Submitter : Mr. EDWARD QUINLAN **Date: 05/30/2006**

Organization : Hospital Association of RI

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-4105-P-972-Attach-1.DOC

Attachment # 97

HARI **The Hospital Association of Rhode Island**
880 Butler Drive – Suite One
Providence. Rhode Island 02906

Edward J. Quinlan
President

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

Re: Notification Procedures for Hospital Discharges

Dear Dr. McClellan:

On behalf of the Hospital Association of Rhode Island's member hospitals, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) notification procedures for hospital discharges, proposed on April 5, 2006 in the *Federal Register.*

In general, the proposal is unnecessarily burdensome and inconsistent with standard discharge planning and physician discharge order patterns. It confuses the issue of beneficiary financial liability and the process for deciding when a patient no longer needs hospital-level inpatient care. Most importantly, it is contrary to the movement to electronic medical records.

PROVISIONS OF THE PROPOSED RULE
The rule would impose a three-step process on hospitals, as opposed to the two-step process followed by post-acute providers because hospitals will be required to provide the Importance Message from Medicare (IMM) at admission. The already-in-place two-step process is the provision of the IMM and of a detailed notice when there is any question raised about the appropriateness of a planned discharge. For an average Medicare length of stay of six days, a three-step process is excessive. The IMM was expressly required by Congress to ensure that beneficiaries would know their discharge rights and was imposed in response to the expectation of "quicker and sicker" discharges under IPPS -- an expectation that did not materialize. A solution to a problem that doesn't exist and that adds more administrative costs versus quality and patient care costs does not make sense.
By requiring a notice on the day before discharge, but after the discharge decision has been made, CMS often would be requiring an extra day of inpatient care after the patient no longer needs it. Please understand that the physician, and not the hospital, makes the discharge decision. In practice, 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 physical status no longer requires hospital-level inpatient care. Patients generally know their expected day of discharge even prior to admission, which is then adjusted as necessary to reflect their condition during the discharge planning process. Again, we need to stress that the decision to discharge is the physician's decision. There are other issues related to timing of

the notice - such as when the discharge gets postponed due to a complication the night before the expected discharge or when an admission is just for one or two days. It may be that CMS' supporting rationale for the 24-hour notice is based on what was done in the post-acute setting. That setting is very different operationally, and the IMM does not need to be provided in that setting.

The proposal requires that the beneficiary or their representative sign a copy of the 24-hour notice of discharge documenting its receipt and their understanding. From a purely logistical perspective, this requirement is contrary to the movement to electronic health records. The paperwork clearance package submitted by CMS to the Office of Management and Budget indicates that the signed notice of discharge must be provided and maintained in hard copy and no provision for electronic alternatives is indicated. In addition, the burden (estimated at five minutes per patient) to prepare and deliver the notice does not reflect the time required to explain the notice nor the reason for signature. It also does not reflect the manpower and capital costs necessary to maintain hard copy files of the signed documents for thousands of admissions a year.

SUMMARY
We appreciate the important responsibility CMS has to Medicare beneficiaries. Our hospitals share in that responsibility. To have them spend precious health care resources to address an unrealized concern is an unfortunate waste.

If you have any questions about this comment letter, please contact me or Pat Moran, VP Finance, at (401)946-7887 or patm@hari.org.

Sincerely,

Edward J. Quinlan

Edward J. Quinlan
President

Submitter : Shelly Russell

Date: 05/30/2006

Organization : Memorial Health Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

While I understand the reasoning behind the discharge notices, my concern is related to the additional burden for Critical Access Hospitals. We do not have the means to provide discharge planners on weekends. Without adding the additional staff, this will fall on nursing staff. Please reconsider your views on implementing this for all hospitals.

Submitter : **Ms. Susan McAndrews** **Date: 05/30/2006**

Organization : **Riverside Regional Medical Center**

Category : **Hospital**

Issue Areas/Comments

Background

Background

RIVERSIDE
REGIONAL MEDICAL CENTER

TO: Joy Hogan Rozman, President & Chief Executive Officer

FROM: Susan McAndrews, VP, Surgical & Women s Services/Nurse Executive
Dr. Christopher Stolle, VP, Medical Affairs
Marybeth Scott, RN, BSN, MSA, Director, Patient Care Services
Melody Livengood, RN, BSN, Clinical Manager, Care Management Department

DATE: May 26, 2006

SUBJECT: Notice of Federal Proposed Rule CMS-4015-P
Notification Procedures for Hospital Discharges

Thank you for the opportunity to respond to the Proposed Rule CMS-4015-P, Notification Procedures for Hospital Discharges .

The following concerns are noted:

1. The supposition that the rule imposes minimal burden on Case Managers, hospitals, and most of all patients, is seriously under calculated.

2. Patients will have another lengthy, time intensive, confusing process added to them. Trust will not be increased but fractured.

3. The Administrative burden of service determination in the manner described in this rule will add cost and time without really impacting patient care. We already provide a detailed letter upon admission about the patient rights as a Medicare patient. Case Management processes already monitor patients/charts for readiness of discharge and work to facilitate patient transfer or discharge.

4. Currently, we consistently provide HINN (Hospital Issue Notice of Non-Coverage) on all patients. This informs the patient that the physician feels they are ready for discharge and could be safely taken care of in another setting/level of care, which would include home. The HINN is sent to the patient, Business Office, Medicare, and the physician. This document is already detailed and provides the same information.

With the goal to ensure patients are informed of their rights, which includes an appeal, we believe this is already accomplished by the notices received on admission and on a HINN when issued.

5. Initially, the impact may be small. However, as noted in our Home Health Division, the appeals are increasing rapidly. Appeals are the burden of the hospital staff and takes a minimum of 30 minutes. Thus, with 50 patients per day, the burden could be significant. Today, our Case Managers spend 2 hours a day explaining the impact of Medicare D and Medicare HMO s. When a HINN is added, we spend another 30-45 minutes of additional education.

Our first recommendation is to maintain current processes and rules. We do not support legislation that applies rules and regulations to rules and regulations that already provide this service. Our second recommendation is to admonish those facilities that are non-compliant with current regulations verses adding additional regulatory burden to those facilities that already supply excellent services to Medicare patients.

Thank you.

Submitter :

Date: 05/30/2006

Organization : AARP

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1002-Attach-1.PDF

Attachment 100

June 1, 2006

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

www.cms.hhs.gov/eRulemaking

Attention: CMS – 4105 – P

RE: Medicare Program; Notification Procedures for Hospital Discharges
71 Fed. Reg. 17052, April 5, 2006

Thank you for the opportunity to comment on this proposed regulation that would change requirements for information that must be given to Medicare beneficiaries being discharged from hospitals.

The proposed changes are a significant improvement and would provide a more timely and detailed notice of the right to challenge hospital discharges that may be premature and thus harmful to health. The new information requirements would increase beneficiaries' understanding and ability to exercise their rights, serve as a needed check against existing financial incentives for hospitals to discharge early, and potentially lead to better health outcomes. The proposed changes also would create consistency with service termination policies in other settings, such as nursing homes and home health care. Use of this standard and more familiar language and procedure will further increase the likelihood that beneficiaries will be able to understand and exercise these important rights.

We have two concerns with the proposed regulations.

First, we disagree with the proposal in 405.1205(b)(1) and 422.620(b)(1) that notices could be provided on the day before discharge. We believe that would be inadequate in many cases where a patient – who may still be very ill – needs time to consult with physicians and family members on how to proceed. The notices should be provided two days before discharge whenever possible, as is the case in nursing homes and other settings. For situations in which that is not practical, such as a two-day hospital stay, notice should be provided no later than noon the day before discharge.

We also disagree with the proposal in 405.1206(e)(3) and 422.622(c)(3) that beneficiaries could be charged fees for access to copies of their own medical records. Individuals should always be able to access their own records, regardless of ability to pay. Allowing hospitals or Medicare Advantage plans to charge beneficiaries who wish to exercise this fundamental right is both wrong in general and particularly unfair to low-income beneficiaries who would lose this right because of inability to pay. We believe a reasonable alternative would be to provide the records free of charge to a beneficiary and to charge a nominal fee for any duplicate copies.

Thank you again for the opportunity to comment on these important proposed regulations. If you have any questions about our comments, please contact Paul Cotton on our Federal Affairs staff at (202) 434-3770.

Sincerely,

David Certner
Legislative Counsel & Legislative Policy Director
Government Relations and Advocacy

Submitter : **Ms. Melanie Opalka** **Date: 05/30/2006**

Organization : **Community Medical Center**

Category : **Hospital**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

CMS-4105-P-1012-Attach-1.DOC

"Provision of the Proposed Rule"

We have concern for the proposed rule CMS-4105-P (Notification Procedure for Hospital Discharges) that will additionally impact hospital finances, along with the proposed rule CMS-1488-P (Proposed IPPS FY 07). This places an added obvious burden on hospital processes and we believe CMS severely underestimated the cost of implementing such a requirement. CMS 's cost estimates in the Federal Register were not congruent with the task at hand. They must take into account:

- Process development, such as who and how will issue the notice of non-coverage
- Development of the discharge notice
- Additional staff that may be required to issue notices to all Medicare, Medicare-Advantage, and Medicaid patients
- Copying the medical records (for appeals)
- Mailing or courier expenses (for appeals)
- Future costs based on increasing Medicare population

Instead of an occasional HINN or NODMAR letters, we are now looking at serving a letter to everyone. This will surely increase hospital length of stay if we needed to issue the notice on the day prior to discharge. Issuing this notice is not necessary on inpatient hospitals as appeals information is already provided to every Medicare patient on admission. It would be rare to be able to deliver a notice of non-coverage on the day prior to discharge. Many times the patient's discharge is contingent on the physicians' evaluation of test results that are preformed the same day as discharge. Then, if the patients were not discharged as planned, we would have to rescind the first notice and deliver another one. This proposed rule is truly a hospital administrative nightmare.

Submitter : **Ms. Neta Lamp** **Date: 05/30/2006**

Organization : **Fostoria Community Hospital**

Category : **Critical Access Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Requiring that discharge decisions be made 24 hours in advance rather than based on the patient's condition any day of the stay is not medically appropriate. Conversely requiring that patients remain hospitalized 24 hours longer than necessary would expose them to unneeded risk and not be cost effective for either the government or the provider. Therefore, both inappropriate care and additional expense would be the result if the proposed rule were put into effect.

Submitter : **Mrs. sherry meyer** **Date: 05/30/2006**

Organization : **Memorial Health Center**

Category : **Social Worker**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I feel this new proposal received is very unreasonable. It will only cause yet more paper compliance in an industry that is already too documentation and paper compliance heavy. Also, it will make it even more difficult for those of us job sharing between Utilization Review and Discharge Planning.

Submitter : Mrs. Karla Edwards **Date:** 05/30/2006

Organization : Overlake Hospital Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

The impact of providing patients with discharge notification is huge in that the average length of stay is less than 3 days and in some cases patients are admitted and discharged within a 24 hour period of time. The process of notification seems to be an unreasonable burden to the hospitals and patients should be aware that by the nature of a hospital stay they will be discharged either to home or a step down care facility.

Submitter : **Dr. Daniel Heyrman** **Date: 05/31/2006**

Organization : **Dr. Daniel Heyrman**

Category : **Physician**

Issue Areas/Comments

Background

Background

I am a family practitioner. I often do not know until the day of discharge whether or not the patient will be ready for discharge on that day. Even when I see patients in the morning I sometimes will tell them that I may discharge them later in the day if they meet certain criteria such as being able to tolerate advancement of their diet.

If this new proposal is adopted, I would have to give the patient written notification regarding their upcoming discharge and then not discharge them the same day but keep them until the following day. This does not make any sense to me. I often cannot tell the patient the day before they are discharged that they definitely will be discharged the following day. It all depends on how they respond to the ongoing treatment. If the patient has already met discharge criteria on a given day I would send him/her home the same day. It would not make sense to give them a letter stating that I'm going to discharge them tomorrow.

This proposal seems to be ill-conceived and illogical. I believe it would lead to longer hospital stays in addition to being an administrative hassle. I believe patients would also consider it a stupid and illogical rule. Most patients want to be discharged as soon as they are medically stable and able to be discharged safely. I also try to discharge patients as soon as they are medically able and have a safe place to go to. I do not see how this proposal helps in any way. I do see that it has the potential to cause many problems in addition to patient and physician dissatisfaction. For these reasons I strongly recommend rejection of this proposal.

Submitter : Ms. Sandy Harm **Date:** 05/31/2006

Organization : Lakeview Medical Center

Category : Hospital

Issue Areas/Comments

Background

Background

This is a rule that would add nothing to the discharge process for Medicare recipients. Notification of non-coverage "the day before" discharge is impossible in many situations. Physicians, discharge planners, and social workers often don't know which day is the day before discharge. Physicians may be awaiting labs, diagnostic tests, or response to interventions prior to making the decision to discharge the patient. When the data is available and the physician determines the patient is ready for discharge, they are discharged. This rule would essentially add another day's stay onto patients if the notice is required to be given the day before they are discharged.

GENERAL

GENERAL

This rule should not be implemented. I'm unclear what issue this rule is trying to address, but in trying to improve one process, it would create significant barriers to the discharge process in our hospital.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Provisions of the rule will be very confusing to the average Medicare recient. They are already confused by medical necessity and coverage parameters. THis rule will add a burden to the discharge process and the medicare beneficiary.

Submitter :

Date: 05/31/2006

Organization : **SILVER CROSS HOSPITAL**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

We appreciate the opportunity to provide comments on the above referenced notice of proposed rulemaking, which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a two-step notice process similar to what is currently in place for other Part A providers.
We have a number of serious concerns with the proposed rule, chiefly among them, the significant administrative and financial burdens this would place on hospitals and the negative impact that would result for both Medicare beneficiaries and non-Medicare patients. CMS has completely underestimated the information collection costs and has failed to recognize the financial impact of the proposal on the overall healthcare delivery system. It is our belief that providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary and longer hospital stays, thus creating significant throughput issues for hospitals by challenging their capacity limitations and threatening their ability to treat other patients who need acute care services.

We estimate the average Chicago-area hospital will incur an estimated $205,000 - $410,000 annually just for the time to deliver the proposed discharge notices, with the anticipated longer length of stay costing the average hospital an estimated $9.9 - $13.3 million annually.

Specific comments, which are explained in greater detail in this letter, include:

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

7 The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not appropriate in an acute care hospital setting.

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

7 The proposed generic discharge notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources and jeopardizing the ability of hospitals to meet the acute care needs of other patients.

7 The hardcopy signature and recordkeeping requirements are at odds with federal efforts to encourage electronic medical records.

7 The cost estimates for delivering generic and detailed hospital discharge notices are grossly understated.

There are also a number of unanswered questions, particularly with respect to situations where a discharge is no longer appropriate due to a change in the beneficiary s health status after the generic notice has been issued.

We recommend that these issues be taken into consideration and that any outstanding questions be fully considered prior to entertaining a change of any kind to current hospital discharge notice procedures. In addition, we recommend that a national multi-disciplinary workgroup be convened to assist CMS in better understanding hospitals day-to-day operational procedures and to ensure that any proposed revised procedures better balance hospital and program administrative costs with beneficiary rights.

Thank You for the opportunity to comment on this proposed rule.

Submitter : Mr. L. Greg Cunningham **Date:** 05/31/2006

Organization : American Case Management Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1082-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 : Ms. Janene Yeater **Date:** 05/31/2006

Organization : MedCentral Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1092-Attach-1.DOC

Attachment #109

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: PROVISIONS OF THE PROPOSED RULE

To Whom It May Concern:

I am writing regarding concerns of the proposed rules requiring hospitals to provide discharge notices under both original Medicare and Medicare Advantage programs.

Concerns are listed below:

-Creates additional cost and resource utilization to hospitals to provide this single or double step process for each discharge.
-The process is unreasonable and unnecessarily burdensome given an average length of stay of 6 days.
-Likely will create an additional length of stay with the 1 day prior to discharge requirement.
-Confuses the issue of beneficiary financial liability and the process for deciding when a patient no longer needs hospital-level inpatient care.
-Creates doubt in the mind of the beneficiary that their planned discharge is appropriate.
-Works at cross purposes with the movement toward electronic medical records.
-Current process of notifying beneficiaries of no longer requiring hospital level of stay gives them the ability to appeal (HINN).

Thank you for the opportunity to comment on this important issue.

Sincerely,

Janene Yeater, RN, MS, MBA
Quality Management Director
MedCentral Health System

Attachment #109

335 Glessner Avenue
Mansfield, OH 44903

Submitter :

Date: 05/31/2006

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

This requirement is not necessary. It will create an added burden on hospitals. It will be time consuming and costly and will not result in better care for patients.

Submitter : Joyce Grace **Date:** 05/31/2006

Organization : Asante Health System

Category : Health Care Industry

Issue Areas/Comments

Background

Background

The proposed 24 hour notification for discharge to Medicare patients will add another layer of confusion to the recipients currently trying to understand their new "drug benefit." As the daughter of one of these patients who had to go on line and "assist" my mother on this easy to understand new benefit, I can tell you that she would not understand why she would be given such a notice in the hospital prior to discharge without thinking she must not be ready to go to the next level of care. And to be trying to put ACUTE care hospitals on equal footing with SNFs and home health is not feasible as we provide very distinct services. We are acute care and as such our patients may respond quickly to appropriate therapy and be ready to move to another setting that has been carefully developed by the case management staff. Thus we will end up with longer stays, angry doctors, shortage of beds, and confused Medicare patients.

GENERAL

GENERAL

The 24 hour notice is an unnecessary addition to all the Medicare rules and regulations we currently are working diligently to follow. We screen for medical necessity, check MD orders for correct patient status, and start discharge planning on admission. Most patients know that they will be discharge when they are medically stable and ready to move on to the appopriate level of care. The preparation for discharge is done by the staff with patient/family considerations and does not come down to a letter that will only confuse the issue. That anyone would think that this would only take 5 minutes shows a complete lack of understanding on what occurs when we present Medicare beneficiaries with the current Medicare notices. Please consider the added burden you will add to the hospitals and instead work on issues that already consume staffs time, such as Observation Services and self administered drugs in the Outpatient/Observation setting. Please reconsider and continue with our current system.

Submitter : Dr. Gregory Van Winkle

Date: 05/31/2006

Organization : Dr. Gregory Van Winkle

Category : Physician

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Requiring notification of pending discharge the day before will add needless delays and add cost with absolutely no value added to the system. In addition, the cost of administering this rule and the additional cost of delayed discharges will be enormous. This rule would be a tremedous waste and would dissatisfy patients and providers alike.

Submitter : Dr. Paul Flink **Date:** 06/01/2006

Organization : Medical Associates Health Centers

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

This will only increase costs in a stressed system. Almost always discharges are planned the day before and patients are notified. Occasionally a discharge is dependent on a consultant or test to be completed in the afternoon, which could extent the stay if we have live with this rule. It always seems like more and more red tape and silly rules that add to frustration and delay.

Submitter : **Ms. Carol Walroth** **Date: 06/01/2006**

Organization : **Raulerson Hospital**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P-1142-Attach-1.DOC

ACMA Call to Action

CMS – 4105-P, Medicare Program; Notification Procedures for Hospital Discharges.

CMS has proposed a new rule (CMS – 4105-P, Medicare Program; Notification Procedures for Hospital Discharges) that will greatly impact discharge planning in hospital/health systems. This new rule requires hospitals to provide written notice of discharge to patients at least one day before discharge.

Background: CMS published this new proposal in response to the settlement of the Weichardt lawsuit (2003) that contested the legitimacy of hospital notice procedures. The settlement agreement resulted in CMS's proposed rule requiring a two-step discharge notice in the hospital setting:

- **Prior to any discharge, the hospital must deliver a valid, generic notice** (see attached: Generic Notice of Hospital Non-Coverage) **to the patient one day before discharge.**
- When a QIO notifies the hospital that a patient has requested an expedited determination, the hospital must deliver a *detailed* notice (see attached: Detailed Explanation of Hospital Non-Coverage) by COB on the day of the QIO's notification. *

Implications:

Estimated time expenditure: CMS estimates it will take approximately 5 minutes to issue the notice to patients. They also estimate that only 2% of patients will disagree with the discharge and request an expedited determination. They estimate it will take hospitals 60 – 90 minutes to prepare the detailed notice of non-coverage and to prepare a case file for the QIO.

LOS issues:

- It is difficult to predict how many patients will request an expedited appeal, but for all patients that make this request an additional 2 – 3 days will be required to prepare the detailed notice, file the notice and wait for a response from the QIO. The patient assumes no financial liability until the QIO responds.
- In the current environment of shortened LOS for medically complex it is difficult to accurately predict discharge 24 hrs. in advance of the discharge. Patients who may be stable may develop fevers. Patients who may have been unstable can just as easily respond to treatment and be ready for discharge that same day.

*Hospitals will no longer be required to issue the HINN or NODMAR at discharge. HINN would continue to be used for preadmission situations and instances where the physician disagrees with the discharge decision.

Next Steps: CMS will accept comments until the close of 5:00PM Eastern Time on June 5, 2006. Please refer to the cover letter for instructions regarding comment submission.

Members are welcome to use the attached template letter. If you choose to write your own response, keep in mind your audience and remember these helpful hints:

- Define your current process of patient notification for discharge
- Define your current process for informing patients of their medicare rights
- Clearly state how this change is a burden to your organization
- Offer some alternatives; remember CMS is proposing this change due to the settlement of a lawsuit.

Please review and use the attached documents as you wish:

1. Cover Letter (directions for comments and important websites)
2. Template Letter (can be used to submit comments)
3. Worksheet (provides important references, highlights key issues of the proposal, includes comments and sites the regulation).

*Hospitals will no longer be required to issue the HINN or NODMAR at discharge. HINN would continue to be used for preadmission situations and instances where the physician disagrees with the discharge decision.

Submitter : Mr. Stephen Brenton **Date:** 06/01/2006

Organization : Wisconsin Hospital Association

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1152-Attach-1.DOC

Attachment #115

WISCONSIN HOSPITAL ASSOCIATION, INC.

June 1, 2006

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

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

To Whom It May Concern:

Wisconsin hospitals are committed to the belief that all patients are entitled to be clearly informed of both their benefit coverage and right to appeal regardless of their payer source. However, the proposed rule related to Notification Procedures for Hospital Discharges are operationally impractical, overly burdensome to hospitals and unsupported from a patient's rights perspective.

CMS notes that the rule is being proposed to create uniformity between acute care hospitals and home health, SNF and hospice care. However, we believe that there is a fundamental difference between acute care settings where a patient's medical condition is subject to rapid changes, and home health, SNF and hospice care which, by its nature, assumes a more stable patient condition.

Hospital staffs, including discharge planners and social workers in more complex cases, begin the discharge process the day the patient arrives at the hospitals to assure that they are discharged to the appropriate setting at the appropriate time in the continuum of their care. Discharge from the hospital depends on patients meeting certain recovery criteria based on their diagnoses, procedure(s) and health status, not a set length of stay or number of visits. Although we can predict what criteria need to be met to safely discharge the patient, we cannot always predict a day ahead of time when a patient will meet these criteria. For example, it is common that the physician determines the day of discharge on that day based on final test results or physical examination. Encouraging patients to stay an additional day to meet this notification requirement will extend length of stay, adding cost to care that yields no real return in value to the patient. At the other end of the spectrum, patients may be planning to leave on a certain day and end up staying longer due to their clinical condition. This scenario will render the notice of discharge inaccurate and require that the hospital rescind and then re-issue the notice.

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

Finally, we believe that CMS has underestimated the amount of time it will take to process and deliver these notices. A provider's discharge estimate (whether documented in the medical record or relayed verbally to the care team and patient) would need to be transmitted to staff who would

then process, deliver and explain the notice. We believe that 5 minutes per patient grossly underestimates the amount of time this would take. (As noted above, this also does not take into account rescinding and then re-issuing notices.) In addition, the rule does not specify whether or not the notice would be a part of the permanent record or not. If it is determined to be part of the permanent record there would be additional work related to scanning the documents for storage since most hospitals are moving the patient's records to an electronic form.

In summary, we support the patients' need to be well informed of their rights under Medicare, as well as their right to request an expedited review. We request that you reconsider the necessity, timing and burden of providing this written notice in the less predicable inpatient setting. Wisconsin hospitals are known to be high quality, low cost providers of health care services. Imposing this proposed rule is unnecessary and will create a burden on hospitals for compliance that will only escalate health care costs. We strongly urge CMS to forgo implementation of this rule.

For questions about these comments, please contact Dana Richardson at 608-274-1820 or drichardson@wha.org.

Sincerely,

Stephen F. Brenton
President

Submitter : Dr. Dan Luchtefeld, PhD **Date:** 06/01/2006

Organization : Kentucky Department for Mental Health and Mental R

Category : Psychiatric Hospital

Issue Areas/Comments

GENERAL

GENERAL

Our psychiatric hospitals have a median length of stay of about 5 days. The majority of patients admitted to our state psychiatric hospitals come in on 72 hour court orders. This is a short period of time to make a determination of whether the individual needs a longer involuntary stay. These decisions often have to be made on the morning of the last day so a day's notice is not feasible. In addition, handing individuals with a severe mental illness another form to review when there are already many forms to deal with is not really consumer friendly. Our facilities do not see any advantage to this rule change but do see significant disadvantages to both the consumer and to staff resources.

Submitter : Mr. Raymond Askey **Date:** 06/01/2006

Organization : Nason Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-4105-P-1172-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

Re: Medicare Program; Notification Procedures for Hospital Discharges.
CMS-4105-P

Dear Sirs:

We are submitting comments regarding the above referenced Proposed Rule.

Nason Hospital strongly supports the rights of patients to be fully informed of their medical care including discharge process and their ability to question and ask for independent review of their pending discharge if they do not agree with it.

We believe the current process of providing all patients with the "Important Message from Medicare" adequately protects the patient's interest and provides the opportunity for review when they feel the need. If there have been compliance issues with the issuing of this message, they should be addressed through the survey and review process and not by issuing additional regulation.

We believe that the requirement to issue a discharge notice 24 hours in advance of the time of discharge to be an excessive burden on the Hospital and is not reflective of how and when discharge decisions are made on a routine basis. Discharge decisions are made by the patient's attending physician and are often made based on many different parameters such as acceptable lab values, ability to tolerate meals without nausea or vomiting, mobility of the patient, acceptable radiology reports, normal temperature, pulse, heart rate and so forth.

It is important to note that for most patients these items are not determinable with a 24 hour advance notice.

If patients were to be required to stay to meet a 24 hour notification period it would unnecessarily raise Hospital costs by requiring the patient to stay beyond what was medically necessary, it could potentially delay admission or force transfer of an incoming patient due to lack of bed availability and it would delay the patient in getting to the most appropriate level of care for their needs.

We request that this Proposed Rule NOT be enacted and that the current process of providing the "Important Message from Medicare" at admission be maintained for the best interest of the patient and the Hospitals.

Please feel free to contact me at the above address for any further information.

Thank you.

Sincerely,

Garrett W. Hoover
President / CEO

Debra McGraw, RN
Vice President, Patient Care Services

Raymond C. Askey
Vice President, Fiscal Services

Howard Black, MD
President of Medical Staff

Submitter : Ms. Jeanette Forey **Date:** 06/01/2006

Organization : Baptist ST. Anthony's Hosp.

Category : Nurse

Issue Areas/Comments

Background

Background

I work as a case manager for a 417 bed hospital. If I understand this proposal right, I would have to give every Medicare/Medicaid patient a letter that they would be discharged the following day.In a perfect patient you can do that, if they follow a normal pathway. However very rarly do patients follow a set path. For example if you have a heart valve surgery and you are waiting on discharge for the coumadin level to be adjusted, It could take a couple of days to more than a week. You dont know what the Protime and INR is till that morning to know if you can discharge. I feel this will give acute care hospitals more headaches and room for errors. I do feel this would work in a subacute settings or rehab where discharges are planned and not based on acute therapy.

Submitter : Dr. Robert Beck **Date:** 06/01/2006

Organization : HealthEast Care System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1192-Attach-1.PDF

1197

Executive Offices
559 Capitol Blvd.
St. Paul, MN 55103
651/232-2300
Fax 651/232-2315

June 1, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1405-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: CMS Proposed Rule - Medicare Program; Notification Procedures for Hospital Discharges (CMS-1405-P)

To Whom It May Concern:

Thank you for the opportunity to comment on CMS' proposed rule on notification procedures for hospital discharges. HealthEast Care System is an integrated health care system comprised of three acute care hospitals, one long term acute care hospital, several primary care clinics, home health agency, transportation company, and retail pharmacies. HealthEast's 6,000+ employees provide health care services primarily to residents of St. Paul and the eastern Twin Cities.

II. PROVISIONS OF THE PROPOSED RULE

Proposed 405.1205

As proposed, 42 CFR 405.1205 calls for a "standardized, generic notice..." Our experience with patients is that any such notice must be individualized and written in plain language to facilitate enrollee understanding. Another required form on top of the "Important Message from Medicare" could cause confusion and anxiety for beneficiaries. With many Medicare discharges at three days or less, the 24-hour requirement would be impractical to administer.

Proposed 405.1206

When the beneficiary requests an expedited determination in accordance with paragraph (b) (1) of this section, the QIO must make a determination and notify the beneficiary, the hospital, and physician of its determination by close of business of the first day after it receives all requested pertinent information. Our patients are discharged seven days a week throughout the day or evening so this would also add the need for staff seven days a week which we don't have currently.

III. COLLECTION OF INFORMATION REQUIREMENTS

CMS is anticipating this process to take five minutes, but our experience tells us it will be more like 15-20 minutes to issue a letter and answer patient questions. In addition, we think there will be an increase in length of stay (LOS) due to physicians and practitioners not being able to predict with adequate precision the discharge date for the individual patient.

Below we've provided estimates of the additional costs associated with these new regulations. Based on our calculations, nearly $150,000 and two FTEs would be necessary to implement the new regulations at our four facilities. An additional $125,000 in direct patient care expenditures would result due to increased LOS.

HealthEast Care System Medicare Census
In FY 2005, HealthEast had 12,471 Medicare fee-for-service (FFS) patients.
In FY 2005, HealthEast had 2,236 Medicare Advantage (MA) patients.
In FY 2005, HealthEast had 14,707 total Medicare covered patients (FFS plus MA).

Cost Estimate of Delivering Notices - Per CMS
Time to Deliver Notices: 14,707 x 5 min = 73,535 divided by 60 = 1,226 hours
Cost to Deliver Notices: 1,226 x $30.00 = $36,780
# of Patients Requesting Expedited Review: 2% of 14,707 = 294
Time to process Expedited review: 294 x 90 min =26,460 divided by 60 = 441 hours
Cost to process Expedited review: 441 x $45 = $19,845
FTE: 1,667 hours annually or .8 FTE

Cost Estimate of Delivering Notices - Per HealthEast Experience and Wages
Time to Deliver Notices: 14,707 x 15 min = 220,605 divided by 60 = 3,677 hours
Cost to Deliver Notices: 3,677 x $34.00 = **$125,018**
# of Patients Requesting Expedited Review: 2% of 14,707 = 294 patients
Time to process Expedited review: 294 x 90 min =26,460 divided by 60 = 441 hours
Cost to process Expedited review: 441 x $51.00 = **$22,491**
FTE: 4,118 hours annually or 2.0 FTEs

Cost Estimate of Increased LOS
# of Patients staying 1 extra day due to notice delivered late : 1% of 14,707 = 147 patients
Incremental cost of additional LOS = 147 x $850 variable cost/day = **$124,950**

We hope CMS will consider the additional time and resources required to meet these new regulations and the complexity and confusion added to the patient experience. Thank you for your consideration in this matter.

Sincerely,

Robert J. Beck, MD
Vice President
Medical Affairs

Submitter : **Mr. Richard Stovall** **Date: 06/01/2006**

Organization : **Southern Regional Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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

Subject: Notification Procedures for Hospital Discharges; CMS-4105-P

To Whom It May Concern:

Pursuant to Federal guidelines pertaining to open public comment periods, I am writing this letter in opposition to the proposed ruling Notification Procedures for Hospital Discharges (CMS-4105-P).

This proposal adds unnecessary procedures and costs to the Medicare beneficiary discharge planning process. The proposal would not only prove to be burdensome and labor intensive to administrate but would also frustrate and confuse Medicare beneficiaries during the sensitive time of an inpatient hospital stay. Please consider the following points in denunciation of CMS-4105-P.

" Adding 1 3 steps to the already extensive process of a Medicare inpatient hospital admission & discharge is unnecessary and unreasonable
" Given the inherent variability and uncertainty of an inpatient hospital admission, it is often difficult to determine prospectively the date of discharge
" The prospective process will result in guessing and a prolonged hospital stay in order to remain within compliance of the proposal
" The additional form(s) will confuse beneficiaries about their financial liability as well as the process for deciding when a they no longer need hospital-level inpatient care
" Language in the proposed document gives the patient the impression that the discharge is not appropriate

Thank you for thoughtfully considering these comments with regard to the aforementioned proposal.

Sincerely,

Richard Stovall
Southern Regional Health System
Riverdale, GA

Submitter : **Ms. Denise Majeski** **Date: 06/01/2006**

Organization : **Lake Forest Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1212-Attach-1.DOC

Lake Forest Hospital
660 N. Westmoreland Road
Lake Forest, IL. 60045

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

6/1/2006

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 Manager of Case Management Services at Lake Forest Hospital, a 130 bed, Community Hospital located in Lake Forest, IL.

As Manager of Case Management Services for 15 years I have been directly involved with discharge planning as one component of our functions as Case Managers. 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/social workers 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 current process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

In addition, the attending physician makes individual patient discharge decisions responsible for the patient's care. The discharge order is entered into the patient's record at the time of the discharge decision that utilizes clinical criteria sets for discharge readiness.

The CMS proposed change places an administrative burden on the hospital that greatly outweighs he 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. This would incur a cost of approximately $205,000 annually to deliver these notices and additional dollars for an increased LOS. These processes are administered by Case Management staff that has been trained and are familiar with Medicare rules and

regulation. appeals rights and clinical implications. Weekend staffing would be a requirement and would pose additional financial burden to the hospital and sorely strain Case Management Staffing. We cannot find Registered Nurses to fill Case Management positions that are currently open and I would not like to see experienced Case Managers leave for more lucrative staff nurse positions.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.1 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 proposed generic notice invites unwarranted appeals consuming valuable hospital resources. There is a current process for Hospital Issued Notice of Noncoverage that is an effective vehicle for expediting discharge decisions that may be delayed by the physician or patient and family.

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.

I am concerned with the hardcopy signature and recordkeeping that are at odds with the promotion of efforts to move to electronic medical record keeping.

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.

I would recommend that further investigation be completed before this proposed rule (CMS-4105-P2) becomes final.

Sincerely,

Denise Majeski, R.N.
Manager
Case Management Services
dmajeski@lakeforesthospital.com

Submitter : **Date: 06/01/2006**

Organization :

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-4105-P-1222-Attach-1.DOC

CMS-4105-P-1222-Attach-2.DOC

CMS-4105-P-1222-Attach-3.DOC

Attachment #122

JUPITER 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 1, 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 of Case Management at Jupiter Medical Center, a 156, community medical center located in Jupiter, Florida.

As a Director of Case Management I have been directly involved with discharge planning for acute hospitalized patients for the past 23 years. Our current discharge planning practices begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, case managers interview all patients meeting the hospital's screening criteria: patients over age 70, medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

The CMS proposed change places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. My recommendation is to allow telephonic notification of the decision maker when the decision maker is not the patient.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.46 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 – 4 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 5 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,

Cathy J. Hamilton, RN, BAMHS, CPHQ
Director, Case Management

Submitter : **Mr. Philip Stuart** **Date: 06/01/2006**

Organization : **Tomah Memorial Hospital**

Category : **Critical Access Hospital**

Issue Areas/Comments

Background

Background

The impact of this proposed rule change is far greater than the $5,200 that is estimated. As a CAH our length of stay must average 96 hours. How will any delays by a patient wishing to stay longer affect this rule? We do not have sufficient staff to handle the regulations as proposed.

GENERAL

GENERAL

This rule will require additional staff, uncompensated mandates, create confusion for providers and patients. It will add pressure on hospital staff to comply with additional burdens that will not, in our opinion, lead to any improved outcomes. Elderly patients, many times, do not want to leave the hospital. They can use this process to delay their discharge while at the same time preventing staff from caring for others and putting additional stress on limited resources.

We can not see how this rule can improve care. It will increase costs, burdens and create additional confusion. It makes little sense.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The provisions of the rule that require notification the day before discharge does not account for the fact that we may not know that a patient is to be discharged until that day (discharge is dependent on lab results etc). If our average length of stay is less than three days this rule would require us to have patients here longer than necessary and may subject us to denials based on not meeting criteria for continued stays. If the QIO notifies us at 1630 that a request for an expedited determination has been made that gives us 30 minutes to respond. If in fact we could respond that fast that would require the QIO to respond back in whatever time there is remaining (assumes close of business is 1700). The amount of copies that would need to be provided to everyone, on such short notice will also be near impossible for us to process.

Submitter : **Ms. Sheila Goethel** **Date: 06/01/2006**

Organization : **Rural Wisconsin Health Cooperative**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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

Rural Wisconsin Health Cooperative is owned and operated by 30 rural Wisconsin hospitals, and as such, are committed to the belief that all patients are entitled to be clearly informed of both their benefit coverage and right to appeal regardless of their payer source. However, the proposed rule related to Notification Procedures for Hospital Discharges are operationally impractical, overly burdensome to hospitals and unsupported from a patient s rights perspective.

CMS notes that the rule is being proposed to create uniformity between acute care hospitals and home health, SNF and hospice care. However, we believe that there is a fundamental difference between acute care settings where a patient s medical condition is subject to rapid changes, and home health, SNF and hospice care which, by its nature, assumes a more stable patient condition.

Hospital staffs, including discharge planners and social workers in more complex cases, begin the discharge process the day the patient arrives at the hospitals to assure that they are discharged to the appropriate setting at the appropriate time in the continuum of their care. Discharge from the hospital depends on patients meeting certain recovery criteria based on their diagnoses, procedure(s) and health status, not a set length of stay or number of visits. Although we can predict what criteria need to be met to safely discharge the patient, we cannot always predict a day ahead of time when a patient will meet these criteria. For example, it is common that the physician determines the day of discharge on that day based on final test results or physical examination. Encouraging patients to stay an additional day to meet this notification requirement will extend length of stay, adding cost to care that yields no real return in value to the patient. At the other end of the spectrum, patients may be planning to leave on a certain day and end up staying longer due to their clinical condition. This scenario will render the notice of discharge inaccurate and require that the hospital rescind and then re-issue the notice.

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

Finally, we believe that CMS has underestimated the amount of time it will take to process and deliver these notices. A provider s discharge estimate (whether documented in the medical record or relayed verbally to the care team and patient) would need to be transmitted to staff who would then process, deliver and explain the notice. We believe that 5 minutes per patient grossly underestimates the amount of time this would take. (As noted above, this also does not take into account rescinding and then re-issuing notices.) Furthermore, if the patient is incompetent, it may take additional time to find and notify the POA. In addition, the rule does not specify whether or not the notice would be a part of the permanent record or not. If it is determined to be part of the permanent record there would be additional work related to scanning the documents for storage since most hospitals are moving the patient s records to an electronic form.

In summary, we support the patients need to be well informed of their rights under Medicare, as well as their right to request an expedited review. We request that you reconsider the necessity, timing and burden of providing this written notice in the less predicable inpatient setting. Imposing this proposed rule is unnecessary and will create a burden on hospitals for compliance that will only escalate health care costs. We strongly urge CMS to forgo implementation of this rule.

Sheila Goethel, RHIT, CCS
RWHC

Submitter : Rhonda Guthrie **Date:** 06/01/2006

Organization : Lakes Regional Healthcare

Category : Nurse

Issue Areas/Comments

Background

Background

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GENERAL

GENERAL

While I can argue little with the intent of this proposal, it hardly seems a viable or efficient process. Operational costs will soar, which will almost certainly have a negative impact on patient care, as well as available services. The reality of a delivery time of no more than five minutes is unrealistic, even grossly underestimated, in most cases with our aged population, not to mention the "behind the scenes" time involved in this entire process. A game of guessing and second-guessing will ensue with regards to the patient's course of illness, response to treatment, and overall status. I am certain that an increased length of stay will result due to this process, as well. Each and every patient has an individual response to their illness, injury or disease, and to propose that any healthcare practioner can state with certainty the exact day that the patient will be stable and ready for discharge is rather absurd.

Submitter : Mrs. Margaret Crymes **Date:** 06/01/2006

Organization : Community Memorial Healthcenter

Category : Nurse

Issue Areas/Comments

Background

Background

A current HINN frequently takes >24 hours when geting a Physician Advisior to review a medical record, call the attending to discuss the case/care and then make a decision based on the medical readiness for discharge. Will a nurse now assume this role???? I have been involved in the Utilization Review process for many years back to the old days of the late 1980's. The time you infer it will take to deliver a generic notice is not accurate. The pre-work prior to this generic notice will be at least 1-2 hours. What will happen is every patient and family member will be put under undue stress as it will give the appearance of "throwing Mama out because she's old". The window of opportunity for readiness for discharge with our elderly patient population is very small in many cases. Medication changes in the morning with follow-up lab work done in the afternoon may indicate a potential discharge the next day. The physician will wait for the clinical reassesment the next morning. So this notice is given, patient gets upset, family gets upset, lab work not improving, discharge not done the next day. What's happened?? Notice in error as patient not discharged, but will need another one for the next day, patient upset, family upset calling administration because someone was trying to send Mama home too soon, MD overworked even more and upset as he IS giving GOOD medical care with a organized Plan of Care based on the patients response to treatment. I work in a small rural facility which is a sole community provider. Our staffing is at a minimum and RN's are at a premium. I see this proposed notification procedure as a response to some patient/family that did not follow the Important Message from Medicare notice for appeal or a facility that did not follow the Medicare Rules and Regulations as directed. The process in place is good and there is no need to change.

GENERAL

GENERAL

The Important Message from Medicare is given at the time of admission or as soon thereafter as is practical. This is adequate and has been in use for 20+ years with the last revision January, 2003 and implementation August, 2003. This is an effective tool and there is no reason to change this process. I fail to see any benefit of this proposed change. Please let the current process stand as is.

Submitter : **Ms. Jane Manners** **Date: 06/01/2006**

Organization : **Blount Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

PLEASE SEE ATTACHMENT

CMS-4105-P-1272-Attach-1.DOC

#127

Blount Memorial
Hospital

TO: Centers for Medicare & Medicare Services

FROM: Jane Manners, Clinical Reimbursement Coordinator
Blount Memorial Hospital, 440011

RE: **CMS-4105-P**, Proposed rule regarding notification procedures for hospital discharges

DATE: June 1, 2006

We are commenting on the above-referenced proposed rule, published in the April 5, 2006, Federal Register, regarding notification procedures for hospital discharges. We strongly believe that the proposed notification procedure to require acute care hospitals to notify all Medicare Advantage and original Medicare patients of discharge on the day prior to discharge would create an undue administrative burden on acute care hospitals. It is redundant and unnecessary in that it essentially duplicates a procedure already in place in the provision of the "Important Message from Medicare" which is currently given at the time of admission. Additionally, the proposed procedure could unnecessarily prolong lengths of stay in some cases and thereby place patients at increased risk for infection and complications inherent in the normal acute care hospital environment.

We strongly disagree with the time estimate in the proposed rule of five minutes per patient to deliver each notice. While the actual delivery of the notice may in some cases be accomplished within the five minute estimate, the tracking of potentially-dischargeable patients in a high-turnover acute care environment and the location of and coordination with an appropriate representative when necessary could conservatively take from twice to ten times longer per patient in many cases. It duplicates the administrative burden on the acute care hospital in that patients or their representatives must already necessarily be engaged with the hospital for administrative activities such as consents and waivers, the Important Message from Medicare, and the collection and verification of insurance information, all within the first day or two of acute care hospitalization. Under this proposal, a second round of administrative activity would be necessitated in all cases on the day prior to discharge, involving hospital administrative personnel re-issuing essentially the same information that is now disseminated during the initial administrative activity.

Due to the fast-moving nature of the acute care environment and the intense efforts of hospitals over recent years to operate at maximum efficiency, a hospital with an average length of stay of less than 5 days will have a large number of patients on a daily basis who will not definitely know the day prior to their appropriate discharge date that they will definitely be able to leave on that date. Tracking such potential discharges would be an administrative nightmare for hospitals. By definition of the proposed procedure, an administrative staff member could be informing many of these patients of "planned" discharge before the attending physician has the medical information to make an appropriate discharge decision. Conversely, if the hospital is conservative in guessing which patients are likely to be discharged the following day, they are likely to have a number of patients with an extended length of stay because those patients will not have received their notice of discharge on the day prior to the day

907 E. Lamar Alexander Pkwy. • Maryville, TN 37804-5016 • (865) 983-7211

the physician can confirm that the patient is medically ready for discharge. While such extensions are a financial threat to acute care hospitals by thwarting efficiency and unnecessarily increasing costs, it is even more important to note that such extensions are not in the best interests of patients medically. It has been proven over and over again that, even in facilities offering the best quality care and safety precautions, an unnecessary hospital day is in fact a hazard to the patient, placing them at increased health and safety risks.

This proposed rule unfortunately tries to draw an inherent conclusion that because an additional notice of discharge near the end of an episode of care is appropriate in certain sub-acute settings, then it must also be appropriate in the acute care hospital setting. We believe that this is the basic fault in the proposal and that such a conclusion is entirely inappropriate. Care in the sub-acute settings may stretch over many weeks or even months, and there is a significant lapse of time between the administrative information given at the beginning of the episode and the possible application of that information at the time of discharge; and such a lapse of time makes the notice just prior to discharge a more reasonable requirement for those sub-acute settings. However, the short average lengths of stay in an acute hospital setting make the repeat administrative episode at discharge redundant and unnecessary. Only in the cases of prolonged length of stay would such additional notification be reasonable in an acute care setting. Therefore, an alternative and more reasonable proposal, if an additional discharge notice is felt to be absolutely necessary in the acute care setting, would be to require such a notice only for those patients in a continuous and prolonged acute care length of stay of 21 to 28 days or longer.

We sincerely hope and request that this proposal be retracted, as it represents a duplicative administrative process. It would be of little if any additional benefit to beneficiaries and could potentially place some at increased risk by unnecessarily delaying discharge. This proposal would also be totally counterproductive to acute care hospital efforts to maintain efficiency and control costs; and the accompanying administrative burden would draw manpower and financial resources away from efforts to maintain and improve quality patient care in the acute care setting.

Submitter : Mrs. vicky larson **Date:** 06/01/2006

Organization : grant regional health center

Category : Nurse

Issue Areas/Comments

Background

Background

Wisconsin hospitals are committed to the belief that all patients are entitled to be clearly informed of both their benefit coverage and the right to appeal of their payer source. However, the proposed rule of Notification Procedures for hospital discharges are operationally impractical, overly burdensome to hospitals and unsupported from a patient's rights perspecitve. CMC notes that the rule is being proposed to create uniformity between acute care hospitals and home health, SNF and hospice care. However, we believe that there is a fundamental difference between acute care settings where a patient's medical condition is subject to rapid changes, and home health, SNF and hospice care which, by its nature, assumes a more stable patient condition.
In the hospital setting, discharge planners and social workers begin the discharge process the day the patient is admitted. Discharge from the hospital depends on patients meeting certain recovery criteria based on their diagnoses, procedure's and health status, not a lenght of stay or number of visits. We can predict what criteria need to be met to safely discharge the pt, we can't always predict a day ahead of time when the patient will meet these criteria. It is common that the physician determines the day of discharge on that day based on final test results or physical examination. Encouraging patients to stay an additional day to meet this notification requirement will extend length of stay, adding cost to care that yields no real return in value to the patient.
At the other end of the spectrum, pts may be planning to leave on a certain and end up staying longer due to their clinical condition. This scenario will render the notice of discharge inaccurate and require that the hospital rescind and then re-issue the notice.

The IMPORTANT MESSAGE FORM MEDICARE is already provided to patients on admission. A second notice for these patients would be duplicative as it would need to be given almost on the heels of the first.

Finally, we believe tha CMS has underestimated the amount of time it will take to process and deliver these notices. We believe that 5 minutes oer patient grossly underestimates the amount of time this would take.

In summary, we support the patients need to be well informed of their rights under Medicare, as well as their right to request an expedited review.We request the you reconsider the necessity, timeing and burnden of providing this written notice in the less predicable inpatient setting. We are known to be high quatlity, low cost providers of health care here at GRHC. Imposing this proposed rule is unnecessary and will create a burden on hospitals for compliance that will only escalate health care costs. We strongly urge CMS to forgo implemenation of this rule.
Sincerely,

Vicky Larson RN/Med/Surg Coordinator

Submitter :

Date: 06/01/2006

Organization :

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

Beneficiaries already have appeal rights with the current NODMAR letter.
Will the proposed changes be applicable to observation status admissions?

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Although proposed changes may be helpful to beneficiaries, they will have significant impact on providers and MA organizations. The requirement to have the notice provided to all beneficiaries being discharged will result in additional staffing needs for providers. It is likely that the number of requests for review by QIO will also increase resulting in additional staffing needs for MA organizations as well.

MA organizations will be impacted by the requirement to pay for additional hospital inpatient days that may not be medically necessary because the beneficiary cannot be held financially responsible while the discharge is being reviewed.

Submitter : Ms. Corrine Neisess

Date: 06/01/2006

Organization : Tri-County Hospital

Category : Nurse

Issue Areas/Comments

Background

Background

Regulatory Impact:
It is noted that you do not expect small rural hospitals to be significantly impacted. In a day and age where hospitals are constantly being pushed to work smarter to get the best outcomes for our patients, this is a measure that will definitely negatively impact our efforts. This proposal will impact our facility financially and we feel the estimated costs are greatly under-estimated in staff time and expense. It will also impact our patients adversely as we redirect staff from direct patient services to an administrative paperwork task. In health care facilities already facing staff shortages we cannot afford to take staff away from direct patient care for tasks that likely will benefit so few.
We have concern about the estimated $31,000,000 this proposed effort will cost. Does this provide a broad reaching benefit for the patients and is this money best spent? We appreciate the reconsideration of this proposal and feel there are other areas these dollars can be better directed to benefit our patients.
Thank-you.

GENERAL

GENERAL

Tri-County Hospital, a rural MN critical access hospital, would like to add comments for consideration regarding the proposed rule for notification procedures for hospital discharges.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Provisions of the Proposed Rule and Collection of Information Requirements:
We have significant concerns about the burden this process will add with a very uncertain return for our patients. This proposal does not appear to be providing a solution to any gap in the patient s benefits or process to assure beneficiary protection. These patients already receive notification of their rights under Medicare in the initial Important Message from Medicare and have the option to appeal their discharge if they feel they are being discharged too soon with present HINNs in use. We already receive numerous comments from patients regarding the complexity of the Medicare system. We are now being asked to give them another form that will require considerable explanation and may give many a sense that there is something not quite right about their discharge. We also know by experience with the use of HINNs in the past that the estimated time required to issue these discharge notifications given within your proposal is significantly under-estimated. The implication appears to be that health care facilities do not notify patients of discharge plans. This is untrue and goes against all our efforts to involve patients in their hospital care and discharge plans. This starts at the time of admission and is important to help identify patients with additional follow-up needs such as home care services. The addition of this requirement will no doubt impact the amount of time our staff has to develop these plans as they now complete this paperwork requirement. There will also be difficulty in being able to predict the course of a patient s response to treatment. Some patients will respond more quickly and may be able to be discharged sooner then the physician initially anticipated. Do we tell these patients they can not be discharged because they did not receive the discharge notification? Do we make them stay an additional hospital day away from their home and family while incurring further costs? For those that do not respond as quickly as we anticipate, are they given repeated discharge notifications as we try to predict their discharge date?

Submitter : **Bonnie Gray** **Date: 06/01/2006**

Organization : **Wayne Memorial Hospital**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-4105-P-1312-Attach-1.DOC

#131

Wayne
MEMORIAL HOSPITAL
Always in Touch

June 1, 2006

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

Re: CMS-4105-P

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 an Administrative Director at Wayne Memorial Hospital, a 316-bed community Hospital/Healthcare System located in Goldsboro, North Carolina.

As an Administrative Director, I have been directly involved with discharge planning for the past 10 years. Our current discharge planning process begins at the time of admission when patients are provided with the Important Message from Medicare during registration. Next, the admission nurse screens the patient's current living situation and available resources. In addition, case managers assess all patients who may need post-acute services or who may be at risk for discharge delays. Patients and their families are involved in discharge planning activities and given a choice of providers for post acute services. Our process also includes ample opportunity for patients and families to consider all options, and if in disagreement with the discharge decision, to appeal the decision to the Carolinas Center for Medical Excellence, the Quality Improvement Organization (QIO) for North Carolina.

In the current environment of shortened lengths of stay for medically complex patients, it is often difficult to accurately predict discharge 24 hours in advance. Patients who may have been unstable can respond to treatment and be ready for discharge the same day. Once diagnostic reports are available to the physician, discharge plans can be finalized quickly. And, bed availability in extended care facilities is totally unpredictable.

The CMS proposed change places administrative burdens on the hospital that greatly outweigh the benefit. CMS estimates it will take only five minutes to deliver the generic notice and have it signed. This is a grossly underestimated time allotment given the fact that most patients and family members will not sign a document without carefully reading it and asking questions. Experience has shown that the delivery of any official governmental notice defining a discharge date and the details of patient financial responsibility consumes a tremendous amount of time. It is more realistic to assume an average of thirty minutes for the delivery of each generic notice. In cases where the patient is not the decision-maker, it will take much more time to locate and wait for the responsible party to arrive to sign the Notice.

CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal. This is an underestimation because patients will become more aware how easy it is to continue their hospitalization. It is difficult to predict how many patients will request an expedited appeal, but for all patients who make this request, an additional two to three days minimally will be required to prepare the Detailed Notice, file the Notice and wait for a response from the QIO. The patient assumes no financial liability until the QIO responds.

Many patients are discharged from the hospital in one to two days, very soon after the patient has received the Important Message from Medicare during the admission process. Several regulations already exist, that if applied appropriately, address this very important part of the delivery of care to patients in the acute care setting. With the combination of the Hospital Issued Notice of Non-Coverage found in the Beneficiary Notice Initiative, the Discharge Planning regulations, the Utilization Review and Patient's Rights Conditions of Participation, there is adequate regulation about notifying a patient of his/her discharge status. There is no need for an additional regulatory requirement.

In fact, the proposed rule appears to be in conflict with an existing condition of participation for discharge planning. Sec. 482.43 Condition of participation: Discharge planning (b) Standard (5) states "*The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.*" The proposed rule will create unnecessary delays in discharge!

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

I appreciate the role of CMS in safeguarding patient rights. I believe we must protect patient rights, but we must also be good stewards of limited resources as we strive to insure timely discharge plans for our hospitalized patients.

Sincerely,

Bonnie S. Gray, MSN, RN, BC
Administrative Director

pc: Congressman Walter B. Jones

POST OFFICE BOX 8001, GOLDSBORO, NORTH CAROLINA 27533
FAX: (919) 731-6791

Submitter : **Ms. Heather Hulscher** **Date: 06/01/2006**

Organization : **Iowa Hospital Association**

Category : **Health Care Provider/Association**

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 : **Ms. Julie Schilz** **Date: 06/01/2006**

Organization : **Physician Health Partners**

Category : **Health Plan or Association**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

To Whom It May Concern,

Physician Health Partners, LLC, is a delegated managed care entity for Secure Horizons Medicare Advantage Plan Members. We are writing in response to CMS-4105-P: Notification Procedures for Hospital Discharges.

Physician Health Partners believes that the proposed two-step notice process would prove to be extremely burdensome and confusing rather than helpful to beneficiaries. The two-step process would also create a significant administrative burden in explaining yet another form to a hospitalized beneficiary.

In addition, Physician Health Partner believes that the proposed two-step notice process may result in medically unnecessary acute hospital days, thus placing the beneficiary at risk for additional medical complications.

We believe that delivery of the Important Message from Medicare notice upon admission and the Notice of Discharge and Medicare Appeal Rights (NODMAR) only when a beneficiary disagrees with the discharge decision are a sufficient means in communicating the Medicare beneficiary s appeal rights.

Thank you for your time and consideration.

Sincerely,

Julie Schilz, Vice President of Operations
Physician Health Partners, LLC

Submitter : **Ms. Susan Lawrence** **Date: 06/01/2006**

Organization : **Lehigh Valley Hospital & Health Network**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1342-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 1, 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 as published in the April 5, 2006, *Federal Register*. I am the Care Continuum Administrator at Lehigh Valley Hospital & Health Network, a 776 bed Hospital System located on 3 clinical campuses located in Allentown and Bethlehem, Pennsylvania.

As the Care Continuum Administrator, I have been directly involved with discharge planning for the past 16 years. Our current discharge planning practices begin at the time of admission when patients are provided with the Important Notice from Medicare. Next, the admission nurses assess the patient's current living situation and needed resources and identify the need for further case management intervention. In addition, case managers interview all patients meeting the hospital's screening criteria: patients over age 70 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. The estimate of 5 minutes would require an additional full time equivalent for our hospital. 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.

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

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

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

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

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

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

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

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

- I 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, I 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.

I appreciate the role of CMS in safeguarding patient rights. 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.

I 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. I strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Thank you for the opportunity to provide input.

Sincerely,

Susan L. Lawrence, M.S., CMAC
Administrator, Care Continuum
Lehigh Valley Hospital & Health Network

Submitter : Mr. Robert Hodges **Date:** 06/02/2006

Organization : Covenant HealthCare

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

In my opinion, this will be a huge undertaking to implement and will most certainly add a lot of work for the hospital case managers as well as I am sure increase the LOS on the majority of the patients this rule impacts. The majority of physicians are reluctant to address the discharge date on a patient until the date of discharge. If this is the case, I anticipate a significant increase in LOS for patients in order to support the rule of the regulation.

I also have concerns about what impact this regulation will have on short length of stay patients. We do have some legitimate inpatients who have a LOS less than 48 hours. This could easily add one day to them since to meet the conditions of the regulation we would have to provide them notice on admission to meet the CMS requirement.

Form Letter #1
136-0
(6)

Submitter : Ms. Nancy Crouthamel **Date:** 06/02/2006

Organization : Western Pennsylvania Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-1362-Attach-1.DOC

June 5, 2006

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

RE: CMS-4105-P

Dear Sir/Madame:

As a hospital case manager who deals with patient discharge issues on a daily basis, I welcome this opportunity to comment on the proposed rule in **"Medicare Program; Notification Procedures for Hospital Discharges,"** as published in the April 5, 2006, *Federal Register.*

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

In response to a final rule promulgated under the Benefits, Improvements, and Protection Act (BIPA) for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospices, HAP submitted a comment letter that outlined the burden and operational requirements associated with home health agencies providing advance written notice to Medicare Advantage enrollees and Medicare beneficiaries and detailed notices to Medicare beneficiaries when an expedited review is filed with the state's QIO. It is evident in both this rule and those already promulgated for other service settings that there is a fundamental lack of understanding on how care is delivered in these settings. HAP's recommendation to CMS in our previous comment letter was that CMS consider implementing the same provisions currently used in hospitals in these other settings—namely to provide a notice at the time of admission for services similar to the "Important Message from Medicare" and to provide information regarding the right for an expedited

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

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

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

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

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

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

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

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

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

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

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

- I 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, I 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.

I 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.

I 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. I strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Should you have any questions or seek clarification, please feel free to contact me at The Western Pennsylvania at 412-578-4696

Sincerely,

Nancy Crouthamel, MSN, CNAA, RN
Director of Case Management,
Western Pennsylvania Hospital

136-2

Submitter : Mrs. Wendy Zimmerman **Date:** 06/02/2006

Organization : West Penn Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1372-Attach-1.DOC

June 5, 2006

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

RE: CMS-4105-P

Dear Sir/Madame:

As a hospital case manager who deals with patient discharge issues on a daily basis, I welcome this opportunity to comment on the proposed rule in **"Medicare Program; Notification Procedures for Hospital Discharges,"** as published in the April 5, 2006, *Federal Register.*

As published, the proposed rule requires 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.

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

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

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

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- 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.

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Should you have any questions or seek clarification, please feel free to contact me at The Western Pennsylvania at 412-578-4696

Sincerely,

Wendy Zimmerman,RN,BSN
Case Manager
Western Pennsylvania Hospital

Submitter : Ms. mary ann shields **Date:** 06/02/2006

Organization : west penn hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P-1382-Attach-1.DOC

June 5, 2006

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

RE: CMS-4105-P

Dear Sir/Madame:

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

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

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

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

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

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

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

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

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

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

- I 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, I 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.

I 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.

I 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. I strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Should you have any questions or seek clarification, please feel free to contact me at The Western Pennsylvania at 412-578-4696

Sincerely,

Mary Ann Shields, RN, BSN
Case Management
Western Pennsylvania Hospital

Submitter : **Date: 06/02/2006**

Organization : **Metropolitan Chicago Healthcare Council**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter.

CMS-4105-P-1392-Attach-1.PDF

#139

MCHC
Metropolitan Chicago Healthcare Council

222 South Riverside Plaza
Chicago, Illinois 60606-6010
Telephone 312-906-6000
Facsimile 312-993-0779
http://www.mchc.org

May 30, 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)

Summary of Comments

I am writing on behalf of the Metropolitan Chicago Healthcare Council, which represents 140 healthcare entities, including more than 100 Illinois hospitals, the majority of which are located in the eight-county metropolitan Chicago area. We appreciate the opportunity to provide comments on the above referenced notice of proposed rulemaking, which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process similar to what is currently in place for other Part A providers.

We have a number of serious concerns with the proposed rule, chiefly among them, the significant administrative and financial burdens this would place on hospitals and the negative impact that would result for both Medicare beneficiaries and non-Medicare patients. CMS has completely underestimated the information collection costs and has failed to recognize the financial impact of the proposal on the overall healthcare delivery system. It is our belief that providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary and longer hospital stays, thus creating significant throughput issues for hospitals by challenging their capacity limitations and threatening their ability to treat other patients who need acute care services.

We believe the average Chicago-area hospital will incur an estimated $205,000 - $410,000 annually just for the time to deliver the proposed discharge notices, with the anticipated longer length of stay costing the average hospital an estimated $9.9 - $13.3 million annually.

Specific comments, which are explained in greater detail in this letter, include:

- The current process adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services.
- The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not appropriate in an acute care hospital setting.
- The proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations.
- The proposed generic discharge notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources and jeopardizing the ability of hospitals to meet the acute care needs of other patients.
- The hardcopy signature and recordkeeping requirements are at odds with federal efforts to encourage electronic medical records.
- The cost estimates for delivering generic and detailed hospital discharge notices are grossly understated.

There are also a number of unanswered questions, particularly with respect to situations where a discharge is no longer appropriate due to a change in the beneficiary's health status after the generic notice has been issued.

We recommend that these issues be taken into consideration and that any outstanding questions be fully considered prior to entertaining a change of any kind to current hospital discharge notice procedures. In addition, we recommend that a national multi-disciplinary workgroup be convened to assist CMS in better understanding hospitals' day-to-day operational procedures and to ensure that any proposed revised procedures better balance hospital and program administrative costs with beneficiary rights.

Background

Current Process

Hospitals currently deliver the "Important Message from Medicare" to all Medicare beneficiaries at the time of admission, and they provide a hospital-issued notice of non-coverage (HINN) to beneficiaries in the original Medicare program who are dissatisfied with a pending discharge. In the case of Medicare Advantage plan enrollees, the responsibility for notification rests with the MA organization, which uses a "Notice of Discharge and Medicare Appeal Rights" (NODMAR) if the patient disagrees with the MA organization's discharge decision or its plans to discontinue coverage of the inpatient stay. Although CMS proposed changes to the hospital discharge notice process in 2001, these changes were not implemented, and hospital responsibilities remained unchanged when final rules were published in 2003 and 2004. (17053)

Comments

The current process adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services. Hospitals already follow a "two-step" process for notifying Medicare beneficiaries of their appeal rights through use of the "Important Message from Medicare" and the HINN. The "Important Message from Medicare," which is given at admission to all Medicare beneficiaries, clearly outlines the beneficiary's discharge and Medicare appeal rights and explains how to appeal a discharge decision if the beneficiary believes he or she is being asked to leave the hospital too soon. Congress specifically required the "Important Message from Medicare" to ensure that Medicare beneficiaries know their discharge rights, and it was imposed in response to concerns with "quicker and sicker" discharges under the Medicare inpatient prospective payment system – an expectation that did not materialize.

Individual patient discharge decisions are made by the attending physician responsible for the patient's care. The hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharged timely, collaborates with the physician to expedite the discharge process. Occasionally, the physician is reluctant to discharge a patient, or the beneficiary or the beneficiary's family is reluctant to make a decision regarding post-acute care. Beneficiaries and their families have an inherent financial interest in delaying post-discharge decisions since their out-of-pocket costs are generally greater in a nonacute setting. The HINN is an effective vehicle for prompting action by both the physician and the patient's family. The HINN is truly an exception process; individual MCHC member hospitals estimate that they prepare and delivery only one to six HINNs annually to their Medicare patients.

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

CMS Proposal

CMS proposes to establish a "two-step" discharge notice similar to the process in effect for SNFs, HHAs, CORFs, and hospices because this process is "helpful to beneficiaries" and is not "overly burdensome to providers or Medicare Advantage organizations" (17053). CMS argues that beneficiaries in an inpatient hospital setting should have the "same notice of

appeal rights to which other beneficiaries are entitled," and explains that the proposal "would provide a more consistent approach to communicating appeal rights" to all Medicare beneficiaries in all settings. (17053) CMS reiterates that the proposed rule "is intended only to provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings." (17054)

The "two-step" process would require hospitals to deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date where the patient's physician agrees with the discharge. This notice, which includes limited patient-specific information, would be delivered "as soon as the discharge decision is made" (17054), and would require the hospital to obtain the beneficiary's signature to acknowledge receipt. If the patient disputes the discharge, the hospital would be required to deliver a more detailed discharge notice similar to that used in other Part A settings. The current HINN and NODMAR forms for discharge would be eliminated (although HINNs would still be used for preadmission situations and other instances where the physician does not concur with a discharge decision). CMS believes the detailed discharge notice would be necessary in "relatively rare situations." (17054) The beneficiary would be instructed to contact the QIO if the discharge is disputed, and if this notice is made prior to noon on the day after receiving the notice, the beneficiary would have no financial liability until at least noon on the day after the QIO's decision is issued. Hospitals would have responsibility for generic notice delivery to all Medicare beneficiaries and for detailed notice delivery to those in the "original" Medicare program; however, Medicare Advantage organizations would retain responsibility for delivery of only the detailed notice to their enrollees.

Comments

The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not appropriate in an acute care hospital setting. CMS has offered no compelling reasons why hospitals should adopt the same discharge notice process as other Part A providers. Medicare beneficiaries already have the same appeal rights for services in various settings. Hospitals are required to provide the "Important Message from Medicare" at the time of admission, which is a form that is not required in other settings. The "Important Message from Medicare" outlines the beneficiary's discharge and appeal rights, and it is not clear what is to be gained, other than uniformity, for hospitals to adopt the additional proposed notification procedures. It is not necessary to have the same procedures for patients already at home who are receiving notice that periodic home health services will soon end and for inpatient hospital patients who need to be discharged and physically moved to another setting because they no longer meet acute care criteria. Hospitals rely on clinical criteria outlined by Interqual or Milliman to determine whether a patient should be treated in an acute care setting.

Acute care hospitals, by definition, have a short length of stay, which continues to decline due to technological advances and the availability of less-expensive post-acute services. For hospital fiscal years ending in 2004, the average hospital length of stay for Medicare patients in the Chicago CBSA was 5.5 days. Because of a short length of stay, discharge planning in a hospital setting frequently begins at the time the Medicare beneficiary is admitted to the hospital. Patients admitted for elective procedures may have a general idea about their expected length of stay, although this is adjusted during the actual stay as the patient's condition responds to the care provided. Hospital social work, discharge planning, and care management staff work closely with the physician throughout a patient's stay to

convey to the beneficiary length of stay expectations, to explore post-discharge options, and to assist with post-discharge arrangements.

The proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations. The generic notice erroneously indicates that the hospital [emphasis added] determines that Medicare will not pay for the hospital stay after the discharge date on the form. The detailed notice also indicates that the hospital [emphasis added] has determined that Medicare coverage for the hospitalization "should end." This type of language does not accurately recognize the role of the physician, and it creates an unwarranted barrier in the hospital/patient relationship. Discharge decisions are made by physicians, not hospitals. The physician may document an anticipated discharge or write a discharge plan, but generally does not make a discharge decision until the day of discharge. The discharge order entered into the patient's record at that time is the discharge decision. The physician may give discharge approval pending certain clinical criteria being met, e.g. test results being negative or within specified limits, or absence of a fever.

The proposed discharge notice process will add at least one additional day to every Medicare stay since CMS requires that the notice be given to the beneficiary at least one day in advance of discharge and since the generic notice cannot be delivered until after the discharge decision is made and documented by the physician and the specific date of discharge is entered on the notice. Although the hospital is working closely with the physician and patient to monitor care and a pending discharge throughout the patient's stay, it is not possible to accurately identify the date of discharge one day in advance for every Medicare patient.

We are concerned with the duplicative effort for hospitals to deliver a patient-specific discharge notice to patients with short stays of one to three days. Consider a two-day stay: The "Important Message from Medicare" would be provided on day one, then the generic discharge notice offering similar appeal instructions would be provided on day two for a planned discharge on day three.

We are also concerned with inadequate staff available at hospitals to deliver a patient-specific generic notice to every Medicare patient. Ideally the notice should be delivered by trained case management staff who are familiar with Medicare regulations regarding notice delivery, appeal rights, and clinical implications. Weekend staffing would be required to appropriately meet Medicare's proposed one-day notice requirement. Although hospitals understand their responsibilities to be adequately staffed, this is a tremendous challenge when faced with shortages of trained case management staff and limited personnel budgets.

The proposed generic discharge notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources and jeopardizing the ability of hospitals to meet the acute care needs of other patients. The language of the generic discharge notice, particularly the repeated references to "an immediate review," will raise doubt in the beneficiary's mind with respect to whether the discharge is appropriate. It basically invites beneficiaries to appeal. Hospitals find that families of some Medicare beneficiaries will take advantage of every opportunity to appeal a discharge decision, especially when there is no financial penalty to do so. Most if not all of the one to six annual HINNs issued by MCHC member hospitals (mentioned in our comments on "Background" above) were appealed. It is our belief that the vast majority of the proposed generic notices will be appealed. The reality is that many Medicare patients do not want to leave the

hospital, not because they are not medically ready to be discharged, but because the acute hospital setting offers a more emotionally secure and comfortable environment than they will find at home or in a post-acute healthcare setting. Other beneficiaries resist discharge because a bed has not become available in a non-acute setting of their choice (although beds are available elsewhere).

The proposed notice emphasizes that the beneficiary's "hospital services will continue to be paid for during the review." This is the only sentence in the two-page proposed notice that is underlined. By highlighting the lack of financial penalty, the message to beneficiaries and their families is that there is no reason not to appeal, even if the patients are medically ready for discharge. This is just the opening that some patients' families are looking for.

While patients may have nothing to lose financially by appealing a discharge decision, hospitals stand to incur significant additional administrative and patient care expenses should the proposed discharge notice procedures be finalized. It is our belief that providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary and longer hospital stays while discharge decisions are being appealed. This will create significant throughput issues for the hospital, which do not have unlimited capacity. Longer Medicare stays, combined with current high occupancy rates, will threaten hospitals' ability to treat other patients who need acute care who are waiting for available beds. We envision back-ups in hospital emergency departments, and the possibility of some hospital EDs being on by-pass, and thus being unable to readily meet the healthcare needs of their communities, including non-Medicare patients.

It is important to recognize that although beneficiaries are advised that "hospital services will continue to be paid for during the review," hospitals will not actually be paid more for Medicare patients who stay longer. Although additional valuable hospital resources would be used for patients who unreasonably request an immediate review, no additional payment will be made to the hospital under the Medicare inpatient hospital prospective payment system to compensate the hospital for the additional costs incurred.

The hardcopy signature and recordkeeping requirements are at odds with federal efforts to encourage electronic medical records. CMS would require that hospitals deliver hard copy discharge notices; no provisions are made for alternative uses of information technology for either the generic or detailed notices. Hospitals would also be required to maintain the signed or, in the case of the patient's refusal to sign, annotated hard copy of the discharge notice. This short-sighted approach fails to recognize the current steps hospitals are taking to implement cost-effective electronic health information record-keeping formats and the strong commitment that the current Administration has made to electronic health records.

There are a number of questions that are not addressed in the notice of proposed rulemaking: If the hospital provides a discharge notice, but discharge is postponed because the patient develops a fever the night before the expected discharge, is the generic notice formally rescinded, and is another generic notice then required, with both steps possibly occurring on the same day? Is another notice required when a discharge is dependent on certain test results, which do not come back with the appropriate values, so discharge is delayed? What are the specific communication and documentation procedures CMS expects hospitals to follow when delivering the proposed discharge notices to a beneficiary's family who does not reside locally? What allowances are made in the proposed discharge notice process for patients who progress faster than anticipated so they

are clinically ready for discharge earlier than planned? Will the QIOs be provided enhanced funding for additional staffing so appropriate access and services are available seven days a week?

Collection of Information and Recordkeeping Requirements

CMS Estimates

CMS argues that the proposed hospital discharge notice process "would enhance the rights of Medicare beneficiaries without imposing any significant or undue financial burdens on hospitals." (17057) It reiterates that it does not anticipate there to be "a significant financial impact on individual hospitals." (17058) CMS estimates it would take hospitals five minutes to deliver the generic discharge notice to each Medicare beneficiary. CMS further estimates that two percent of Medicare beneficiaries will request an immediate review (a number that CMS considers "high"), resulting in an estimated 60-90 minutes of additional effort by the hospital to prepare the detailed notice and associated records for the patient and the QIO. Based on a $30 per hour rate (again, a number that CMS considers high if non-clinical staff are used for any task such as copying medical records), CMS estimates overall annual costs of complying with the proposed requirements of $7,075 per hospital.

Comments

The cost estimates for delivering generic and detailed hospital discharge notices are grossly understated. The CMS estimates are based on faulty assumptions, and they fail to properly take into account a number of significant costs related to the delivery of the proposed discharge notices.

- **Explanation of generic notice, appeal rights, and securing patient signature from a competent Medicare patient** – Under the proposed discharge notice procedures, hospital case management or discharge planning staff would be responsible for identifying when a discharge decision is made by the physician, completing the generic discharge notice with patient-specific information, obtaining any necessary interpreter services, explaining the content and purpose of the generic notice to the beneficiary, answering the beneficiary's questions, securing the beneficiary's signature on the form to acknowledge understanding and receipt, and copying the signed form for the beneficiary. MCHC hospitals estimate that it would take an average of 25 minutes, as opposed to the five minutes estimated by CMS, to prepare and deliver the generic discharge notice to a Medicare patient who is competent and able to understand the form. At $30 per hour, this is $12.50 per beneficiary, for an average annual administrative cost of $60,000 for a hospital in the Chicago/Naperville/Joliet CBSA.

- **Valid receipt of notices for incompetent patients and obtaining guardianships** - The proposed estimated delivery costs for the generic notice fail to account for situations where the patient is not competent, family members are unavailable, or guardianship through court order is required. Unfortunately the families of some Medicare patients deliberately avoid contact with the hospital during the patient's stay. It could take several hours or days to locate the beneficiary's family. The $12.50 cost estimated above to deliver the generic notice could easily be $50-125 or more per beneficiary for incompetent patients.

If the family cannot be located, it may take up to a week by the time guardianship is obtained. MCHC member hospitals report that guardianship is currently required for one Medicare patient per month, with up to three or four patients per month requiring guardianship for inner city hospitals. These figures would increase under CMS' proposal. Securing guardianship typically adds a week to the patient's hospital stay, at an estimated cost to the hospital of more than $10,000 per patient for these additional days. The legal fees for the guardianship itself are estimated at $2,000-5,000 per occurrence.

- **Effort to prepare detailed notices and work with QIO** – CMS failed to account for the full cost of the preparation of a detailed notice and the review by the QIO in estimating the time to deliver the detailed discharge notice. MCHC hospitals estimate that the detailed notice would take at least three hours to complete and deliver to the Medicare beneficiary because of the level of detailed information requested and the need to translate clinical information into plain English. The process will take even longer for non-English speaking patients. At $30 per hour, this is at least $90 per detailed notice. With a very conservative one-third of beneficiaries appealing their discharges, the average Chicago-area hospital will bear a minimum annual cost of $145,000 to prepare and deliver the detailed notice. If the vast majority of beneficiaries request an immediate review as we anticipate (say, 80 percent), this direct annual cost per hospital increases to $350,000.

  Unlike the current HINN, which makes a generic statement that the inpatient services are not medically necessary or the patient's condition could be safely treated in a non-acute setting, the proposed detailed notice requires the hospital to outline the patient-specific facts used to determine that Medicare coverage should end, to provide detailed and specific reasons why services are no longer reasonable or are no longer covered by Medicare, and to provide specific citations for Medicare coverage rules or policies that are specific to the beneficiary's individual case. Hospitals expect that direct input from the physician, a resident, or a hospitalist will be required to complete the detailed notice and that they will not be able to cite specific applicable Medicare coverage policies. Hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria, not on a specific Medicare coverage rule or policy.

  The QIO review process will require interviews with at least three key individuals (the director of UR/case management, the physician, and the social worker or QIO liaison), two of whom are hospital employees. Based on current experience, each of these discussions will take 10-15 minutes. The annual costs of these interviews alone for the average Chicago hospital are estimated to be $24,000-$87,000, depending on the length of the conversations and the number of beneficiaries requesting immediate reviews.

- **Additional length of stay** – MCHC member hospitals estimate that the proposed requirement to provide a patient-specific generic discharge notice would add at least one day to each Medicare beneficiary's stay, and the requirement to issue a detailed notice would add a minimum of two days to the stay. We also believe that the generic notice will prompt most Medicare beneficiaries to seek an immediate review. Using an average cost per day of $1,525, and assuming a very conservative one-third of beneficiaries request an immediate review, we estimate that CMS' proposed discharge notice procedures will cost the average Chicago-area hospital $9.9 million just from the additional length of stay. Based on 80 percent of Medicare beneficiaries requiring a

detailed notice, this figure climbs to $13.3 million per year for the average Chicago-area hospital.

- **Additional staffing needs** – The costs estimated above are for the direct costs of preparing and delivering the generic and detailed discharge notices. Additional costs would be incurred for hospital staff to witness and document valid delivery of the notices by telephone to patient representatives. Hospitals will incur yet additional costs for interpreter services, which can be significant at certain hospitals that have a disproportionate share of non-English speaking patients. Hospitals would also face additional costs for weekend or on-call staff who would be required for timely delivery of the required notices.

- **Rework by hospital staff to secure post-discharge placement** - Another expense hospitals will face when more beneficiaries appeal their discharges is rework necessary to locate and secure an available bed in a non-acute setting. For example, an isolation bed may be available in a nursing home on the day of expected discharge, but by the time the QIO review is complete, the bed is no longer available, and the search begins anew.

Recommendations

MCHC recommends that CMS not implement the proposed discharge notice procedures. We suggest that prior to making any changes to current hospital procedures for notifying Medicare beneficiaries of their appeal rights and issuing HINNs, CMS needs to better understand hospital operations and to develop more realistic estimates of the administrative and financial burden of the proposed requirements on hospitals.

MCHC also recommends that CMS convene a national workgroup comprised of hospital, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures impact the various parties, and to ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights. We would be happy to make recommendations for hospital staff to participate as members of this workgroup.

Further Information

Thank you again for the opportunity to review CMS' proposal and to offer comments. If you have any questions about the issues raised above or you need any additional information, please feel free to contact me at 312/906-6007, email smelczer@mchc.com.

Sincerely,

Susan W. Melczer
Director, Patient Financial Services

cc: American Hospital Association
Illinois Hospital Association

Submitter : Mr. Brian Pisarsky **Date:** 06/02/2006

Organization : DCH Regional Medical Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P-1402-Attach-1.DOC

Attachment #140

DCH Regional Medical Center

DCH Health System

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P2
P.O. Box 8010
Baltimore, MD 21244-1850

June 1, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P2, Medicare Program; Notification Procedures for Hospital Discharges. I am the Director of Case Management at DCH Regional Medical Center, a 610 bed teaching hospital located in Tuscaloosa, AL.

As a Director of Case Management I have been directly involved with discharge planning for inpatients for the past year. Our current discharge planning practices begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the Case Manager assesses the patient's current living situation and needed resources. 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.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is approximately 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.

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.

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,

Brian K. Pisarsky, RN, BS, ACM
Director of Case Management

Submitter :

Date: 06/02/2006

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am the Manager of Utilization Review/ Case Management at the DuBois Regional Medical Center. We are a community hospital in rural Pennsylvania with a licensure of approximately 250 beds. We serve a large Medicare population.

I have been directly involved with discharge planning including all the rules and regulations included in this position for the past twenty - six years. Our current discharge planning practice begins at the time of registration when our patients are provided, as required, with the Important Message from Medicare. On a daily basis we along with the patient and their families, case managers, discharge planners, UR staff, physicians and many other ancillary staff collaborate to develop an aftercare plan for our patients.

This CMS proposal places an administrative burden on an already overburdened hospital system 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. Sometimes patients have no family, no POA or even a guardian.
In addition, a days notice also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.7 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.

Many patients are discharged from the hospital in 1 or 2 days, very soon after the patient has received their Medicare rights information during the admission process.

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.

I appreciate the role of CMS in safeguarding patient rights. We believe we must protect patient's rights while also stewarding government resources and ensuring patients do not take advantage of an opportunity to unnecessarily extend a length of stay adding significant costs to the hospital and putting them at risk for infection and falls. We want to be known for our high standards of care and promotion of patient safety. Please do not add to our increasing financial burdens. Incoming revenue continues to shrink while our expenditures continue to grow. For example: We implant Internal Cardiac Defibrillators (ICD). The DRG payment barely covers the cost of the device. All other costs such as supplies, high tech equipment, qualified staff and just the utilities to keep the facility running are basically provided free of charge. Reimbursement changes were made to this DRG by CMS without knowing or investigating the financial impact to rural hospitals such as ours. You are once again proposing a change that you estimate will have little impact. Please be sure that you understand what you are proposing and how it will affect us. I am all for beneficiary rights. Let us make sure that seniors are provided with workable options for medication, skilled care, home care services and transportation. Let us be cognoscente of what is important and logical. Why not focus your efforts on changes that will have positive and worthwhile outcomes for the Medicare Beneficiary?

Sincerely,

Denise M. Lukens, A.A.S., LPN
Manager UR/CM
DuBois Regional Medical Center

Form Letter
142-0
(36)

Submitter : Mrs. Anne Williams **Date:** 06/02/2006

Organization : Clarian Health Partners

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attach

CMS-4105-P-1422-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 1, 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 care coordinator at Clarian Health Partners, a 1300 bed, teaching Hospital located in Indianapolis, IN.

As a care coordinator I have been directly involved with discharge planning for 20-30 patients per day for many 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 60, 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. Should this proposal come to be, please consider 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 7 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. Hospitals make decisions and update the care plan hourly. 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,

Submitter : Mrs. Tammy Helm **Date:** 06/02/2006

Organization : clarian health partners

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

see attach

CMS-4105-P-1432-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 1, 2006

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Sincerely,

Submitter : Kim Brandisinio **Date:** 06/02/2006

Organization : clarian health partners

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

see attach

CMS-4105-P-1442-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 1, 2006

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