need to be addressed, a national workgroup of affected parties should be convened. See Attached.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

We appreciate CMS s attempt to accommodate the the greater volatility of hospital discharge patterns, by requiring that hospitals deliver the standardized notice to beneficiaries one day prior to the day of discharge, rather than the two-day prior requirement for post-acute care providers. However, a one-day requirement will not solve the volatility problem.

It often is impossible for a hospital to know 24 hours in advance whether a patient will be discharged. First and foremost, the discharge decision is made not by the hospital, but rather by the patient s physician who determines, based on the patient s clinical status, that hospital level care is no longer needed. These decisions often are made on the morning of the day of discharge, after the physician confirms that the patient s medical status no longer requires inpatient care, and may be reinforced by an event-free prior overnight period. This process is particularly common for the complex and severely ill patients often treated in teaching hospitals whose health status can change quickly and whose discharge determination may require the concurrence of multiple treating physicians.

In light of this common discharge practice, the one-day prior requirement would result in hospitals providing an extra day of inpatient care when beneficiaries would no longer need it. Not only would this outcome result in significant and unnecessary costs to hospitals, which run counter to the efforts by hospitals and policymakers alike to find ways to improve efficiencies in hospitals, it also would be at odds with the desires of many beneficiaries who wish to expedite the discharge process.

For teaching hospitals with large volumes of patients, many of whom are complex, the financial implications could be staggering. For example, one member hospital estimated that the discharge decision is not made until the day of discharge for approximately 20 percent of its patients. This would result in approximately 2400 patients being kept in the hospital an extra day, with concomitant costs of over a million dollars for this institution alone. For a hospital that is at full occupancy (which is not uncommon for major teaching hospitals), this would also mean a delay for new patients being admitted. This latter outcome not only has financial consequences to the hospital, but also potentially has quality of care consequences for patients, particularly those who have come through the emergency department and must be housed in that department until an inpatient bed becomes available.

Regulatory Impact

Regulatory Impact

Under the proposed rule, hospitals must comply with a two-step notice process in connection with the termination of Medicare coverage for services provided during an inpatient hospital stay. Prior to discharging any Medicare beneficiary, hospitals would be required to deliver on the day before the planned discharge a standardized notice to each Medicare beneficiary whose physician agrees with the discharge decision. The notice would inform each beneficiary when Medicare

coverage ends and financial liability for continued services begins, and would explain the beneficiary s appeal rights. The second step is triggered if the beneficiary disagrees with the decision to terminate services. In such cases, the hospital would be required to deliver a detailed notice providing specific information about the decision to terminate services. The proposed process would extend to hospitals the process that currently is required of post-acute care providers, such as home health agencies (HHAs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs) and hospices.

CMS-4105-P2-307-Attach-1.WPD

June 5, 2006

Mark B. McClellan, M.D., Ph.D.
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 Administator McClellan,

UConn Health Center & John Dempsey Hospital (07-0036) welcome this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Notification Procedures for Hospital Discharges"* 71 Fed. Reg. 17052 (April 5, 2006).

We have serious concerns about this proposed rule. It is redundant to current requirements, would result in unnecessary extensions to length of stay, and would be unduly burdensome on hospitals. We respectfully urge the Agency to maintain the current process which already provides beneficiary notification procedures by means of the "Important Message from Medicare (IMM)" notice and a detailed notice if the beneficiary expresses dissatisfaction with the discharge decision. We support the recommendation of the American Hospital Association (AHA) that if discharge planning issues need to be addressed, a national workgroup of affected parties should be convened.

We appreciate CMS's attempt to accommodate the "the greater volatility of hospital discharge patterns," by requiring that hospitals deliver the standardized notice to beneficiaries one day prior to the day of discharge, rather than the "two-day prior" requirement for post-acute care providers. However, a one-day requirement will not solve the volatility problem.

It often is impossible for a hospital to know 24 hours in advance whether a patient will be discharged. First and foremost, the discharge decision is made not by the hospital, but rather by the patient's physician, who determines, based on the patient's clinical status, that hospital level care is no longer needed. These decisions often are made on the morning of the day of discharge, after the physician confirms that the patient's medical status no longer requires

inpatient care, and may be reinforced by an event-free prior overnight period. This process is particularly common for the complex and severely ill patients often treated in teaching hospitals whose health status can change quickly and whose discharge determination may require the concurrence of multiple treating physicians.

In light of this common discharge practice, the "one-day prior" requirement would result in hospitals providing an extra day of inpatient care when beneficiaries would no longer need it. Not only would this outcome result in significant and unnecessary costs to hospitals, which run counter to the efforts by hospitals and policymakers alike to find ways to improve efficiencies in hospitals, it also would be at odds with the desires of many beneficiaries who wish to expedite the discharge process.

We believe that the current process to provide the IMM followed by a "hospital-issued notice of noncoverage (HINN)" if a beneficiary expresses dissatisfaction with an impending discharge sufficiently protects the rights of Medicare beneficiaries. As the proposed rule acknowledges, the IMM provides "much of the same information about appeal rights" as the proposed standardized discharge notice. (71 Fed. Reg. at 17054). The only real difference between the notice being proposed and the IMM is that the IMM is provided earlier in the stay and not in an individualized form. However, unlike stays in post-acute facilities, Medicare patients generally are in the hospital for slightly over 5 days, on average (MedPAC June 2005 Data Book, Chart 8-6). Thus a need for beneficiaries to receive a second notice only days after receiving the IMM is unnecessary and could be confusing to patients.

We also respectfully disagree with the Agency's five minute estimate of the time associated with delivering the notice. This estimate does not reflect the time that would be required to explain the notice to the beneficiary or explain why they have to sign for it. In addition, if the patient is not capable of understanding and signing the notice, the hospital would need to deliver the notice to the patient's representative and obtain a signature. This undoubtedly would add time and effort that is not reflected in CMS's estimate.

While we appreciate the Agency's efforts to propose a process that would accommodate the discharge practices of hospitals, we do not believe that goal has been achieved. Moreover, implementing this process could have serious negative consequences for both hospitals and beneficiaries. To the extent that improvements to the current system are desired by CMS, we urge the Agency to work within the current notice framework. If needed, we would be happy to work with CMS staff and others to ensure that the rights of beneficiaries are met in a manner that balances the administrative burden and financial consequences on hospitals.

Sincerely,
Steven Strongwater, MD

Submitter :

Date: 06/05/2006

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-308-Attach-1.DOC

CentegraHealthSystem

Memorial Medical Center
3701 Doty Road
Woodstock, IL
60098

Attachment #308

June 2, 2006

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

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

Summary of Comments

We are writing on behalf of Centegra Memorial Medical Center in Woodstock, Illinois. Memorial is a community hospital based in northern Illinois. We are licensed for 86 beds. The establishment of addition requirements for hospital discharge notices under the Medicare fee-for-service and Advantage programs similar to the two-step notices for other Part A providers presents administrative and financial burdens for our organization. We believe that providing a patient-specific discharge notice to every Medicare beneficiary will lead to longer hospital stays. Longer stays will increase our current capacity problems.

We estimate the administrative burden of this requirement to be approximately $46,250 to issue and deliver the generic notices and conservatively, $109,900 to deliver the detailed notices as required.

The current process of discharge planning (as required by state operations, Conditions of Participation and the Social Security Act 1861 already establish requirements for appropriate discharge plans and the inclusion of the patient or their representative in this plan. Patient Rights provides the patient the right to participate in their plan of care. We do not believe additional requirements are needed to insure the patient's rights and interests.

Acute care hospitals have a relatively short length of stays. Case Management, Social Work and Discharge planning staff work closely with physicians and patients to prepare beneficiaries for discharge and complete post-discharge arrangements. The proposed discharge notice process is not consistent with physician decision-making and hospital operations. There is a distinct possibility that the proposed discharge notice could add at least one day to every Medicare hospitalization.

We recommend that CMS not implement the proposed discharge notice procedures. A national workgroup consisting of hospitals, beneficiaries, CMS and quality representatives should meet to improve understanding of how any proposed changes will impact the interested parties.

Thank you for the opportunity to offer comments. Please feel free to contact Dr. Martinez at 815-728-0438 or Linda Gray at 815-334-3149, or email lgray@centegra.com.

Sincerely,
Dr. D. Martinez D.O.
7404 Hancock Dr.
P.O. Box 415
Wonder Lake, IL 60097

Linda Gray
Manager, Utilization
Centegra Memorial Medical Center
3701 Doty Road

Woodstock, IL 60098

Submitter : Mrs. Marilyn Heitlinger **Date:** 06/05/2006

Organization : Good Shepherd Specialty Hospital, Bethlehem, PA

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 : Mrs. Patricia Sutton **Date:** 06/05/2006

Organization : Adventist Hinsdale Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment enclosed with this message

CMS-4105-P2-310-Attach-1.RTF

Adventist Hinsdale Hospital
120 N. Oak Street
Hinsdale, Illinois, 60521

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:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am the Director of Case Management at Adventist Hinsdale Hospital, a 426 bed community hospital; and Adventist LaGrange Memorial Hospital, a 225 bed community hospital; both of which are located in the western suburbs of Chicago, Illinois.

As a Director of Case Management, I have been directly involved with discharge planning for adult medical and rehabilitation patients for the past 6 years.
I believe that our current processes adequately inform beneficiaries of their Medicare appeal rights. 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 nurse assesses the patient's current living situation and needed resources. In addition, case managers screen all patients meeting the hospital's "at risk" criteria for needing post acute services and refer these patients to the social workers for assistance in developing a safe discharge plan. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. The hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharged timely, hospital staff collaborate with the physicians to expedite the discharge process. Our process also includes ample opportunity for patients to change their minds, or to disagree with the discharge process and request appeals to the QIO. The process of issuing a HINN when there is disagreement regarding readiness to discharge is not a common occurrence at either Adventist Hinsdale Hospital or Adventist LaGrange Memorial Hospital, and takes place less than 6 times in a calendar year at these facilities.

I am concerned that the proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations. The decision to discharge a patient is made by the physician, not the hospital. Our physicians may document an anticipated discharge date or write a discharge plan, but do not commonly make a discharge decision until the day of discharge. The physician may give discharge approval pending certain clinical criteria being met, e.g. test results being negative or within

specified limits, or the absence of a fever, and the decision to discharge is only given after those results are reviewed by the physician.

Thus the concept of giving 24 hour notice to a patient once the physician has made a clinical interpretation that the patient is ready for discharge would likely lead to patients remaining in the hospital a day after they were determined medically stable for discharge. This adds significant financial burden to the hospital, and will also significantly impact patient throughput in our hospital system, where it is currently common for us to have patients waiting in the ED to be admitted to our medical units for care. Longer medical stays for patients who meet no criteria to remain in the hospital, combined with our current high occupancy rates, would threaten our ability to treat other patients who need acute care and are waiting for available beds, and could lead to more frequent intervals of having to go on by-pass, thus in effect, not meeting the healthcare needs of those living in our community.

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. Ideally this notice would be delivered by trained case management staffs that are familiar with Medicare regulations regarding notice delivery, appeal rights, and clinical implications. Additional 7 day per week staffing would be required to appropriately meet Medicare's proposed one-day notices requirement. This additional staffing would be necessary to address the volume of notices that would have to be delivered. The cost of adding more staff would create additional financial burden to the hospital personnel budget, assuming that staffing the additional positions would be accomplished without difficulty in a time of shortages in finding trained case management staff to employ in the suburban Chicago area.

Other factors of concern in delivering a discharge notice to a patient are in regard to those situations where the patient is not the decision maker. If a signature is required AND the patient is NOT the decision maker, it could take an additional day to obtain the signature of the patient's decision maker.

I have read that CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal. 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 staff have found that many patients are reluctant to leave the hospital, not because they are not medically ready for discharge, but because the acute care setting offers a more emotionally secure and comfortable environment than they will find at home or in a post-acute healthcare setting. Other patients resist discharge because a bed is not available in the non-acute setting of their choice (although beds are available elsewhere). Also, given the wording of the proposed notice that "hospital services will continue to be paid for during the review," patients have nothing to lose by initiating an appeal, even if they are medically ready for discharge. Unfortunately, this is just the type of opening that families may be looking for to delay taking the patient home or to an alternate setting.

A final expense that the hospital would face is the rework necessary to locate and secure an available bed in a non-acute setting for patients who appeal their discharges and lose the bed that was available. For example, an isolation bed may be available in a nursing home on the day the discharge order is written, but by the time the QIO review is complete, the bed is no longer available, and the search must begin anew.

My recommendation would be for CMS to not implement the discharge notice procedure until CMS has a better understanding of hospital operations and can take another look at the many regulations that currently are in place that speak to appropriate notice of discharge and patient rights to be actively involved in their hospital care.
Should some version of this requirement to issue advance notice of discharge be implemented by CMS, I would suggest the following:

- allow telephonic notification of the decision maker when the decision maker is not the patient;
- allow the hospital to notify the patient by 12 noon on the expected day of discharge of the actual discharge order, and then allow the patient to appeal the discharge by 5:00PM that evening. This should be ample time for the patient to consider the discharge and notify the hospital and QIO if they would like an expedited appeal.
- Given that patients receive their Medicare rights information at time of admission, and that many patients are discharged from the hospital in 1 – 2 days, a discharge notice should only be required for patients in the hospital for 3 days or more.

I appreciate the role of CMS in safeguarding patient rights. The staffs at Adventist Hinsdale Hospital and Adventist LaGrange Memorial Hospital believe we must protect patients rights while also stewarding government resources and ensuring that patients do not take advantage of an opportunity to unnecessarily extend a length of stay, thereby adding significant costs to Medicare.

Sincerely,

Patricia Sutton, L.C.S.W
Director of Case Management
Adventist Hinsdale Hospital/Adventist LaGrange Memorial Hospital
120 N. Oak Street
Hinsdale, Illinois 60521
(Phone: 630-856-7253)

Submitter : Deborah Gordon **Date:** 06/05/2006

Organization : Community Memorial Hospital

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am writing in response to the proposed rule to provide notification the day prior to discharge to each Medicare and Medicaid beneficiary and notification of appeal rights for the hospitalization. I am a Medical Social Worker and work with patients daily regarding discharge planning. This proposed rule would put enormous burden on hospitals in maintaining compliance with such notifications and appeals, and the benefit would not outweigh the burden. The actual implementation of providing such notice to each and every patient would not take only 5 minutes , not if it is done appropriately. Providing such notice would involve an enormous investment of time and manpower.

Additional consideration must be given the fact that it is not uncommon for the discharge of a patient on a particular day to be anticipated, but the final decision for that discharge to be deferred until the actual day of discharge due to the need to monitor certain contingencies. Same day discharges are reasonable, and can be appropriately managed. If advance notice prior to the day of discharge becomes a requirement, same day discharges will no longer be a possibility. Hospital lengths of stay will increase, and so will the resultant costs associated with such. Bed availability will also become a problem, as beds are often needed for another patient on the same day that a discharge opening that bed takes place. I wish to add my voice to the multitude of other voices that I am sure are expressing grave concern over this proposed new rule.

Deborah Gordon, MSW
Social Work Coordinator
Community Memorial Hospital
Menomonee Falls, WI

Submitter : Ms. Susan Long **Date:** 06/05/2006

Organization : Loyola University Medical Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I am writing to oppose this regulation. This documentation will mean additional paper work that will actually lengthen a patient's stay in the hospital. At a time when length of stay is related to DRG and payment, any delay puts an additional economic burden on hospitals and providers who are trying to be as effecient as possible while making patient safety a priority.

Submitter : Mrs. Patricia Sutton **Date:** 06/05/2006

Organization : Adventist LaGrange Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment included with this message

CMS-4105-P2-313-Attach-1.RTF

Adventist Hinsdale Hospital
120 N. Oak Street
Hinsdale, Illinois, 60521

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:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am the Director of Case Management at Adventist Hinsdale Hospital, a 426 bed community hospital; and Adventist LaGrange Memorial Hospital, a 225 bed community hospital; both of which are located in the western suburbs of Chicago, Illinois.

As a Director of Case Management, I have been directly involved with discharge planning for adult medical and rehabilitation patients for the past 6 years.
I believe that our current processes adequately inform beneficiaries of their Medicare appeal rights. 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 nurse assesses the patient's current living situation and needed resources. In addition, case managers screen all patients meeting the hospital's "at risk" criteria for needing post acute services and refer these patients to the social workers for assistance in developing a safe discharge plan. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. The hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharged timely, hospital staff collaborate with the physicians to expedite the discharge process. Our process also includes ample opportunity for patients to change their minds, or to disagree with the discharge process and request appeals to the QIO. The process of issuing a HINN when there is disagreement regarding readiness to discharge is not a common occurrence at either Adventist Hinsdale Hospital or Adventist LaGrange Memorial Hospital, and takes place less than 6 times in a calendar year at these facilities.

I am concerned that the proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations. The decision to discharge a patient is made by the physician, not the hospital. Our physicians may document an anticipated discharge date or write a discharge plan, but do not commonly make a discharge decision until the day of discharge. The physician may give discharge approval pending certain clinical criteria being met, e.g. test results being negative or within

specified limits, or the absence of a fever, and the decision to discharge is only given after those results are reviewed by the physician.

Thus the concept of giving 24 hour notice to a patient once the physician has made a clinical interpretation that the patient is ready for discharge would likely lead to patients remaining in the hospital a day after they were determined medically stable for discharge. This adds significant financial burden to the hospital, and will also significantly impact patient throughput in our hospital system, where it is currently common for us to have patients waiting in the ED to be admitted to our medical units for care. Longer medical stays for patients who meet no criteria to remain in the hospital, combined with our current high occupancy rates, would threaten our ability to treat other patients who need acute care and are waiting for available beds, and could lead to more frequent intervals of having to go on by-pass, thus in effect, not meeting the healthcare needs of those living in our community.

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. Ideally this notice would be delivered by trained case management staffs that are familiar with Medicare regulations regarding notice delivery, appeal rights, and clinical implications. Additional 7 day per week staffing would be required to appropriately meet Medicare's proposed one-day notices requirement. This additional staffing would be necessary to address the volume of notices that would have to be delivered. The cost of adding more staff would create additional financial burden to the hospital personnel budget, assuming that staffing the additional positions would be accomplished without difficulty in a time of shortages in finding trained case management staff to employ in the suburban Chicago area.

Other factors of concern in delivering a discharge notice to a patient are in regard to those situations where the patient is not the decision maker. If a signature is required AND the patient is NOT the decision maker, it could take an additional day to obtain the signature of the patient's decision maker.

I have read that CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal. 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 staff have found that many patients are reluctant to leave the hospital, not because they are not medically ready for discharge, but because the acute care setting offers a more emotionally secure and comfortable environment than they will find at home or in a post-acute healthcare setting. Other patients resist discharge because a bed is not available in the non-acute setting of their choice (although beds are available elsewhere). Also, given the wording of the proposed notice that "hospital services will continue to be paid for during the review," patients have nothing to lose by initiating an appeal, even if they are medically ready for discharge. Unfortunately, this is just the type of opening that families may be looking for to delay taking the patient home or to an alternate setting.

A final expense that the hospital would face is the rework necessary to locate and secure an available bed in a non-acute setting for patients who appeal their discharges and lose the bed that was available. For example, an isolation bed may be available in a nursing home on the day the discharge order is written, but by the time the QIO review is complete, the bed is no longer available, and the search must begin anew.

My recommendation would be for CMS to not implement the discharge notice procedure until CMS has a better understanding of hospital operations and can take another look at the many regulations that currently are in place that speak to appropriate notice of discharge and patient rights to be actively involved in their hospital care.
Should some version of this requirement to issue advance notice of discharge be implemented by CMS, I would suggest the following:

- allow telephonic notification of the decision maker when the decision maker is not the patient;
- allow the hospital to notify the patient by 12 noon on the expected day of discharge of the actual discharge order, and then allow the patient to appeal the discharge by 5:00PM that evening. This should be ample time for the patient to consider the discharge and notify the hospital and QIO if they would like an expedited appeal.
- Given that patients receive their Medicare rights information at time of admission, and that many patients are discharged from the hospital in 1 – 2 days, a discharge notice should only be required for patients in the hospital for 3 days or more.

I appreciate the role of CMS in safeguarding patient rights. The staffs at Adventist Hinsdale Hospital and Adventist LaGrange Memorial Hospital believe we must protect patients rights while also stewarding government resources and ensuring that patients do not take advantage of an opportunity to unnecessarily extend a length of stay, thereby adding significant costs to Medicare.

Sincerely,

Patricia Sutton, L.C.S.W
Director of Case Management
Adventist Hinsdale Hospital/Adventist LaGrange Memorial Hospital
120 N. Oak Street
Hinsdale, Illinois 60521
(Phone: 630-856-7253)

Submitter : Mr. Michael Hill

Date: 06/05/2006

Organization : New Hampshire Hospital Association

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-314-Attach-1.DOC

New Hampshire Hospital Association

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:

On behalf of the New Hampshire Hospital Association (NHHA), with its 26 acute care hospital members, we 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 NHHA 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 NHHA does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process.

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

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

- The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an

increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.

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

Background

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

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

Provisions of the Proposed Rule

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

There are several problems with the proposed approach.

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

care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.

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

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

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

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

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

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

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

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

- *The estimated cost and burden of the proposal is grossly understated.* CMS believes to prepare and deliver the generic discharge notice to a patient will take five minutes, but this does not include the time needed to explain the notice or why it must be signed. It also does not reflect the additional time and effort required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent. Nor does it reflect the manpower and capital costs to maintain hard copy files of the signed copy for 13 million or more admissions a year for an indefinite period of time. The most significant cost, however,

is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge (as explained above). Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals for the reasons cited above.

We believe this price is too high just to ensure consistency with requirements designed for very different operating environments. If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice. If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. More paperwork does nothing to improve care – it simply consumes resources that would be better devoted to direct patient care. **The NHHA 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 NHHA 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 Paula Minnehan, VP, Finance and Rural Hospitals at (603) 225-0900 or pminnehan@nhha.org

Sincerely,

Mike Hill

Michael Hill
President

Submitter : **Ms. Holly French**

Organization : **Newman Regional Health**

Category : **Hospital**

Date: **06/05/2006**

Issue Areas/Comments

GENERAL

GENERAL

June 5, 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

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,

Holly R. French
Chief Financial Officer

Submitter : **Ms. Kathie Butcher**

Organization : **Newman Regional Health**

Category : **Hospital**

Date: 06/05/2006

Issue Areas/Comments

GENERAL

GENERAL

June 5, 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

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,

Kathie J. Butcher, RHIA
Assistant Administrator for Quality Services

Submitter : Mrs. Joann Shere

Date: 06/05/2006

Organization : Little Company of Mary Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-4105-P2-317-Attach-1.DOC

CMS-4105-P2-317-Attach-2.DOC

Attachment #317

Little Company of Mary Hospital
and Health Care Centers

June 2, 2006

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

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

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

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

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

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

Kindly consider the following in regard to this proposed rule:

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

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

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

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

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

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

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

Sincerely,

Joann Shere
Director, Case Management
Little Company of Mary Hospital

Submitter : **Ms. Ronald Ashworth**

Organization : **Sisters of Mercy Health System**

Category : **Hospital**

Date: **06/05/2006**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-318-Attach-1.PDF

Attachment
#318

MERCY

SISTERS OF MERCY
HEALTH SYSTEM

June 2, 2006

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

RE: "Medicare Program; Notification Procedures for Hospital Discharges"

The Sisters of Mercy Health System is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. We have a significant number of inpatient stays and rely heavily on Medicare as a major payor for those services. We are writing to provide comments in areas of concern relating to the proposed rule. Thank you for considering our comments.

Specifically, we offer the following comments:

Provisions of the Proposed Rule

In this rule, CMS proposes that hospitals be required to provide a standardized discharge notice on the day before the planned discharge from any inpatient hospital stay. While this requirement is similar to the one already in place for other setting types (SNF, Home Health, and Comprehensive Outpatient Rehabilitation Facilities), acute care settings encompass a different patient mix. Typically, discharge date predictions are much more complex for patients in acute care settings. While discharge dates for patients in the acute care settings could be estimated, they may not be as accurate in this type of setting due to extremely short stays, unpredictability of discharge decisions by the physician or unforeseen complications/events. This creates a real risk of providing duplicative discharge notifications. We believe providing duplicative discharge notifications (revised for estimated discharge date only) would be administratively burdensome. We believe this practice would also cause unnecessary concern and/or confusion from the patient. Therefore, Mercy requests that CMS not implement the requirement to provide advance discharge notification. However, if CMS implements the requirement for advance discharge notification, we request that CMS specifically address the duplicative discharge notification risk in the proposed regulations. We believe it should be noted that if the estimated discharge date is revised, and the discharge notification has already been provided, a revised discharge notification is not required. For example, if a patient is scheduled to be discharged on Tuesday and the notification is provided on Monday, but the physician does not discharge the patient until Friday, Mercy should not have to reissue the discharge notification in light of the new Friday discharge date.

Currently hospitals are required to provide patients with 'Important Message from Medicare" pamphlet at time of admission. With the proposed discharge notice, hospitals are concerned this requirement may confuse patients with short lengths of stay as there may be times the standardized discharge notice is provided to the patient the same day (or within a day or two) of the "Important Message from Medicare" pamphlet. In addition to causing confusion for patients, it may also require additional time for hospital personnel to handle patient questions relating to the issuance of this newly required discharge notice, increasing the administrative burden of this requirement. If CMS implements the advance discharge notification requirement, we propose that CMS make this an "optional" rather than "mandatory" requirement for patients with estimated discharge dates within 3 days of admittance into the hospital inpatient setting to avoid any such patient confusion.

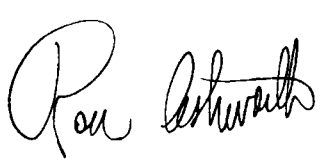
Hospitals may also face additional challenges when applying this requirement as it may not be "adopted" for all patients due to other payor expectations. Lack of consistent requirements for all payor types, can increase administrative time necessary to implement this new requirement as it may only be applicable for our Medicare patient population. Therefore, if CMS implements the advance discharge notification, we would request that CMS mandate this as a standard notification that all other payors must follow.

One additional concern that hospitals may face will be those instances where the patient is not capable of comprehending or making decisions regarding their treatment. In the event a patient does not have anyone "available" (either power of attorney or family members visiting regularly), we request that the requirement for providing this discharge notice be waived for two reasons. We believe it would be administratively burdensome to identify the appropriate contact to which to mail the discharge notice information. There could also be questions regarding whether or not the discharge notice was given to the "most appropriate" patient contact. We also believe it is CMS' intent to provide this information in a timely manner. Mailing information to the appropriate patient contact would prevent hospitals from meeting CMS' intended timely requirements and therefore would not provide any additional benefit to the patient. Therefore, we respectfully request this be specifically identified as an exception to any notification requirements implemented as a result of the final regulations.

As you can see, we have significant concerns with the advance discharge notification as proposed by CMS. We strongly suggest CMS reconsider this provision or at least consider the changes we have discussed above.

Thank you again for considering our comments. Should you have additional questions you may contact Bill Colletta at 314-364-3525.

Sincerely,



Ron Ashworth
President / Chief Executive Officer

Submitter : **Ms. Paula Taylor** **Date: 06/05/2006**

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
Attn: 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,

Paula J. Taylor, R.N., Ph.D.
Assistant Administrator for Nursing Services

Submitter : **Dr. Charles Robbins** **Date: 06/05/2006**

Organization : **Stony Brook University School of Social Welfare**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-320-Attach-1.DOC

Attachment #320

3 Seward Lane
Stony Brook, NY 11790
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

Dear Sir/Madam:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am an Associate Professor in the School of Social Welfare at Stony Brook University in Stony Brook, New York. Our curriculum has health care as its foundation.

As a professional social worker I have been directly involved with discharge planning for all patients from hospitals for the past thirty five 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 5 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. I 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,

Charles L. Robbins, DSW
Associate Professor

Submitter : **Brian Day** **Date: 06/05/2006**

Organization : **Vanderbilt University Medical Center**

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 : **Mrs. Marilyn Heitlinger** **Date: 06/05/2006**

Organization : **Good Shepherd Specialty Hospital, Bethlehem, PA**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-322-Attach-1.DOC

June 5, 2006

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

Dear Dr. McClellan:

I am writing this letter in response to the request for comments regarding the CMS proposed rule on Hospital Discharge Notices (Proposed Rule Medicare Program; Notification Procedures for Hospital Discharges—File Code CMS 4105-P) to both fee for service Medicare beneficiaries and the Medicare Advantage (MA) program. Good Shepherd Rehabilitation network is comprised of two long term care facilities, an inpatient rehabilitation hospital, a long term acute care hospital (LTACH) and fifteen outpatient rehabilitation sites. This proposed rule would have a direct effect on our discharge process for patients in our acute inpatient rehabilitation hospital and LTACH.

In review of the proposed regulations, the following concerns have been identified:

1. Under the current process, the "Important Message from Medicare" is provided to the patient at admission and a hospital issued notice of non-coverage (HINN) or Notice of Discharge Medicare Appeal Rights (NODMAR) is only issued to beneficiaries or enrollees who disagree with the discharge decision. The new two step process proposed could cause confusion to the patient who is in agreement with the discharge decision and lead to the patient potentially questioning whether s/he should request an appeal. Currently, there is an infrequent need to issue a HINN or NODMAR compared to the number of discharges from the hospital level of care.
2. The two step process may lead to an increased length of stay for patients as suitability for discharge is often determined on the patient's medical stability on the day of discharge.

3. The two step process will create an additional burden to hospitals in both generating the notices and having professional staff, such as case managers, available to deliver the notice seven days per week.
4. There is duplication of information between the "Important Message from Medicare" and the generic Notice of Discharge.

Thank you for the opportunity to respond to the proposed rule in the open comment period. If you have any questions, please do not hesitate to contact me at 610-776-3256.

Sincerely,

Marilyn Heitlinger, RN, MS
Corporate Director, Care Management
Good Shepherd Plaza
850 South Fifth Street
Allentown, PA 18103

Submitter : **Brian Day** **Date: 06/05/2006**

Organization : **Vanderbilt University Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-323-Attach-1.DOC

June 1, 2006

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

To Whom It May Concern:

Vanderbilt University Medical Center would like to submit comments regarding the April 5, 2006 proposed rule regarding Notification Procedures for Hospital Discharges (CMS-4105-P).

Comments on "PROVISIONS OF THE PROPOSED RULE"

Although CMS believes that the "new approach would not be overly burdensome for providers", the reality is that a tracking system as well as the staff to maintain it would need to be implemented by providers in order to track and issue notices timely and to provide appropriate documentation to all Medicare patients, not just to those who disagree with a discharge decision.

The burden of ensuring that the process is followed flawlessly is placed on the provider who will be subject to non-payment of claims if even the slightest of technical errors occurs.

There is already a process in place (i.e. HINN) for patients who disagree with a discharge decision. It serves no purpose to provide a notice to every Medicare patient and could be confusing for patient who receives two notices during the duration of their hospital stay. The additional staffing resources that will be required to explain the notice to the beneficiary and to obtain the necessary signature place an additional burden on the provider.

Many times the discharge time is not determined until the results of lab tests. These results are often made available on the day of discharge which then enables the patient's physician to determine that inpatient care is no longer necessary for the patient. The requirement to issue a notice 1 day prior to discharge would result in a hospital providing an additional day of care that is not medically necessary. For a hospital that is operating at full capacity, this requirement could have not only significant financial implications, but also a significant effect on quality of care as patients who are admitted through the emergency room have to wait in that department for beds to become available.

If a provider issued a notice based on a potential discharge for the next day, would the provider need to retract and re-issue another notice if the discharge did not occur on that day?

We appreciate the opportunity to submit comments on this proposed rule. If you have any questions or need additional information, please contact me at (615) 322-0337 or at brian.day@vanderbilt.edu.

Sincerely,

Brian J. Day
Assistant Director, Finance
Vanderbilt University Hospital

Submitter : **Dr. Stephen Olin** **Date: 06/05/2006**

Organization : **Lancaster General**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please see attachment for Lancaster General Comment Letter

CMS-4105-P2-324-Attach-1.DOC

Lancaster General Hospital

June 5, 2006

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

RE: CMS-4105-P

Dear Sir/Madame:

In conjunction with The Hospital & Healthsystem Association of Pennsylvania (HAP) Lancaster General Hospital (LGH) appreciates this opportunity to comment on the proposed rule in **"Medicare Program; Notification Procedures for Hospital Discharges,"** as published in the April 5, 2006, *Federal Register.*

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

LGH believes that CMS has proposed a solution that is not operationally workable in its attempts to improve the hospital discharge planning process and that the proposed rule does not support how care is delivered in hospitals. Nor does it address the physician-patient relationship or that the decision to discharge is determined by the physician and the patient. It should be noted that there are other existing federal regulations that indicate the expectation that hospitals do not differentiate care provided to patients based on financial class. To require a 24-hour notice only for Medicare and Medicare Advantage patients requires these patients to be treated differently during the course of rendering care to all patients on a unit.

While CMS was well intentioned in proposing this rule in response to concerns raised by consumer advocacy groups with respect to hospital discharge planning processes, this rule

Case Management Department
Lancaster General Hospital • 555 North Duke Street • P.O. Box 3555 • Lancaster, PA 17604-3555
(717) 544-4061 • Fax (717) 544-5689 • www.LancasterGeneral.org

will have many unintended consequences for the health care delivery system as a whole and will complicate other critical issues including patient flow, hospital capacity, emergency department crowding, emergency department diversions, and additional dissatisfaction for frontline nurses who will be burdened with more paperwork rather than providing care to patients. Additionally, the proposed rule serves to confuse the terms non-coverage with decisions about hospital discharge.

Operational Implications

- LGH agrees with HAP that the proposed rule is 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 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. This new process that adds a third step for Medicare beneficiaries where the average length of stay is less than six days is unreasonable and potentially very cumbersome, confusing and burdensome for patients in the hospital 72 hours or less. CMS should consider taking 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. 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, if a psychiatric patient in a freestanding psychiatric facility has a medical emergency requiring admission to a general acute care hospital, the patient must be discharged immediately and transported to the medical facility for treatment. Similarly, there may be circumstances where a general acute care hospital needs to discharge the patient to another acute care hospital because that hospital provides services or higher levels of care than what can be provided in the original hospital of admission, (e.g., moving a patient from a community hospital to an academic medical center or children's specialty hospital). 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 unit/hospital, and/or psychiatric unit/hospital. In some Pennsylvania communities, it is particularly difficult to move patients from the acute care facility to other levels of care, since there is a moratorium on adding skilled nursing beds and psychiatric beds. The change in federal reimbursement for rehabilitation hospitals has also impacted the numbers of rehabilitation beds available for patient placement. As a result, many hospitals are waiting for notification from another health care facility that a bed has become available to accept a patient from the acute care 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 hospitals have been discussing the placement with the patient and patient's family.

- 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 planned, another 24-hour notice would be required. In essence hospitals may be providing several generic notices in order to be in compliance.

- It is problematic that the proposal requires hospitals to provide a notice of non-coverage on behalf of Medicare Advantage plans. This places hospitals 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 the hospital may disagree with that determination. It also appears that the hospitals would then be required to follow-up with a second generic notice to the same patient when the hospital determines the patient is ready for discharge. The delivery of multiple notices to patients by hospital staff would be confusing to patients and families.

- It is likely that **the** 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 by the hospital in accordance with the proposed rule, hospitals are not certain that they 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 from the acute care hospital.

- Increasing the hospital length of stay to comply with the proposed rule will result in holding up placement of emergency admissions, add to overcrowded situations in hospital emergency departments, and cause unnecessary ambulance diversions in communities across this country. This proposal has the potential to add to the already difficult problems being faced in our hospital's emergency departments.

- At LGH it is probable that provision of the advance notice could fall to nurses because the volume of discharges will be beyond the current case management and financial office staffing capabilities. Hiring additional staff in these departments solely for 24/7 provision of the notice is not feasible in the current economic climate. Adding more paperwork to case managers and direct care nurses will create job dissatisfaction among nurses at a time when hospitals are working to decrease paperwork by nurses so that they can better spend their

time in efficient plan of care facilitation and 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

- Extending the length of stay for many Medicare patients by at least one day in order to comply with the requirement to provide advance written notice 24-hours before discharge will create capacity issues that could lead to decreased patient satisfaction.

- LGH supports the HAP conclusion that the CMS estimate regarding the percentage of patients who would request an expedited review is seriously underestimated. Initially, there may be a small percentage of patients who request an expedited review, but once it becomes common knowledge among Medicare patients 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. Per HAP, 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. Today's Medicare population is more knowledgeable about their rights and has access to better education resources.

- The following as presented by HAP is a detailed list of the variables involved in the delivery of the notice. LGH agrees that the rule does not accurately estimate the time it will take to deliver the notice to patients and costs associated with the proposed rule.
- We are concerned that the estimated time of five (5) minutes to provide, explain and obtain the patient's signature on the form is a significant underestimation of the time that will be required to provide the advance notice. Additionally, CMS must 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 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 financial office staff, 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 timeframes as proposed in this rule;

- the costs associated with training nurses and other health care professionals who would need to deliver the notices;
- the costs associated with the maintenance and storage of these documents for a period of years.

In short, CMS has proposed a rule that creates another unfunded mandate for hospitals across the country.

- An additional concern is the complex and detailed process required for the detailed explanation which 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. Hospital staff will require ongoing training in the Medicare policies that they would need to cite to be in compliance with the proposed rule. 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

- Another concern is that the proposed rule fails to make a clear distinction between decisions 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". HAP 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. This process makes the most sense because 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 plans' 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, hospitals 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 turn around at the time of discharge and give yet another notice. HAP and LGH believe that this could be confusing to Medicare patients, especially when both notices would have to be provided by hospital staff. Additionally, the hospital 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, the hospital 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

- The hospital community has shared concerns about requiring hospitals to place their hospital logos on the "Generic Notice of Non-coverage" and the "Detailed Explanation of Non-coverage." Hospitals 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 hospitals 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.

Other

- The proposal requires that the beneficiary or their representative sign the advance notice form in order to document its receipt and their understanding of the notice. From a purely logistical perspective, this requirement works at cross-purposes with the movement to electronic health records. The paperwork clearance package submitted by CMS to the Office of Management and Budget (OMB) indicates that the record must be provided and maintained in hard copy and that they are not making any provision for electronic alternatives.

- Finally, hospital care, including the discharge process, does not solely occur Monday through Friday, 8 to 4. The rule describes that access to the Quality Insights Organization (QIO) needs to be during the business hours of the QIO. To require hospitals to implement a process to protect beneficiary's rights without also addressing the required access to dispute resolution does not protect the patient or the provider. It would not work for the QIO to only be available during business hours. HAP and DVHC understand that QIOs have already increased hours of operation to deal with expedited review requests for home health agencies and skilled nursing facilities, but they are currently not adequately resourced to deal with an increased demand for such reviews from hospitals

LGH supports the following HAP recommendations:

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

- CMS should consider convening a stakeholder group in concert with national hospital associations, key professional groups, and consumer advocacy groups to develop a

better perspective of the various constituency group concerns and how best to address these concerns about discharge planning. A review and revision of current hospital discharge planning provisions in the Medicare hospital Conditions of Participation and surveyor interpretative guidelines would be more productive than overlaying these requirements on what is already in existence.

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

In the event that CMS decides to proceed with enforcing a process for Medicare Notification Procedures for Hospital Discharges, LGH agrees with HAP's suggested modifications to the proposed rule for consideration by CMS:

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

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

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

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

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

HAP along with LGH appreciate the interest that CMS has in receiving comments on this proposed rule and believe that CMS has a legitimate interest in ensuring that Medicare beneficiaries have access to an expedited determination review process when they disagree with hospital discharge, termination of hospital services, or when a Medicare Advantage plan determines that the plan will not cover the hospital stay. However, the rule as proposed would create operational problems for hospitals and result in increased lengths of stay that will negatively impact others' access to patient care. Additionally, CMS has not carefully considered the financial implications of what it is proposing on hospitals or the potentially confusing aspects of mingling decisions made by Medicare Advantage plans about hospital non-coverage versus hospital decisions to discharge the patient in this rule.

HAP and LGH 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 HAP or LGH, please feel free to contact Lynn Leighton, Vice President, Professional and Clinical Services, HAP at (717) 561-5308 or by email at lgleighton@haponline.org or Stephen Olin, MD, **FAAFP**, Lancaster General Hospital Case Management Physician Advisor at (717) 544-4061.

Sincerely,

Stephen T. Olin, M.D., **FAAFP**
Physician Advisor and Medical/
Quality Management Coordinator

Submitter : Ms. Linda Harris **Date:** 06/05/2006

Organization : Spartanburg Regional Healthcare System

Category : Hospital

Issue Areas/Comments

Background

Background

The proposed rule will negatively impact utilization of services because hospitals do not have authority to discharge patients - physicians do. These discharge decisions are not always made 24 hours in advance of discharge, so this rule will negatively impact LOS, driving up the cost of care.

GENERAL

GENERAL

PLease consider working with a hospital association or group such as Amercian Case Management Association to develop a sound notification process that will meet the needs of all concerned.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The proposed rule does not offer a plan for short stays or transfers. It does not address availability of the QIO 24-7 for beneficiary discharge disputes. It does not address the Medicare Advantage PLans views and processes. The notice process time will be far greater than 5 minutes, we estimate 30-60 minutes per patient.

Submitter : Beverly Beckman **Date:** 06/05/2006

Organization : Jewish Hospital and St Mary's Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Response to the proposed rule CM-4105-p, Medicare Program.
See Attachment

CMS-4105-P2-326-Attach-1.DOC

CMS-4105-P2-326-Attach-2.DOC

Jewish Hospital &
St. Mary's HealthCare
200 Abraham Flexner Way
Louisville, KY 40202-1886

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 Beverly Beckman, RN, and Corporate Director for Jewish Hospital and St. Mary's Healthcare System, a 735 bed teaching Hospital/Healthcare System located in Louisville, Kentucky.

As a Director, I have been directly involved with discharge planning for acute care for the past six 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, the admission nurse assesses the patient's current living situation and needed resources. In addition, our Care Managers continue the case review throughout the patient stay. 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 Q10.

- *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. 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 bed.

Jewish Hospital and St Mary's Healthcare appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS.

Sincerely,

Beverly Beckman, RN, CPHQ, CHAM, ACM,
Corporate Director – Care Management
Jewish Hospital and St Mary's Healthcare
100 Abraham Flexner Way
Louisville, Kentucky 40202-1886
502-587-4652
Bev.Beckman@JHSMH.org

Submitter : Russ Ranallo **Date:** 06/05/2006

Organization : Owensboro Medical Health System

Category : Hospital

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-P2-327-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:

Owensboro Medical Health System (OMHS) of Owensboro, Kentucky 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 that 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.

Similar changes were proposed for hospitals in January 2001 and rejected by CMS in 2003 due to considerable administrative burden. We again have significant concerns with this proposal, which are outlined in detail below. In short, we believe that this proposal would be extremely burdensome and costly for hospitals, and is unnecessary in light of standard discharge planning and physician discharge order patterns as well as existing notices hospitals already provide to beneficiaries. *If CMS has concerns with the hospital discharge planning process, then a task force of hospital discharge planners should be convened to discuss how those concerns could be addressed without imposing unreasonable additional workload and cost on hospitals. Therefore, OMHS recommends that CMS postpone making these proposed regulatory changes until they consult with hospital discharge planners. Representatives of OMHS would be happy to participate in such a task force.*

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 OMHS with an average Medicare length of stay of fewer than five 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 OMHS, 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. OMHS also operates utilization management and quality improvement programs to ensure appropriate care in the appropriate setting. However, 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. 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 complication the evening before, the discharge date will be postponed until that complication is gone. Conversely, a patient may experience a quicker recovery than expected and be discharged early.

- *Impractical for Short Stays or Weekend Admissions.* The proposal is impractical for short stay patients (those admitted on one day and discharged the next) and for weekend stays (admitted Friday and discharged Sunday). If the hospital is forced to provide a notice the day before discharge but the physician's order is not written until the morning of the date hat they determine the patient no longer needs hospitalization, CMS in essence will be mandating the hospital provide an extra day of unnecessary care.

- *Additional costs for providers.* As mentioned above the rule has the potential to force the hospital to incur unnecessary days of care. Will CMS be adjusting the payment rates to cover this cost for providers? Hospitals will also need to employ additional personnel to administer this rule correctly. Will CMS be adjusting payments rates upward to cover these costs?

  CMS' estimated burden of five minutes per patient for hospitals to prepare the deliver the notices woefully underestimates the actual cost burden because it fails to include the time that would be required for hospital staff to explain the notice and why it must be signed to beneficiaries and their families. CMS also underestimates the time involved for hospitals to issue and deliver a detailed notice if beneficiaries exercise their right to an expedited review. In some cases, OMHS has found that HINN letters can take two to three hours to explain, not 60 to 90 minutes. In addition, the proposal works at cross purposes with the movement to electronic health records, since the rule would require hospitals to provide and maintain such notices in hard copies

- *Increased patient/family issues.* The proposed rule requires that the beneficiary or their representative sign a copy of the discharge notice documenting its receipt and their understanding of it. Hospitals are also required to determine whether a patient is capable of comprehending and signing the notice, yet there is no specific guidance as to how this determination is to be made nor any guidance on the use of representatives to sign the notice instead of the patient. Additional staff will need to be hired to comply with these new requirements in terms of educating staff, preparing notices, and educating patients and their families. This will add substantial cost, as half of the OMHS discharges are Medicare.

  The appeal process is labor intensive, time consuming, and confusing to beneficiaries. Without proper lengthy education, this additional notice will appear to most patients as a denial by the hospital. The proposed language of the notice itself (which was included in the paperwork clearance package) seems designed to create doubt in the mind of beneficiaries that their planned discharge is appropriate. Patients will say, "It looks and feels like you are kicking me out". This could result in patient distrust of their physician and hospital and lead to more requests for detailed notices and appeals than are warranted.

  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 that 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.

- *Any other information required by CMS.* Proposed 405.1205 under the description for the notice #5 states "any other information required by CMS" is very open ended. We request that we be allowed to review and comment on any item that CMS desires to include in the notice.

- *Billing issues.* Hospitals will not be allowed to bill beneficiaries for services provided before noon of the day after a QIO issues a decision. It will take system modifications and/or additional personnel for OMH to become functionally compliant with this requirement.

- *Physician Dissatisfaction with CMS.* 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.

  Further the requirement that a physician concur with the discharge before the letter is given appears redundant. The physician indeed agrees when he/she writes a discharge order that he/she concurs with the discharge.

OMHS 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. As mentioned above OMHS would be happy to participate in a task force of discharge planners to address the issues.

Please feel free to contact me at 270-688-2855 or RRANALLO@OMHS.ORG if you have questions of if you need additional information.

Sincerely,

Russ Ranallo
Vice President, Financial Services

Submitter : Mr. Steven Hand

Date: 06/05/2006

Organization : Memorial Hermann Hospital System

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

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. Leigh Miller **Date:** 06/05/2006

Organization : AnMed Health

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

CMS 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.
The current process with the Important Message at admission serves the purpose of providing notice at discharge of the right to appeal. Our discharge planners work with the patient and family from the day of admission to inform them of discharge plans.

Submitter : Mrs. Denise Gard **Date:** 06/05/2006

Organization : St. Margaret Mercy Healthcare Centers

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-330-Attach-1.DOC

Attachment #330

Case Management Department
St. Margaret Mercy Healthcare Centers
Provider Numbers: 150004 and 150090
5454 Hohman AV Hammond, IN 46320
24 Joliet St. Dyer, IN 46311

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

Dear Sir or Madam:
I would like to comment the proposed rule file code CMS-4105-P:
Provisions for the Proposed Rule:
As the manager of the case management department of two hospitals I am concerned regarding the proposed requirement for hospitals to issue a notice of proposed discharge to all Medicare recipients 1 day prior to expected discharge for the following reasons:
Comments on "Provisions for Proposed Rule":

1) **Unlike** Home Health, Hospice and Long Term Care providers, hospitals have short-term relationships with Medicare recipients compared to those providers since acute care is meant to be brief. So by virtue of shorter lengths of stay for the hospitalized Medicare recipient this requirement would be a burden.
   It would be my department staff who would be held responsible for issuing these letters to the patients. I am concerned that we do not open cases until the day after admission so that for very short stay patients we would have to keep them in the hospital an additional day to meet the requirement. Also I currently only staff 1 case manager to work on Saturdays and only have On-Call coverage on Sundays and holidays. I am concerned that I would have to add staff and increase my budget- to meet this expectation of delivering letters on Sunday when discharges are planned for Monday.
1) Physicians do not always know the day of discharge until the actual discharge date. For medical patients in particular, physicians base discharge on results of tests so that the actual day of discharge is often left as pending the results. That is why as a hospital the discharge planning process begins on admission by the admitting nurse then my staff get involved 24 hours after admission. We pride ourselves in working timely with the patient, family and physician so that when the patient is medically stable for discharge we have the discharge plan in place. Staff work hard to keep the patient and family informed.
2) Problems in communicating timely with family of incompetent patients resulting in lengthening of hospital stays:
   At times patients are not able to make decisions for themselves (mentally

3) incompetent) or they defer discharge planning to their families. By having a timed requirement of notifying the family / designee – requiring their written acceptance- it would be a hardship. There are times families will not return phone calls to my staff nor work cooperatively with the hospital staff. In those situations we could be hard pressed to meet the one day notice timeframe since we would be required to meet face to face with the family to accomplish this notification and if they will not cooperate then it would result in a delay in discharge.

Comments on "Regulatory Impact":

1) Time burden on staff and hospital budget: Although the proposed rule minimizes the time and cost of printing these generic letters and delivering them to the patient/family, I am concerned that I will need to increase staffing to ensure staff can reach all patients/families as per the timeframe requirements then have the ability to spend extra time answering patient-family questions when delivering the letters.

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

Sincerely,
Denise Gard, BSN, RN, CCM
Manager Case Management
St. Margaret Mercy Healthcare Centers
Hammond and Dyer, Indiana

Submitter : Mr. Steven Hand **Date:** 06/05/2006

Organization : Memorial Hermann Hospital System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-331-Attach-1.DOC

Attachment #331

MEMORIAL HERMANN

VIA Electronic Submission
www.cms.hhs.gov/eRulemaking

June 5, 2006

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

Attention: CMS-4105-P

Dear Dr. McClellan:

Memorial Hermann Hospital System (MHHS) submits these comments on the proposed rule entitled ***"Medicare Program; Notification Procedures for Hospital Discharges"*** published per Federal Register Vol. 71, No. 65 Wednesday, April 5, 2006, 17052 et seq. This rulemaking seeks to make significant changes to Medicare discharge planning and beneficiary notifications process for Acute Care Hospitals. MHHS is the largest not-for-profit community based health system operating in Houston Texas. It serves a significant percentage of Medicare patients residing in the Greater Houston area (currently over 35,000 discharges annually). The changes being proposed will not only affect our hospital system but will affect Medicare patient's ability to access post acute facilities and movement through the continuum of care. This jeopardizes our ability to provide cost effective Medicare Hospital stay and our ability to meet the communities' needs.

We have serious concerns about this proposed rule. It is redundant to current requirements, would result in unnecessary extensions to length of stay, and would be unduly burdensome on hospitals. We support the recommendation of the American Hospital Associations (AHA) that if discharge planning issues need to be addressed, a national workgroup of affected parties should be convened.

Staff Productivity/Added Cost
The vast majority of our Medicare patients do not fully understand their Medicare benefits. Some are becoming more educated, but the majority believes if they have Medicare, all care will be covered with no limitation on time. Our experience in issuing notices of non-coverage and advance beneficiary notices is it takes a tremendous amount

of time to explain what the notices mean, what the patient responsibility will be if the benefit is not covered, and what the appeal rights are. The explanations are frequently repeated multiple times to the patient, the patient's spouse, the children or other caregivers. On average it takes a staff member 30 minutes to deliver the letter and provide the first explanation. That time increases as the number of individuals with whom we must communicate increases. If, on average, we discharge 20 Medicare patients per day in a facility, we are looking at 10 hours of intervention or one full FTE dedicated just to this process.

While one might anticipate once the initial notice of non-coverage is provided to a beneficiary at discharge the time associated with issuing these notices should decrease with subsequent admissions, however our experience demonstrates that Medicare beneficiaries require the same level of reinforcement and education about their medication, diet, physician follow-up etc. with each hospitalization. We project that this same level of effort will be required with each hospitalization when the discharge notice of non-coverage is issued.

Patient Satisfaction

With the increased emphasis CMS is placing on patient satisfaction, we anticipate this proposed rule will negatively impact the patient's perceptions of care, as well as their satisfaction with services provided by the provider. Presenting the patient with a letter should Medicare determine that all or some of the services provided during the stay may be deemed to be medically unnecessary, and ultimately then become the financial responsibility of the patient; will only add to the anxiety and stress of the most recent hospitalization and discharge. We anticipate this can seriously impact the satisfaction of the patient with services received.

Conclusion

We believe the current proposed one-day notice of discharge with appeal option will only slow down and overburden our current Medicare acute care system. Many times a physician will make the decision to discharge a patient that afternoon while making morning rounds. To require that we keep the patient an additional night will only confuse the situation, add unneeded cost and has the potential of preventing other patients from being seen. This proposal has negative consequences on both the hospital and the beneficiary.

If you have any questions concerning these comments, please contact Steven W. Hand at steven.hand@memorialhermann.org, or 713-448-4191.

Sincerely,

Steven W. Hand, M.P.A., C.P.A., FHFMA
AVP of Government Reporting-Operations

Submitter : **Ms. Lynn Kahn** **Date: 06/05/2006**

Organization : **BESLER Consulting**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See attachement

CMS-4105-P2-332-Attach-1.DOC

I have reviewed the proposed rule change regarding 42 CFR Parts 405, 412, 422 and 489 along with the NJ Hospital Association's (NJHA) comments as said forth in its letter to the Centers for Medicare & Medicaid Services dated May 31, 2006.

For hospital stays greater than three days, I am not concerned about the timing of the initial, standardized notice because the proposed rule change allows for service of the notice on the day before the "planned" discharge. The use of the term "planned" allows the hospital sufficient opportunity to provide a beneficiary with the standardized notice. However, I believe it may be difficult for hospitals to provide the standardized notice on the day prior to the planned discharge for anticipated hospital stays of three days or less. It may simply be impossible for the medical provider to know early enough on the first day of a two day hospital stay or by noon on the second day of a three day hospital stay that discharge is being planned. Accordingly, I would suggest that the rule be amended so that it only applies to hospital stays of four days or longer.

If the rule is amended as said forth above then the second more detailed notice on those rare occasions when a beneficiary is appealing the termination of additional services should not pose a problem. However, if the rule change applies to all hospital stays irrespective of duration, then I believe it would very difficult for hospitals to provide the second more detailed notification.

I agree with the NJHA's comment that the current rule set forth in section 422.620 (a)(2), which specifically states that a beneficiary is entitled to coverage until at least noon of the day after a notice of non-coverage is provided, should not be removed because the removal of this coverage obligation may have a significant financial impact on hospitals.

Lastly, although I have not calculated the per-notice cost associated with providing a beneficiary with the second more detailed notice, the calculation set forth in the Regulatory Impact section appear to be very conservative. This impact is an area that needs to be more fully evaluated by hospitals.

Submitter : **Mr. Patrick Monahan** **Date: 06/05/2006**

Organization : **Connecticut Hospital Association**

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-P2-333-Attach-1.DOC

CHA CONNECTICUT HOSPITAL ASSOCIATION

June 5, 2006

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

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

Dear Dr. McClellan:

Please accept these comments from the Connecticut Hospital Association (CHA) on behalf of its thirty not-for-profit acute care hospital members regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule: Medicare Program; Notification Procedures for Hospital Discharges (CMS – 4105 – P). The proposed rule concerns 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 that 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.

This proposal does not account for some of the practical processes related to how patient care decisions are made in a hospital setting and how the discharge planning process works. Also, there has been no compelling case for the need to implement this change. Therefore, CHA does not believe CMS should proceed with these changes without a more thorough 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 inconsistent with standard discharge planning and physician discharge order patterns.

- The language of the proposed generic discharge notice could cause beneficiaries to doubt the appropriateness of the planned discharge. 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 record keeping requirements are contrary 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 an unreasonable three-step process. 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, the Joint Commission on Accreditation of Healthcare Organizations standards and Connecticut state law.

These 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. There are fundamental differences between the discharge process in hospitals as compared with the process used by home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices that make the proposed rule inappropriate for hospital settings.

- *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. This would impose a significant financial burden on hospitals, and 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 exacerbate patient backlog in the Emergency Department (ED) and contribute to increased ED diversions because of the number of patients who would be kept in the ED waiting for an open inpatient bed.

Based on these facts, CHA 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 Record Keeping 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 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 that hospitals and the QIO 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 required to maintain hard copy files of the signed copy for the high volume of admissions each year. 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.

CHA believes this price is too high merely 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 the quality of care – it simply consumes resources that would be better devoted to direct patient care. CHA 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.

Sincerely,

Patrick J. Monahan II
General Counsel and Vice President, Patient Care Regulation

PJM:mb
By E-mail

cc: Melissa Musotto, Office of Strategic Operations and Regulatory Affairs
Carolyn Lovett, Office of Information and Regulatory Affairs

Submitter : Mrs. Catherine Sprouse **Date:** 06/05/2006

Organization : Altoona Regional Health System

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please consider the following comments in regards to the MEDICARE PROGRAM: NOTIFICATION PROCEDURES FOR HOSPITAL DISCHARGES - PROPOSED Rule. This proposed rule would require hospitals to comply with a two-step notice process when discharging patients from the hospital level of care. I am responding on behalf of an acute care hospital. I work as Director of Case Management. All utilization review and discharge planning activities are performed by members of the Case Management Department. I feel that the requirements of the proposed rule are unreasonable, inefficient and confusing. Requiring what amounts to a 3-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. It will be difficult, if not impossible, to deliver an advance written notice the day before "planned" discharge. If we are to comply with the 24-hour notice, patients will be staying an additional day in the hospital in order to comply with the rule. This increase in length of stay will result in a delay in placing emergency admissions into beds and add an additional burden to our overcrowded emergency department. The delivery and execution of these notices will at times be delegated to staff nurses who do not totally understand the process and will perceive this as an additional burden. Patients will be asked to process this additional information at a time when they are least able to comprehend or act on the information. If anything, it will produce more confusion and anxiety in our patient population. I feel the estimated time of five minutes to provide, explain and obtain the patient's singature on the form has been grossly underestimated.

In closing, I would like to state that I feel all of the information regarding appeal rights in the discharge process whould and could be addressed succinctly in the "Important Message from Medicare" which is given to all Medicare Patients at the time of a hospital admission.

Catherine Sprouse, RN
Director of Case Management

Submitter : Mr. Kenneth Becker **Date:** 06/05/2006

Organization : Catholic Health East

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-335-Attach-1.PDF

Attachment
#335

CATHOLIC HEALTH EAST

CORPORATE OFFICE

14 Campus Boulevard, Suite 300
Newtown Square, PA 19073-3277
www.che.org
(610) 355-2000 (610) 355-2050 fax

June 5, 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: CMS-4105-P – Medicare Program; Notification Procedures for Hospital Discharges *(71 Federal Register 17052).*

Dear Dr. McClellan:

On behalf of Catholic Health East (CHE), I would like to thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding notification procedures for hospital discharges, published April 5, 2006 in the *Federal Register*. Catholic Health East (CHE) is a multi-institutional, Catholic health system located in 11 eastern states from Maine to Florida, including 33 acute care facilities.

CHE agrees that Medicare beneficiaries need to be given appropriate notice of their rights under the Medicare program including their right to appeal discharge decisions with which they disagree. However, we have several concerns about the proposals advanced by CMS in this rule and therefore, I would like to offer the following comments.

BACKGROUND

CMS states that currently, hospitals do not follow the same two-step discharge notice process that applies to HHAs, SNFs, CORFs and hospices. While that is an accurate statement, hospitals do follow a two step process of informing Medicare beneficiaries of their rights. That process includes issuing the Important Message from Medicare to the beneficiary upon admission and then issuing a hospital-issued notice of noncoverage to any Medicare beneficiary that expresses dissatisfaction with an impending hospital

discharge, or a Notice of Discharge and Medicare Appeal Rights (NODMAR) in the case of Medicare Advantage organizations.

PROVISIONS OF THE PROPOSED RULE

CHE is concerned that the proposals advanced by CMS would be administratively difficult to implement for a number of reasons. Current discharge procedures do not provide hospitals with enough advance notice to comply with the requirement that the generic discharge notice be delivered to the beneficiary at least 24 hours prior to discharge. First, it is the Medicare beneficiary's doctor, not the hospital, that decides when a patient should be discharged. Second, the physician usually does not issue the discharge order until the morning of the day of discharge after the patient has been examined and deemed well enough to leave the acute care facility. Without the 24 hour advance notice, the beneficiary would have to remain in the hospital for an extra day in order for the time requirements of the generic discharge notice to be met. In addition to this extra day being clinically unjustified, the extra day would be financially burdensome to hospitals as hospitals are reimbursed the same amount under the Medicare program regardless of whether the patient stays the average number of days for their diagnosis or a day longer. Finally, having Medicare patients stay an extra day would have an negative impact on bed availability and could result in patients waiting in hospital emergency rooms for an inpatient bed, adding further to already overcrowded emergency departments.

CHE is also concerned about the time it will take hospital personnel to deliver the generic notice of hospital non-coverage to Medicare beneficiaries. CMS estimates that it will take approximately five (5) minutes to deliver each notice. CHE believes this is an underestimation. Experience would suggest that delivering, explaining and answering any questions about a document that details a prospective discharge date and a description of the beneficiary's appeal rights would take much longer than five minutes. This does not take into account other very common circumstances that would add to the time it would take to deliver the generic discharge notice, such as beneficiaries whose first language is not English, beneficiaries who wish to have their family members present for the discussion, or a beneficiary who is incompetent.

CMS does not indicate they have any concerns regarding the current process for notifying Medicare beneficiaries of their rights under the Medicare program, including the right to appeal discharge decisions with which they disagree. Rather, they state in the proposed rule that they propose these changes because they "believe that the two step notice process, including a standardized, largely generic notice of non-coverage, is helpful to beneficiaries" and that the "notice process is intended only to provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings." Given that the current process provides the necessary notification of rights to Medicare beneficiaries, the proposed rule does not appear to balance the rights of beneficiaries with the additional burden it would impose on hospitals.

Therefore, CHE requests that CMS withdraw the Notification for Hospital Discharges Proposed Rule and retain the current requirements with which hospitals comply to

provide Medicare beneficiaries notice of their rights under the Medicare program. If CMS has concerns with this current process, then CHE would request that CMS address those specific concerns in a manner that appropriately balances the administrative costs of hospitals with the rights of beneficiaries.

Thank you for your review and consideration of these comments. If you have any questions, please feel free to contact me at (610) 355-2121.

Sincerely,

Kenneth A. Becker
Vice President, Advocacy & Government Relations

Submitter : Mrs. Renee Hlavaty **Date:** 06/05/2006

Organization : St. Margaret Mercy Healthcare Centers

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-336-Attach-1.DOC

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

Re: *Two Step Discharge Notice Process*

To Whom It May Concern:

This letter is in response to the proposed *Two Step Discharge Notice Process* being considered for acute care hospitalizations. I object to the proposal for a number of reasons. An acute care hospital is intended to be a short stay with the average length of stay of approximately 5 days. The goal is to diagnose and expeditiously treat the patients so they can return to their previous living situations. It is not intended to be interim or permanent residency. The decision to discharge is made quickly, based on test results and patient progress.

Adding this requirement will add an additional 24 hours to each patient stay. This will increase hospital costs and increase paperwork. Extending the stay also places the patients at added risk. Being hospitalized places any patient in an unfamiliar environment and for the elderly, this can precipitate confusion, falls and exposure to infectious organisms.

If a patient requires extended care facility placement, the timing of the discharge is not within the hospital's control, but rather dictated by when the receiving facility can accept. No other payer requires a 24-hour notice for discharge. This policy is not in the patient's best interest.

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

Renee Hlavaty, Vice President Professional Services
St. Margaret Mercy Healthcare Centers
Hammond and Dyer, Indiana

Submitter : Mrs. Millicent DesCamp **Date:** 06/05/2006

Organization : St. Margaret Mercy Healthcare

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-337-Attach-1.DOC

Case Management Department
St. Margaret Mercy Healthcare Centers
Provider Numbers: 150004 and 150090
5454 Hohman AV Hammond, IN 46320
24 Joliet St. Dyer, IN 46311
June 5, 2006

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

Dear Sir or Madam:
I would like to comment the proposed rule file code CMS-4105-P:
Provisions for the Proposed Rule:
As the member of the staff of the case management department of two hospitals I am concerned regarding the proposed requirement for hospitals to issue a notice of proposed discharge to all Medicare recipients 1 day prior to expected discharge for the following reasons:

Comments on "Provisions for Proposed Rule":

1) Unlike Home Health, Hospice and Long Term Care providers, hospitals have short-term relationships with Medicare recipients compared to those providers since acute care is meant to be brief. So by virtue of shorter lengths of stay for the hospitalized Medicare recipient this requirement would be a burden.
   I would be responsible for issuing these letters to the patients. I am concerned that we do not open cases until the day after admission so that for very short stay patients we would have to keep them in the hospital an additional day to meet the requirement. Also we currently only staff 1 case manager to work on Saturdays and only have On-Call coverage on Sundays and holidays. I am concerned that our department would have to add staff and increase our dept./hospital budget- to meet this expectation of delivering letters on Sunday when discharges are planned for Monday.
2) Physicians do not always know the day of discharge until the actual discharge date. For medical patients in particular, physicians base discharge on results of tests so that the actual day of discharge is often left as pending the results. That is why as a hospital the discharge planning process begins on admission by the admitting nurse then our department gets involved 24 hours after admission. We pride ourselves in working timely with the patient, family and physician so that when the patient is medically stable for discharge we have the discharge plan in place. We all work hard to keep the patient and family informed.
3) Problems in communicating timely with family of incompetent patients resulting in lengthening of hospital stays:
   At times patients are not able to make decisions for themselves (mentally

incompetent) or they defer discharge planning to their families. By having a timed requirement of notifying the family / designee – requiring their written acceptance- it would be a hardship. There are times families will not return our phone calls nor work cooperatively with the hospital staff. In those situations we could be hard pressed to meet the one day notice timeframe since we would be required to meet face to face with the family to accomplish this notification and if they will not cooperate then it would result in a delay in discharge.

Comments on "Regulatory Impact":

1) Time burden on staff and hospital budget: Although the proposed rule minimizes the time and cost of printing these generic letters and delivering them to the patient/family, we will need to increase staffing to ensure staff can reach all patients/families as per the timeframe requirements then have the ability to spend extra time answering patient-family questions when delivering the letters.

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

Sincerely,

Case Manager
St. Margaret Mercy Healthcare Centers
Hammond and Dyer, Indiana

Submitter : **Trula Foughty** **Date: 06/05/2006**

Organization : **Iowa Health System**

Category : **Hospital**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached document

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.

Case Management Department
St. Margaret Mercy Healthcare Centers
Provider Numbers: 150004 and 150090
5454 Hohman AV Hammond, IN 46320
24 Joliet St. Dyer, IN 46311
June 5, 2006

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

Dear Sir or Madam:
I would like to comment the proposed rule file code CMS-4105-P:
Provisions for the Proposed Rule:
As the member of the staff of the case management department of two hospitals I am concerned regarding the proposed requirement for hospitals to issue a notice of proposed discharge to all Medicare recipients 1 day prior to expected discharge for the following reasons:

Comments on "Provisions for Proposed Rule":

1) Unlike Home Health, Hospice and Long Term Care providers, hospitals have short-term relationships with Medicare recipients compared to those providers since acute care is meant to be brief. So by virtue of shorter lengths of stay for the hospitalized Medicare recipient this requirement would be a burden.
   I would be responsible for issuing these letters to the patients. I am concerned that we do not open cases until the day after admission so that for very short stay patients we would have to keep them in the hospital an additional day to meet the requirement. Also we currently only staff 1 case manager to work on Saturdays and only have On-Call coverage on Sundays and holidays. I am concerned that our department would have to add staff and increase our dept./hospital budget- to meet this expectation of delivering letters on Sunday when discharges are planned for Monday.
2) Physicians do not always know the day of discharge until the actual discharge date. For medical patients in particular, physicians base discharge on results of tests so that the actual day of discharge is often left as pending the results. That is why as a hospital the discharge planning process begins on admission by the admitting nurse then our department gets involved 24 hours after admission. We pride ourselves in working timely with the patient, family and physician so that when the patient is medically stable for discharge we have the discharge plan in place. We all work hard to keep the patient and family informed.
3) Problems in communicating timely with family of incompetent patients resulting in lengthening of hospital stays:
   At times patients are not able to make decisions for themselves (mentally

incompetent) or they defer discharge planning to their families. By having a timed requirement of notifying the family / designee – requiring their written acceptance- it would be a hardship. There are times families will not return our phone calls nor work cooperatively with the hospital staff. In those situations we could be hard pressed to meet the one day notice timeframe since we would be required to meet face to face with the family to accomplish this notification and if they will not cooperate then it would result in a delay in discharge.

Comments on "Regulatory Impact":

1) Time burden on staff and hospital budget: Although the proposed rule minimizes the time and cost of printing these generic letters and delivering them to the patient/family, we will need to increase staffing to ensure staff can reach all patients/families as per the timeframe requirements then have the ability to spend extra time answering patient-family questions when delivering the letters.

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

Sincerely,

Case Manager
St. Margaret Mercy Healthcare Centers
Hammond and Dyer, Indiana

Submitter : Mrs. Lynn Leoce **Date:** 06/05/2006

Organization : Adventist Health System

Category : Nurse

Issue Areas/Comments

Background

Background

Regulations currently exist that notification of pending discharge to patients or representative. Notifications via HINN, ABN, Utilization review, and JCAHO standards provide adequate regulation and provisions for patient notification of discharge status.

GENERAL

GENERAL

This proposed rule would make notification very difficult for short stay patients and when notification of discharge(by the physician)does not occur until the of discharge. Since many physicians defer to their consultants for prior to discharge, this presents difficulty with timing their responses and appropriate discharge notification. The delay in discharge as a result from such notification would make time of discharge and discharge facilitation an even more complex process than currently exists. This would lead to increased and extended emergency room wait times, and a hospitals inability to appropriatley manage patient discharges and throughput in a timely fashion.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Existing regulations address discharge plan and notification: Discharge planning must be included in the patient's medical record for use in establishing an appropriate discharge plan. The patient and/or representative must discuss the plan prior to discharge. In addition, hospitals must arrange for implementation of discharge plan, reasses patient's discharge plan based on care needs as appropriate, and provide counsel to patient and family members to prepare them for alternate level of care.

Submitter : Ms. Torona Stokes **Date:** 06/05/2006

Organization : Redmond Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I 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, GHA 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.

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

I 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.

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.

Submitter : **Carla Jackson** **Date: 06/05/2006**

Organization : **Magellan Health Services**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment.

CMS-4105-P2-342-Attach-1.DOC

Attachment #342

6950 Columbia Gateway Drive
Columbia, MD 21046

June 1, 2006

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

To Whom It May Concern:

I am writing on behalf of Magellan Behavioral Health, a subsidiary of Magellan Health Services (Magellan), to comment on the proposed rule for the Medicare Program Notification Procedures for Hospital Discharges (CMS-4105-P). Magellan Behavioral Health, a subsidiary of Magellan Health Services, is the industry leader in comprehensive behavioral care delivery management. Magellan is a subcontractor to several Medicare Advantage Plans. This language should be binding on all QIOs and not be applied at their discretion.

The following comments refer to **PROVISIONS OF THE PROPOSED RULE.**

In the discussion concerning the *Proposed Two-Step Notice Process,* it states "The notice processes as specified in Sec. 405.1208, addresses the situation where the hospital requests a Quality Improvement Organization (QIO) review because the physician does not concur with the discharge decision, would remain unchanged." Magellan suggests that the Centers for Medicare & Medicaid Services (CMS) extend this right to request a QIO to a Medicare Advantage (MA) organization in 42 CFR 422.622 when the physician does not concur with the discharge determination made by the MA organization.

Medicare Advantage (MA) plans were developed to provide quality health care to Medicare enrollees while at the same time controlling the out of pocket expenses for enrollees and costs for CMS. To create an efficient product, the Medicare Advantage organizations develop a provider network comprised of providers that meet strict credentialing requirements. MA plans develop and/or use nationally recognized medical necessity guidelines to evaluate the enrollee's need for and response to treatment. These

guidelines are used to make benefit determinations to ensure the enrollee is receiving treatment at the appropriate level of care. However, 42 CFR 422.620(b) impedes the MA plan from performing these functions and the process is further complicated if the treatment relates to behavioral health needs.

42 CFR 422.620(b) requires that before discharging an individual or changing the level of care in an inpatient hospital setting, the MA organization must obtain the concurrence of the physician who is responsible for the enrollee's inpatient care. This provision restricts the MA organization's ability to manage the enrollee's benefits. If the patient is admitted for treatment related to a behavioral health need, there is no prescribed regimen. Treatment for behavioral health needs usually involves varying sequences of treatment and drug dosages. Additionally, in behavioral health, the physician and facility are paid on a per diem basis, not a DRG basis; therefore, there is no incentive on the part of the physician to discharge the patient.

Typically, the enrollee has been admitted utilizing medically necessary or emergency guidelines. The MA organization is responsible for ensuring the enrollee's limited benefits (190 inpatient days) are used in the best interest of the enrollee. Frequently, the MA organization determines (based on enrollee's clinical presentation, medical necessity guidelines and member benefit plan requirements) that the enrollee is in a position to transition to a lower level of care or the enrollee's condition is stable and enrollee can be transferred to a participating facility; however, the physician does not concur with the decision to discharge or transfer to a lower level of care. Under current law/regulation there is no appropriate remedy in situations where the MA organization and the physician have this disagreement concerning the enrollee's care. The outcome is that the physician insists on continued inpatient care resulting in the unnecessary consumption of limited inpatient days; inappropriate care; and, exponential cost increases. The MA organization is not entitled to initiate a QIO review.

CMS permits hospitals to initiate an expedited QIO review when the physician responsible for the enrollee's inpatient care does not agree with the hospital's decision to discharge the enrollee. Magellan is requesting that MA organizations be afforded the same opportunity that hospitals currently have to initiate a QIO review when the attending physician does not agree with the decision to discharge (or transfer to a lower level of care). This will allow for optimal care and management of the enrollee's benefits.

In proposed §422.620 and §422.622, CMS indicates "that responsibility for delivery of the detailed notice would still rest with the MA organization." MA organizations would be required to deliver a detailed notice to enrollees who request an immediate QIO review by the close of business of the day of the QIO's notification of the enrollee's request for an immediate QIO review. In theory, this seems a reasonable proposal. However, there are a few problems with the proposed process. First, if the physician/provider makes the discharge decision, the MA organization will not have the information necessary to complete the detailed notice. In such instances, the discharge is not based on the medical necessity determination of the MA organization. Second, there

are instances where the enrollee is discharged at the direction of the physician/provider and the MA organization is not notified until after discharge. Again, it would be difficult for the MA organization to issue the detailed notice without having the necessary information and the physician/provider's rationale. It would be helpful if CMS would clarify the hospital's role in delivery of the detailed notice, particularly when the physician has made the discharge decision and the MA organization will likely not have the information required to complete the notice nor have any representatives on site to deliver such a notice.

The requirement that notice be delivered to enrollees by the close of business of the day of the QIO's notification of the enrollee's request for an immediate QIO review is burdensome and may be challenging for the MA organization to meet. A MA organization might not receive notice until 4:00 pm and would have an hour or two to prepare to gather the necessary information and deliver the letter. We would suggest that the MA organization have until close of business the day following notification of the request for QIO review.

Thank you for your consideration of Magellan's requests/suggestions.

Sincerely,

Carla S. Jackson
Associate Regulatory Counsel
Magellan Health Services
6950 Columbia Gateway Drive
Columbia, MD 21046

Submitter : Ms. lori thomas **Date:** 06/05/2006

Organization : St. Margaret Mercy Healthcare - North

Category : Hospital

Issue Areas/Comments

Background

Background

Since we do not work weekends the hospital would have to hire more staff to work in order issue letters on Saturdays and Sundays.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

We would see a delay in discharges since some patients are only here one to three days.
Physicians do not determine day of discharge until the actual day due to waiting on diagnostic test results, thus delaying discharge.
Sometimes families and patients are uncooperative in returning calls in a timely fashion, so if I was required to obtain a signature 24 hours prior to day of discharge this would again delay discharge.

Regulatory Impact

Regulatory Impact

Hospitals are not like Home Care Agencies who have longer term relationships with their patients and have increased contact and time with clients and families in order to obtain needed signatures.