Submitter : sue packard **Date:** 06/05/2006

Organization : grady memorial hospital

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

The issue of time required to issue the proposed notices of hospital discharge is not likely to be a problem. It is the delay in discharge that will be an issue. Since physicians can check lab work, x-ray results and other data 24/7, then they are more able than ever before to precisely identify a patient's medical readiness for discharge at various points through the day.
Requiring the 1 day notice of disharge will result in 1)additional costs of providing care incurred by the hospital while the patient stays the extra day and/or 2) exposure of hospital inpatients to the widely recognized hospital acquired infections or medication errors. This proposed change does not make good economic sense. Nor is it good practice for patient safety reasons.
For example, the physician reviews lab work at 6PM after the patient has been given a course of medication through that day and finds that the patient is no longer in need of hospital acute care services. But the 1 day notice must be given before the patient can be discharged. What sense does it make to delay the discharge until the following day just to satisfy the 1 day regulation?
And what about those patients who are anxious to return home and want to leave at the earliest possible time? Will the notice allow them to waive their right to the 1 day notice period or must they then sign out "against Medicare advice"?

Submitter : **Ms. Suzanne Raab-Long** **Date: 06/05/2006**

Organization : **Delaware Healthcare Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

The Delaware Healthcare Association (Association) on behalf of its member hospitals and health systems appreciates the opportunity to provide comments and feedback on the proposed rule concerning notification procedures for Medicare hospital inpatients regarding their discharge appeal rights. This notice is in addition to information already provided to the Medicare population upon admission to a hospital.

The Association has received and reviewed the comments provided by the American Hospital Association (AHA) and we concur fully with their concerns. We have received the following comments from our member hospitals. While similar to those provided by the AHA, we wish to share them with you.

" The proposed rule was discussed with representatives of the Delaware Association of Healthcare Quality Board, (a professional organization representing many of the Quality and Utilization Administrators of Delaware s hospitals) at a recent meeting. All of those attending expressed concern about the impact of the proposed rule on the Utilization functions at the hospitals. The representatives felt strongly that this proposed rule is unreasonable and functionally impossible to carry out given current utilization staffing at the hospitals. In addition, it will likely add to the length of stay of patients who become stable for discharge before predicted, but will be allowed to stay the extra day because they received a 24-hour discharge notice.

" Current reality is that a patient's "readiness for discharge" may change within an 8-hour period in an acute care setting and there is no correlation to the more predictable criteria for discharge for the patient groups in the non-acute setting. There is no "crystal ball" that can accurately predict discharge within 24 hours to be able to carry out the proposed delivery of "notice of non-coverage" in a reliable manner without numerous "reinstatement of benefits" when it turns out the patient does not meet discharge criteria the day after the notice is delivered.

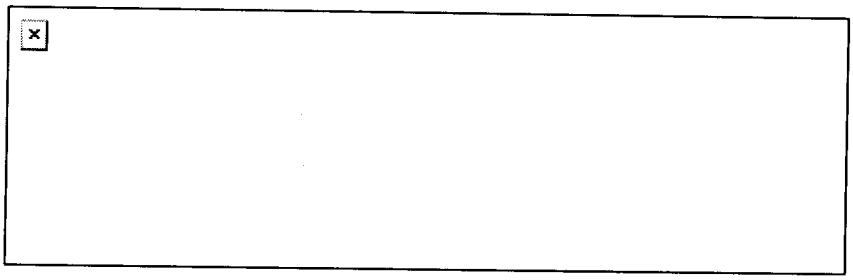
" On average, a non-contested notice of non-coverage delivery process in the acute care setting takes 2= to 3 hours. The process includes the verification of meeting discharge criteria, preparation of paper work, confirmation with attending physician of discharge readiness, review of notice of non-coverage with patient and/or guardian, and final disposition of notices (including data entry). The proposed rule change becomes a financial and compliance nightmare if adopted due to the potential of adding unnecessary days of care to DRG length of stays; reducing hospital payments further; and additional denial related activities.

Again, we want to thank you for this opportunity to comment on this proposed rule. If there are any questions, please contact us at (302) 674-2853.

Sincerely,

Suzanne Raab-Long
Vice President, Professional Services

CMS-4105-P2-345-Attach-1.TXT



June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

The Delaware Healthcare Association (Association) on behalf of its member hospitals and health systems appreciates the opportunity to provide comments and feedback on the proposed rule concerning notification procedures for Medicare hospital inpatients regarding their discharge appeal rights. This notice is in addition to information already provided to the Medicare population upon admission to a hospital.

The Association has received and reviewed the comments provided by the American Hospital Association (AHA) and we concur fully with their concerns. We have received the following comments from our member hospitals. While similar to those provided by the AHA, we wish to share them with you.

- The proposed rule was discussed with representatives of the Delaware Association of Healthcare Quality Board, (a professional organization representing many of the Quality and Utilization Administrators of Delaware's hospitals) at a recent meeting. All of those attending expressed concern about the impact of the proposed rule on the Utilization functions at the hospitals. The representatives felt strongly that this proposed rule is unreasonable and functionally impossible to carry out given current utilization staffing at the hospitals. In addition, it will likely add to the length of stay of patients who become stable for discharge before predicted, but will be allowed to stay the extra day because they received a 24-hour discharge notice.

- Current reality is that a patient's "readiness for discharge" may change within an 8-hour period in an acute care setting and there is no correlation to the more predictable criteria for discharge for the patient groups in the non-acute setting. There is no "crystal ball" that can accurately predict discharge within 24 hours to be able to carry out the proposed delivery of "notice of non-coverage" in a reliable manner without numerous

"reinstatement of benefits" when it turns out the patient does not meet discharge criteria the day after the notice is delivered.

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Again, we want to thank you for this opportunity to comment on this proposed rule. If there are any questions, please contact us at (302) 674-2853.

Sincerely,

Suzanne Raab-Long
Vice President, Professional Services

Submitter : Lyn Snow **Date:** 06/05/2006

Organization : State of Colorado, Mental Health Institutes

Category : Psychiatric Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-346-Attach-1.DOC

#346

STATE OF COLORADO

cdhs

Colorado Department of Human Services
people who help people

OFFICE OF BEHAVIORAL HEALTH AND HOUSING
Deborah L. Trout, Ph.D., Manager

HOSPITAL SERVICES
3520 West Oxford Avenue
Denver, Colorado 80236
Phone 303-866-7087
FAX 303-866-7007
www.cdhs.state.co.us

Steve Schoenmakers
Director

Bill Owens
Governor

Marva Livingston Hammons
Executive Director

June 2, 2006

Mark McClellan, MD, Ph.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Dear Dr. McClellan,

I appreciate the opportunity to comment on file code CMS-4105-P, on behalf of the two State psychiatric hospitals in the State of Colorado. The proposed Medicare Program: Notification Procedures for Hospital Discharges has presented us with the following questions:

- Community Behavioral Health Organizations (BHOs) refer patients to the psychiatric hospital. They provide case management and authorize payment. If they do not provide two days notice to the hospital, is the hospital liable and unable to bill Medicare?

- How would a psychiatric hospital handle a patient who is admitted for a 72 hour evaluation and then released? Would the hospital be required to keep the patient an additional day to comply with the two-day discharge requirement?

- One psychiatric hospital has an acute care hospital on the grounds. If a patient is transferred from the psychiatric hospital to the acute care hospital, is a two-day notice required? How would you handle an emergency?

- One psychiatric hospital has both certified and non-certified beds for treatment reasons. Would a two-day notice apply to transfers within the same hospital from a non-certified to a certified unit?

- Finding appropriate placements for psychiatric patients can be difficult. If the appropriate placement has an opening, is two-day notice required?

- When Medicare Part A is exhausted and only Medicare B is billed, does the two-day notice apply?

- When Medicare Part A is exhausted and a patient does not have Medicare B, does the two-day notice apply?

- Psychiatric forensics patients are currently not notified of pending discharges due to security concerns. This would require a different policy for Medicare patients.

- There is concern that psychiatric patients with certain diagnoses may "act out" with a longer notice of discharge in order to prolong their stay.

- Will patients be provided a toll free number to appeal a decision that a hospital level of care is no longer medically necessary?

- The additional workload will be higher than the proposed estimate, particularly with people with mental illness.

- Some patients do not have a personal representative or family involvement. What are the legal consequences for hospital employees in determining that the patient has comprehended the notice?

- Hospital caregivers do not know the insurer of the patient. Implementing a system that informs the medical providers the Medicare status of a patient will impose an additional workload.

- How would CMS differentiate between a patient appealing where he is being **discharged to**, as opposed to the fact that he is being discharged from the hospital?

We believe a two-day discharge requirement presents unique challenges to a psychiatric hospital and its patients. This proposed procedure seems to be more appropriate in an acute medical setting.

Thank you for your consideration.

Lyn Snow
Compliance Officer

Submitter : Mr. John Nelson **Date:** 06/05/2006

Organization : St. Margaret Mercy

Category : Social Worker

Issue Areas/Comments

Background

Background

Hospital have short term relations ships with patients and it would be a burden staffing 7 days a week to issue these letters timely.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Doctors rely on test results to determine patient discharge. They do not always know discharge until the actual day. This rule could result in delaying discharges. Patients and families are not always cooperative in returning phone calls so if the hosptial needed to meet with a family to sign the letter this cvould result in a delay of discharge.

Submitter : **Mrs. Penny Block** **Date: 06/05/2006**

Organization : **Shawano Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

June 5, 2006

Re: New Discharge Notice Requirements Proposed

To Whom It May Concern:

To be required to provide all inpatient Medicare beneficiaries with a standardized, generic notice of non-coverage the day before discharge is not a feasible proposal. Con-current lengths of stay averages at our facility are 3 or fewer days. To anticipate discharge dates would be very difficult. This process would be inefficient and a wasteful use of our time and resources. Of utmost importance, this process will be very confusing and anxiety provoking to our elderly clients.

Please do not move forward with this proposal.

Sincerely,

Penny Block, Director of Patient Care
Sharon Weed, Utilization Review Coordinator
Joanne Bartz, Utilization Review Coordinator

Submitter : Mrs. Barbara Stark **Date:** 06/05/2006

Organization : St. Margaret Mercy Healthcare Center

Category : Nurse

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 : Mr. Chip Kahn **Date:** 06/05/2006

Organization : Federation of American Hospitals

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-4105-P2-350-Attach-1.DOC

June 5, 2006

By Electronic Mail

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

Attn: CMS-4105-P

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

Dear Dr. McClellan:

The Federation of American Hospitals (FAH) appreciates the opportunity to comment on the proposed rule on Medicare notification procedures for hospital discharges issued April 5, 2006 in the Federal Register (Vol. 71, No. 65, pages 17052-17062) (Proposed Rule). FAH is the national representative of investor-owned or managed hospitals and health systems. Our members include general community and teaching hospitals in urban and rural areas as well as rehabilitation, long-term acute care, cancer, and psychiatric hospitals.

Proposed Rule

The Proposed Rule expands current Medicare requirements for hospitals to match those applicable to skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities. It proposes that hospitals deliver a standardized, largely generic notice, to all Medicare Advantage (MA) enrollees and Medicare beneficiaries no later than the day before discharge. This notice is called the "Generic Notice of Hospital Non-Coverage." The rule also proposes that hospitals give this notice

to Medicare Advantage enrollees when the managed care organization determines that the plan will no longer pay for hospital services even if the hospital is not planning on discharging the patient. As proposed, the notice would contain the following information:

- The date that coverage of inpatient hospital services ends;
- The right to an immediate review by a quality improvement organization (QIO), including information on how to contact the QIO;
- The availability of other Medicare Advantage appeal procedures if the enrollee fails to meet the deadline for immediate QIO review (for Medicare Advantage enrollees only);
- The right to receive additional information about the decision to discharge or discontinue coverage of hospital services; and,
- The date that personal financial liability for continued hospital services begins.

The Proposed Rule also requires the patient, or patient's representative, to sign the "Generic Notice of Hospital Non-Coverage." If the patient opts to request an expedited review/determination, then the hospital or managed care plan, depending on whether the patient is an enrollee or beneficiary as defined in the Proposed Rule, must provide a "Detailed Notice of Hospital Non-Coverage."

FAH Concerns with Proposed Rule

FAH fully supports efforts to ensure that Medicare patients understand their rights to review and appeal processes before they are discharged from a hospital. However, for the majority of patients receiving inpatient hospital care, it is difficult to predict with certainty whether patients will be cleared for discharge until the actual day of discharge. This is particularly true for complex medical and surgical patients admitted with co-morbidities and chronic diseases whose care is also being managed by several specialty physicians in addition to the attending physician. Often the decision to discharge a patient is dependent upon the patient's condition overnight or the results of therapeutic lab work. Consequently, it is virtually impossible to comply with the Proposed Rule's requirement of providing the notice at least 24 hours prior to discharge. To comply with the 24-hour notice, patients would have to stay an additional day in the hospital which would lead to an increased cost for hospitals in providing care to patients who are ready for discharge. Hospitals should not be providing unnecessary care (and possibly depriving another patient of that bed) simply to comply with a notice regarding non-coverage.

FAH also believes that the Proposed Rule applies an unreasonable burden of care on hospitals. CMS estimated that the average time spent in delivering the notices would be 5 minutes per patient. A more realistic estimate for time spent on the delivery of the notice would need to include the preparation of the notice, discussion of the notice with the elderly Medicare patient and/or their family (many elderly patients request that important conversations be repeated for their family members), and obtaining the patient's or family's signature. Consideration would also need to be given for those patients whose family or legal representative might not be readily available 24 hours prior to the patient's anticipated discharge.

The responsibility of the issuance of the notices would typically fall on the case management department, thus increasing the need for the case manager to see every Medicare and Medicare Advantage patient the day prior to discharge. In addition, case management involvement on weekends, after hours, and for one day stays; and case management involvement with the physician to get him/her to commit to a discharge date so that the notice could be issued, would add additional administrative burden.

It should be noted that when CMS proposed a similar process in 2001, this provision was eliminated in the final rule because CMS acknowledged that the proposed rule placed an unreasonable administrative burden on hospitals. We see no reason to conclude differently at this time.

FAH Recommended Alternative

FAH supports an alternative approach that has been recommended by the Blue Cross and Blue Shield Association (BCBSA). In the BCBSA comment letter to CMS,

> "BCBSA recommends that CMS use this proposed rule as an opportunity to revise the current hospital notice process for original Medicare and MA beneficiaries and provide all beneficiaries with a more useful notice of their appeal rights at the time of admission to streamline the notice delivery process for hospitals and MAOs. Specifically, we [BCBSA] propose that, in lieu of the proposed notices in the rule under consideration or the current notices in use today (i.e. HINN and NODMAR), that a single "universal" form be developed that incorporates the necessary information concerning appeal rights for both original Medicare and MA beneficiaries. We [BCBSA] recommend one single detailed notice be delivered by the applicable hospital to every beneficiary at the time of admission."

The BCBSA comment letter to CMS also suggests:

> "This new notice would provide a detailed and complete description of Medicare appeal rights for every beneficiary at the time of admission (and therefore prior to any pending discharge no matter what the length of the stay) and would also be supplemented by a simple second notice that would be delivered to the beneficiary by the applicable hospital once a QIO review was initiated. This second notice would acknowledge the QIO's review of a pending discharge and confirm timelines for final notification to the beneficiary, their coverage status while the review was underway, and additional appeal processes available after discharge to MA as well as traditional Medicare beneficiaries."

The two-step alternative process recommended by BCBSA, and supported by FAH, is described by BCBSA as follows:

> **"Step One**: For every Medicare beneficiary admitted to a hospital, all hospitals would provide a universal notice "Important Message to Medicare Beneficiaries Admitted to a Hospital," which would be a newly created document and one that is a more detailed notice than the notice provided today at the time of admission. The new notice would contain, at a minimum:
>
> - a statement of a beneficiary's right to appeal any discharge by noon of the day of the pending discharge;
> - detailed information as to how to contact the QIO;
> - timelines for a QIO response;
> - information as to the issue of hospital coverage while the review is being conducted; and,
> - additional appeal/reconsideration processes available after discharge.
>
> **Step Two**: A second notice would be developed and subsequently would be provided to a beneficiary by the hospital after a QIO has been formally notified to initiate a review to:
>
> - acknowledge the QIO review of the stay in question;
> - provide information as to the required timelines for a QIO decision;
> - provide information as to what coverage is available while the review is underway; and,
> - provide detailed information as to what processes or additional appeals are available to the beneficiary if the QIO rules the pending discharge should proceed."

BCBSA's comment letter suggests, and FAH concurs, that the recently published CMS document entitled "Your Medicare Rights and Protections" could be used as a starting point for the notice provided by hospitals in Step One described above.

This suggested alternative approach would accomplish the overall objective to notify beneficiaries of their rights as a hospital patient and additional processes available to them if a QIO review results in a denial of their continued hospital stay.

FAH Conclusions

We respectfully recommend that CMS withdraw the Proposed Rule. Instead, we recommend that CMS adopt BCBSA's suggested alternative in a new proposed rule. Providing more information at the time of admission, rather than the day before discharge, will give beneficiaries a better opportunity to understand their rights and options. Providing the same two notices to all Medicare beneficiaries will ensure a consistent and standardized approach is used by every hospital and every managed care plan, regardless of the length of time they spend in a hospital. If CMS is unable to consider adopting this proposed alternative, then we respectfully suggest that there be no change to the current rule as the proposed rule is simply unworkable.

We would be happy to follow up with any questions regarding our comments. Please contact Susan Van Gelder on my staff at 202-624-1528 or email her at svangelder@fah.org.

Sincerely,

Charles N. Kahn III
President

Submitter : Mrs. Nancy Sulzberger **Date:** 06/05/2006

Organization : Provena Saint Joseph Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-351-Attach-1.PDF

Attachment #351

PROVENA
Saint Joseph Medical Center
WE ARE BUILDING **EXCELLENCE**
333 North Madison Street • Joliet, Illinois 60435
(815) 725-7133 • www.provenasaintjoe.com

June 5, 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 Provena Saint Joseph Medical Center, Joliet, Illinois. 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.

The Metropolitan Chicago Healthcare Council estimates 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.

Provena Saint Joseph Medical Center recommends 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.

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 appeals 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 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 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 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 Provena Saint Joseph Medical Center's 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 the 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

Provena Saint Joseph Medical Center 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.

Provena Saint Joseph Medical Center 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 (815) 773-7005, email nancyasulzberger@provenahealth.com

Sincerely,

Nancy A. Sulzberger RN, BSN, MN
Director of Care, Quality & Risk Management

cc: Jeff Brickman
Linda Charley
Lon McPherson

Submitter : Sherry McElroy **Date:** 06/05/2006

Organization : Osceola Community Hospital, Inc

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P2-352-Attach-1.DOC

Comments made regarding the Proposed Rule: Notification Procedures for Hospital Discharges

1. There is difficulty with anticipating discharge 24 hours in advance for every patient.
    a. Even with physician daily assessments that are completed on all patients; many medical patients are difficult to 'predict' as many factors weigh in on this decision.
    b. Physician communication to patient's and staff will be essential to try and capture the 24 hour window to comply with this proposed rule.
    c. Educating physicians and staff on this new rule and rationale will be an ongoing difficult process.
    d. Some patients, i.e. surgical for example, are easier to 'predict' discharge plans for; however there are situations that arise that will make it difficult if not impossible to predict discharge within 24 hours.

2. Estimate time projection of 5 minutes per generic notice is extremely unrealistic:
    a. In working w/a recent Medicare client, explanation of a Medicare notice involved 2 staff members (UR and SW) 45 minutes trying to explain/educate the patient on the notice.
    b. Education to Medicare clients on regulations becomes very involved and time consuming even with a 'simple and standard form'; This is for the average person; a person with disabilities will take much longer.

3. Estimate time projection of 60-90 minutes for a detailed notice/ information to the QIO is significantly under estimated:
    a. The Medicare review involving a QIO will take approximately 3-4 hours working with the family and physician.

4. Hospitals strive to provide quality health care, communicate effectively w/ patients and families; work to ensure patient safety and patient rights;
    a. Implementing something of this magnitude from the result of 1 lawsuit from 1993 involving Medicare Advantage plans is unrealistic and adds to the cost of health care.

5. Hospitals will be forced to be held financially liable for Medicare continued coverage of an individuals hospital stay during an appeal process and review.
    a. This will impact the Critical Access Hospital length of stay putting this status in jeopardy.

b. Medicare will incur additional expense when a patient requests an appeal as the patient is allowed to stay until the QIO review is completed.

Respectfully yours,

Sherry McElroy,
HIM/Privacy/QA Coordinator
Osceola Community Hospital, Inc.
9th Avenue North
Sibley, Iowa 51249

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

Organization : **Greater New York Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

Please see complete comments regarding the regulatory impact in the attachment

GENERAL

GENERAL

Please see complete comments in the attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Please see complete comments regarding the provisions of the proposed rule in the attachment

Regulatory Impact

Regulatory Impact

Please see complete comments regarding the background in the attachment

CMS-4105-P2-353-Attach-1.DOC

June
Five
2006

VIA E-MAIL

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

RE: Proposed Rule CMS-4105-P, Notification Procedures for Hospital Discharges
Background
Provisions of the Proposed Rule
Regulatory Impact

To Whom It May Concern:

Greater New York Hospital Association (GNYHA) represents more than 175 not-for-profit and public hospitals in New York State, New Jersey, Connecticut and Rhode Island. We welcome the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) notice of proposed rulemaking (NPRM), CMS-4105-P, Notification Procedures for Hospital Discharges.

The NPRM proposes a two-step process whereby Medicare beneficiaries will receive a standardized, generic notice of discharge 24 hours in advance of the scheduled discharge and a detailed notice if the patient disputes the discharge. GNYHA supports CMS's efforts to create a simplified process for issuing standardized notices so that Medicare Advantage (MA) and original Medicare beneficiaries receive the same, single detailed notice. However, we are concerned that the two-step process CMS is proposing will have a number of unintended consequences, in some cases to the detriment of the Medicare beneficiary, the very party it seeks to protect. Our concerns are as follows:

- We believe it is unrealistic to expect that hospital staff will be able to reliably predict a patient's discharge date in advance in order to comply with the CMS proposed rule that a standardized, generic notice be issued to original Medicare and MA beneficiaries or authorized representative the day before discharge. We believe that in trying to comply, the two-step process will be confusing and unnecessarily alarming for the Medicare beneficiary.

- We believe the cost calculations for the two-step process grossly underestimate the actual financial impact and fail to consider the extreme administrative burden that will be imposed on providers to comply.

Our recommendations are as follows:

- CMS should not proceed with its proposed requirement and instead should retain the current discharge appeals process. CMS should explore avenues to strengthen the process associated with the Important Message from Medicare (IMM) that is issued on or about the time of admission.

- CMS must institute an adequate oversight mechanism that addresses the problem of MA plans a) circumventing the hospital discharge appeals process and b) habitually authorizing inadequate levels and amounts of post-acute care services. This should include that MA plans share the costs associated with all beneficiary appeals and additional penalties whenever a MA plan impairs the timeliness of the appeals process.

- CMS should convene a working group to review and revise the content of the nine different hospital-issued notices of noncoverage (HINN) letters so the notices can be consolidated and the formats uniform.

Timing of Generic Discharge Notice

The basic premise that discharge from an acute care setting can be predicted a day in advance of the actual discharge date is impractical and flawed. Hospital length of stay has over time been reduced to the point where a significant portion of hospital admissions is comprised of relatively short lengths of stay of three days or less. It is this subset of admissions that would pose the greatest challenge to hospital providers. GNYHA has firsthand knowledge of the difficulties involved since New York State regulations similarly have attempted to impose this requirement for non-Medicare beneficiaries, with only marginal success. The experiences recited by GNYHA hospital discharge planners underscore the logistical difficulties and staff concerns that patients' perceptions of their care experience could be adversely impacted.

Hospital discharge planners report that as a practical matter, the decision to discharge a patient is a relatively last-minute determination made by the attending physician on the day of discharge. While there are many discussions between the patient and doctor (and the entire interdisciplinary team of caregivers) about impending discharge and ensuring that the appropriate post-acute care services are in place, actual physician concurrence (i.e., a signed discharge order) for all intents and purposes is not executed until the day of discharge because physicians wish to be satisfied that the patient's condition is appropriate for discharge at that actual time. It is our experience that patients and their doctors amply manage the discharge process and hospital discharge planners serve to enhance that relationship by ensuring the adequacy and safety of the discharge plan. We note that the fact that the vast majority of patients do not dispute their discharges is a testament that the existing process works effectively. We strongly believe that the balance of interests is already appropriate and that introducing cumbersome administrative protocols will not achieve additional benefit.

Notwithstanding the practical aspect of the written discharge order, a significant percentage of hospital admissions are of relatively short duration. Imposing this requirement would mean that staff would have to deliver a notice of discharge essentially on admission for short-stay hospitalizations (at the same time the -IMM is issued) even before a condition has been ruled out. In certain circumstances it is likely that the discharge notice will be issued inappropriately

when a predicted discharge does not occur and instead a condition is ruled in. Receiving an ill-timed notice or duplicative notices in all likelihood will end up being confusing and unduly alarming for the Medicare beneficiary. In this regard, the proposed process does not balance the beneficiary's need to be informed at an appropriate time. Since the proposed requirement would be redundant to the IMM, likely adversely impact the consumer, and create a requirement that providers will be unable to fulfill, we strongly urge CMS to leave the current process unchanged.

Recommendation:

CMS should not proceed with its proposed requirement that a standardized, generic notice be issued a day in advance of discharge. Instead, CMS should retain the current discharge appeal process and strengthen the process for issuing the IMM that is delivered on or about the time of admission.

Medicare Advantage and Hospital Discharge Planning

GNYHA, the American Hospital Association, and others have submitted numerous comments to CMS in response to prior proposed rules with regard to the longstanding, objectionable behavior of MA organizations and the hospital discharge process. It is well documented that plans do not issue the NODMAR and instead habitually reduce or deny payment to hospitals. This is contrary to CMS's notation in the proposed rule (pg. 17053) that the MA organization is required to issue a NODMAR when it no longer intends to cover the inpatient stay.

Based upon past experience, we are very doubtful that MA organizations will comply with the proposed two-step process and issue a timely detailed notice, particularly when the plan has no financial risk for delays it creates in the discharge appeals process. This is often the case with non-participating providers or where participating providers are reimbursed case rates from a plan. We note that because most MA plans do not staff their Medical Management departments on weekends, the two-step process will further delay the discharge appeals process when a weekend o r ho liday is inv olved. E ven m ore t roubling a re t he r eports by ho spital dis charge planning staff that certain MA plans chronically authorize inadequate amounts of post acute care service such that when a patient's condition requires a certain level of service, the plan limits the amounts and types of care it will pay for. While the patient can appeal the MA plan's adverse service determination, it is an unsettling and arduous process that can take six to 10 days until the Independent Review Entity issues a determination. As CMS correctly no tes, the hospitalized patient is appropriately afforded financial protections while awaiting the outcome of an appeal, but on the flip side, the hospital typically receives no additional reimbursement during this prolonged process and the patient is made to wait for the decision when he or she should be proceeding to the next appropriate level of care. If CMS is to protect the best interest of the Medicare beneficiary and the providers that render care, it has to create sufficient regulatory oversight so that the MA plan shares in the financial consequence when it prolongs the appeals process and creates discharge planning delays. CMS cannot divorce itself from these well-known issues and we respectfully urge that it establish a mechanism that will deter MA plans from this persistent and unacceptable practice. As noted above, there is clearly a need for CMS direction to plans when enrollees are hospitalized in non-contracted providers. We believe it is equally important for CMS to get involved when MA contractor practices lack integrity and work against

the best interest of efficiency and an optimal patient experience, and therefore ask that CMS address these issues for providers that have contracts with MA plans as well.

Recommendation:

CMS must institute an adequate oversight mechanism to prevent MA plans from a) circumventing the hospital discharge appeals process and b) habitually authorizing inadequate levels and amounts of post acute care services. MA plans should share the costs associated with all beneficiary appeals and in curr additional penalties when it delays the appeals process.

Uniformity of Notices

We appreciate CMS's attempt to create uniformity by trying to adapt the same discharge notice process that applies to HHAs, SNFs, and CORFs to the hospital setting, but this new process falls short of its goal. It will not consolidate the nine different hospital issued notices of noncoverage (HINN) in a meaningful manner. As a practical matter, the new standardized, generic notice seemingly will only replace the HINN letter issued for continued stay when the physician concurs. Accordingly, it will simply add another letter format and introduce a different appeals process to that which currently exists, thereby failing to achieve the consistent approach that it seeks.

Recommendation:

CMS should convene a working group to review the content of the current collection of HINN letters and focus on consolidating and creating uniformity in the notices in a meaningful fashion.

Estimate of Financial and Administrative Burden

We believe that CMS has significantly underestimated the financial and administrative burdens associated with the proposed two-step process for the following reasons:

- CMS expects that the standardized, generic form can be issued in five minutes, but has not taken in account a variety of factors including the additional time that will be required to explain the notice and to answer patient and/or family questions.

- CMS has not considered the intensive effort that will be required to pursue the signature of the authorized representative when the patient is not capable of comprehending and signing the standardized, generic notice. This is often the case when a nursing home resident is hospitalized. We do not believe CMS has accounted for the additional outreach and work effort by hospital staff to solicit written consent (e.g., repeated phone calls) nor the cost associated with overnight mailing and/or faxing the generic and detailed notices.

- It is very likely that this proposed two-step process will prolong hospital length of stay, especially in those circumstances when the discharge is not known in advance and the notice is issued on the day of discharge, thereby permitting the patient an extra day. If one calculates the impact of increasing hospital length of stay by just one day in 25% of the eligible cases, the fiscal impact is significant.

- Indeed, hospital Case Management departments will incur additional costs to increase staff coverage during weekends and after hours to ensure compliance with issuance of the generic and detailed notices.

- While CMS calculates 60-90 minutes in which to prepare the chart, we do not believe this reflects the cost the hospital incurs to refer the discharge appeal through the UR process. This typically requires that a Physician Advisor be consulted (at a significant hourly rate) to review the chart and document impressions and comments. Nor does CMS include the time involved and the cost of providing copies of the medical record and other related materials to the beneficiary.

- In addition, CMS's requirement that the detailed notice include the applicable Medicare coverage guidelines, instructions, and/or policies will add to the expense of issuing the detailed notice. In some instances this may mean that providers will need to research and identify applicable regulation, Medicare Coverage Manual citation, or related resources. If the citation is for some reason inaccurate or incomplete, will a technical denial be issued and the hospital faced with additional unfunded days?

- Finally, as previously discussed, CMS has not calculated the hospital cost when the MA organization causes delays in the discharge appeals process or authorizes inadequate post-acute care services and prolongs a hospitalization for appeal purposes.

We appreciate your consideration of these comments. If you have any questions or would like further information, please contact Lillian Forgacs, Associate Vice President Utilization Management and Managed Care, at (212) 506-5534 or forgacs@gnyha.org.

My best.

Sincerely,

Kenneth E. Raske
President

cc (via e-mail): Office of Strategic Operations and Regulatory Affairs, Regulations Development Group
Office of Information and Regulatory Affairs, Office of Management and Budget

Submitter : jamie Zweig **Date:** 06/05/2006

Organization : sisters of saint francis

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

see attachments

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

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

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

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

Organization : Bon Secours Richmond St. Mary's Hospital

Category : Social Worker

Issue Areas/Comments

Background

Background

I disagree that the regulatory impact may not reach the economic threshold. If patients are held in the hospital to implement the 24 hour notice of discharge, or if patients refuse to be discharged, there may be a financial impact to the hospitals bottom line. This would drive up costs to the hospital tremendously. The hospitals are trying to decrease the length of stay for patients. Our cost would go up if patients remain in the hospital for another day.

GENERAL

GENERAL

I also have a concern regarding the 5 minutes to deliver a notice to the patient. It is my belief that it would longer than this time for the majority of our patients. If the patient is competent to understand the notice and has no questions, 5 minutes may be accurate. In the case where the patient is not competent or choses not to be presented the letter (i.e. wants a relative to get the letter), finding the representative and getting them to the hospital will take longer than five minutes. It is my estimate that it would be 30 minutes to complete. Many times, if a patient is going to a nursing home, relatives do not come to the hospital for discharge. In these cases, requiring the relative to come to the hospital can be a burden. The family is dealing with many transitional issues and putting one more requirement on the family can literally break the camels back. These factors will delay the discharge.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

In the discussion of the proposed rule, it is stated thatyou believe the proposal would not be overly burdensome. At Bon Secours St. Mary's Hospital in Richmond, we disagree with this statement, and find that it would put a great burden on both the staff and the physicians. Our average length of stay is 4.53 days with many of our discharges occurring over the weekend. To maintain our current length of stay, physicians would need to communicate at the earliest thought of potential discharge to make this arrangement. If the physician is waiting on test results and/or reports to clear the patient/s for discharge, or needs additional time for the patient's condition to stabilize, the discharge process would be slowed down and/or stopped until the discharge letter could be given to the patient/s. It would be difficult to five a notice of discharge of admission to the one-day stay admission. It is unclear if a new notice would be needed if the discharge were delayed due to an inforseen event.

The appeal process has potential to increase the length of stay, and therefore increase the cost of health care. If a physcian writes a discharge order and the letter is given to a patient at 5:00 p.m. and the patient wants to appeal the decision, technically, there will be 2 days added to the lenfth of stay. The chart would need to be copied and delivered to the QIO for the appeal decision. The earliest this would be accomplished would be by noon of the following day. Discharge would then depend when the QIO would decide and communicate the decision back the the hospital.

Regulatory Impact

Regulatory Impact

At St. Mary's Hospital in Richmond, we currently have a process to descharge patients when they no longer meet medical necessity criteria. The criteria set used by Bon Secours St. Mary's Hospital and the state QIO is InterQual. When a patient is discharged, no longer meets criteria for hospital admission, and does not wish to be discharged, a Hospital Issued Notice of Non-Coverage (HINN) is issued. The patient's rights of appeal are outlined inthis letter. It is unclear why there is need for additional notice to patients re: discharge.

Submitter : Darlene Jurgens **Date:** 06/05/2006

Organization : Osceola Community Hospital, Inc.

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-356-Attach-1.DOC

Comments made regarding the Proposed Rule: Notification Procedures for Hospital Discharges

1. There is difficulty with anticipating discharge 24 hours in advance for every patient.
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    c. Educating physicians and staff on this new rule and rationale will be an ongoing difficult process.
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    a. The Medicare review involving a QIO will take approximately 3-4 hours working with the family and physician.

4. Hospitals strive to provide quality health care, communicate effectively w/ patients and families; work to ensure patient safety and patient rights;
    a. Implementing something of this magnitude from the result of 1 lawsuit from 1993 involving Medicare Advantage plans is unrealistic and adds to the cost of health care.

5. Hospitals will be forced to be held financially liable for Medicare continued coverage of an individuals hospital stay during an appeal process and review.
    a. This will impact the Critical Access Hospital length of stay putting this status in jeopardy.

b. Medicare will incur additional expense when a patient requests an appeal as the patient is allowed to stay until the QIO review is completed.

Respectfully yours,

Darlene Jurgens, RN
UR/Swing Bed Coordinator & Compliance
Osceola Community Hospital, Inc.
9th Avenue North
Sibley, Iowa 51249

Submitter : Ms. Kay Marsyla **Date:** 06/05/2006

Organization : Trinity Health West MI Shared Services

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-357-Attach-1.DOC

Attachment #357

TRINITY HEALTH

June 5, 2006

West Michigan Finance Shared Services
1820 44th Street SE
Kentwood, MI 49508

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

Re: Medicare Proposed Discharge Notice
CMS-4105-P

Dear Administrator McClellan:

Battle Creek Health System (23-0075), Mercy General Health Partners (23-0004), and Saint Mary's Health Care (23-0059) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled "Medicare Program: Notification Procedures for Hospital Discharges" 71 Federal Register No 65, starting page 17052 dated April 5, 2006.

"Provisions of the Proposed Rule"

The proposed rule states that the hospitals would be required to provide the standardized notice on the day before the planned discharge from any inpatient hospital stay for patients in the original Medicare or Medicare Advantage programs. For one to three day stays, this essentially means that the discharge papers would have to be handed to the patient upon admission. This would be burdensome on the admissions process. The admissions area would now have to start explaining the discharge procedure to patients before they are even treated. The estimate of five minutes is understated. **The patients will get the feeling of being kicked out of the facility before being treated.** The ramifications would be additional stress and undo worry to the patient.

Second, on longer stays, the attending physician usually does not determine discharge status until the day of discharge. By requesting the hospitals to notify the patient 24 hours before would put undo burden on the hospital. It would mean a radical change in procedures and getting physicians to notify the hospital the day before possible discharge. A patient's condition can change drastically in 24 hours for the better or worse. This could change the physician's orders. If a determination cannot be made until the morning of discharge, a hospital will be required to delay the release of a patient due to this notification requirement. The delay in discharge will decrease patient satisfaction and unnecessarily increase the cost of the stay. As reimbursement rates for most Medicare stays do not cover cost already, there will be additional financial strain on the facility. In addition, when beds are in short supply, this delays treatment for other patients who are in need of admission.

The hospital is also being required in this rule to keep a signed copy of the additional paperwork to keep on file or to document the refusal to sign. This is additional cost to the facility with additional storage costs and goes against CMS policy to move to electronic medical records.

The detailed notice that will be required if a patient decides to an expedited review will also be burdensome. **It is the physician's determination to discharge,** however the hospital is responsible for not only detailing the physicians reason for the discharge but must also include the applicable Medicare coverage rule; this document is becoming a legal brief. To expect that a discharge planner or nurse would be able to complete all of this documentation without extensive input from other areas (physicians, patient accounting, reimbursement etc) in 60 – 90 minutes appears to be underestimated.

Even though the proposed rules have changed since the original inception in 2001, the burden on the hospitals is too great for little gain. As an alternative, modifying the Important Message from Medicare

(IMM) would achieve the CMS objective. This revision could include a highlighted, bolded section explaining patient discharge appeal rights. This would be sufficient for many hospital inpatients as it is impossible to predict the discharge date prior to having the proper information on the well being of the patient.

Again, I appreciate the opportunity to provide comments to CMS regarding the proposed discharge notice. If you have any questions on this comment letter, I can be reached at (616) 643-3569 or at marsylkp@trinity-health.org.

Respectfully,

Kay Marsyla
Senior Reimbursement Specialist
Trinity Health West Michigan Finance
Shared Services

Submitter : Julie Schroder **Date:** 06/05/2006

Organization : Osceola Community Hospital, Inc.

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-358-Attach-1.DOC

Comments made regarding the Proposed Rule: Notification Procedures for Hospital Discharges

1. There is difficulty with anticipating discharge 24 hours in advance for every patient.
    a. Even with physician daily assessments that are completed on all patients; many medical patients are difficult to 'predict' as many factors weigh in on this decision.
    b. Physician communication to patient's and staff will be essential to try and capture the 24 hour window to comply with this proposed rule.
    c. Educating physicians and staff on this new rule and rationale will be an ongoing difficult process.
    d. Some patients, i.e. surgical for example, are easier to 'predict' discharge plans for; however there are situations that arise that will make it difficult if not impossible to predict discharge within 24 hours.

2. Estimate time projection of 5 minutes per generic notice is extremely unrealistic:
    a. In working w/a recent Medicare client, explanation of a Medicare notice involved 2 staff members (UR and SW) 45 minutes trying to explain/educate the patient on the notice.
    b. Education to Medicare clients on regulations becomes very involved and time consuming even with a 'simple and standard form'; This is for the average person; a person with disabilities will take much longer.

3. Estimate time projection of 60-90 minutes for a detailed notice/ information to the QIO is significantly under estimated:
    a. The Medicare review involving a QIO will take approximately 3-4 hours working with the family and physician.

4. Hospitals strive to provide quality health care, communicate effectively w/ patients and families; work to ensure patient safety and patient rights;
    a. Implementing something of this magnitude from the result of 1 lawsuit from 1993 involving Medicare Advantage plans is unrealistic and adds to the cost of health care.

5. Hospitals will be forced to be held financially liable for Medicare continued coverage of an individuals hospital stay during an appeal process and review.
    a. This will impact the Critical Access Hospital length of stay putting this status in jeopardy.

b. Medicare will incur additional expense when a patient requests an appeal as the patient is allowed to stay until the QIO review is completed.

Respectfully yours,

Julie Schroder
Director of Nursing
Osceola Community Hospital, Inc.
9th Avenue North
Sibley, Iowa 51249

Submitter : Mr. Thomas Tynan **Date:** 06/05/2006

Organization : Society for Social Work Leadership in Health Care

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

Social workers and others in healthcare are taxed with the awesome responsibility of assisting individuals at very difficult and trying periods in their lives. They therefore require the time and attention needed to address their clinical needs. Adding another piece of paper to an already voluminous amount of documents that need to be read, sometimes interpreted and signed by the patient, in our view, diverts needed resources from the effort to provide care, treatment and assistance to patients. We share the view of other professional healthcare organization that the CMS estimate (5 minutes) of the amount of time expended for the provision of the second step notice is grossly understated. Given the time required for delivery of the document, explanation and discussion of the letter s intent and to respond to questions posed by patients in their families the process would take at least 20-30 minutes. Patients who have language barriers or are unable to communicate due to their medical condition would require even greater expenditures of time.
One outcome from this new rule will be more unnecessary appeals by patients or their families who wish to extend the hospital staff for the 2 or 3 days necessary to resolve an appeal. Hospital resources such as hospital beds are often at a premium. CMS has prided itself on its efforts to prevent unnecessary acute care hospital days. This new rule would have the opposite effect.

GENERAL

GENERAL

The Society for Social Work Leadership in Health Care recommends that the CMS proposed discharge notice procedures not be implemented. The current process already protects the rights of Medicare patients to appeal a physician s discharge physician. As an organization dedicated to advocating for the rights of our clients, we propose that the patient s interests would be much better served by eliminating CMS rules such as the three day hospital stay requirement to be eligible for skilled nursing facility benefits.

Our Society (SSWLHC) would welcome any opportunity to participate in any dialogue or workgroups to enable CMS to achieve its goal of protecting the rights of its beneficiaries while at the same time avoiding any negative impact on the utilization of valuable healthcare resources and on the caregiver/patient relationship. Thank you for allowing us the opportunity to comment on CMS-4105-P.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The new proposed requirements under CMS-4105-P and in particular the two-step notice process in our view would, in addition to imposing significant administrative costs on hospitals, potentially undermine the partnership between caregivers, such as social workers and the patients and their families. This partnership is critical to produce the best possible clinical outcomes and to effect an optimal transition from acute to the next level of care. The second step that requires hospitals to provide written notice of discharge one day prior to discharge may suggest to patients that criteria for the discharge date was determined by the GMLOS or other financial considerations rather than medical/clinical criteria. Such a misunderstanding would change the dynamics of the relationship from collaborative to adversarial.

Regulatory Impact

Regulatory Impact

Patients already receive notice of their rights to appeal a discharge decision as prescribed by the Important Message from Medicare . Needing to provide a second notice is at best redundant and at the very worst intimidating to patients and their families. It is difficult to understand what can be gained by the second letter. It presumes that all patient discharges are predictable. Often the physician may be awaiting a laboratory result or other diagnostic indicator to make his or her final decision regarding discharge. Would we keep the patient in the hospital an extra day solely on the need to provide 24 hour prior notice? If a planned discharge needs to be postponed, do we issue another letter? How do we reassure the patient that his or her benefits will not be cut off?

Submitter : Sherri Hietbrink **Date:** 06/05/2006

Organization : Osceola Community Hospital, Inc.

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-360-Attach-1.DOC

Comments made regarding the Proposed Rule: Notification Procedures for Hospital Discharges

1. There is difficulty with anticipating discharge 24 hours in advance for every patient.
    a. Even with physician daily assessments that are completed on all patients; many medical patients are difficult to 'predict' as many factors weigh in on this decision.
    b. Physician communication to patient's and staff will be essential to try and capture the 24 hour window to comply with this proposed rule.
    c. Educating physicians and staff on this new rule and rationale will be an ongoing difficult process.
    d. Some patients, i.e. surgical for example, are easier to 'predict' discharge plans for; however there are situations that arise that will make it difficult if not impossible to predict discharge within 24 hours.

2. Estimate time projection of 5 minutes per generic notice is extremely unrealistic:
    a. In working w/a recent Medicare client, explanation of a Medicare notice involved 2 staff members (UR and SW) 45 minutes trying to explain/educate the patient on the notice.
    b. Education to Medicare clients on regulations becomes very involved and time consuming even with a 'simple and standard form'; This is for the average person; a person with disabilities will take much longer.

3. Estimate time projection of 60-90 minutes for a detailed notice/ information to the QIO is significantly under estimated:
    a. The Medicare review involving a QIO will take approximately 3-4 hours working with the family and physician.

4. Hospitals strive to provide quality health care, communicate effectively w/ patients and families; work to ensure patient safety and patient rights;
    a. Implementing something of this magnitude from the result of 1 lawsuit from 1993 involving Medicare Advantage plans is unrealistic and adds to the cost of health care.

5. Hospitals will be forced to be held financially liable for Medicare continued coverage of an individuals hospital stay during an appeal process and review.
    a. This will impact the Critical Access Hospital length of stay putting this status in jeopardy.

b. Medicare will incur additional expense when a patient requests an appeal as the patient is allowed to stay until the QIO review is completed.

Respectfully yours,

Sherri Hietbrink
Social Services
Osceola Community Hospital, Inc.
9th Avenue North
Sibley, Iowa 51249

Submitter : **Mrs. Krystal Nickelson** **Date: 06/05/2006**

Organization : **Coffey County Hospital**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

June 5, 2006

Re: CMS-4105-P Proposed Rule: Hospital Discharges, Notfication Procedures

As a discharge planner in a small rural hospital, I implore you to reconsider the passing of the proposed rule CMS-4105-P. There are several reasons that this rule will not contribute to the well-being of Medicare beneficiaries.

Delivery of the proposed notice would be a duplication of services, as patients already receive the "Important Notice of Coverage" given at the time of admission.

The estimated time of delivery of the notice is five minutes. I can assure you that with our most competent patients, the minimum delivery time will be 15 minutes. Unfortunately, most of our patients have an increasing amount of anxiety over the additional required paperwork associated with their hospital stay.

If patients are willing to sign additional documentation at all, they want family members present, or they request hospital staff return when family members are present to further explain the notices. This would be fine if most family members lived in town and were available at all hours of the day, but that is simply not the case.

We also have several patients with guardians and/or healthcare powers of attorney. Reaching these individuals for "delivery" can take hours out of the day, or even continue into at least the next business day. Therefore, the estimated delivery time is a far cry from reality. This obviously can add to a patient's length of stay.

If we were dealing with another insurance company other than Medicare, a patient's length of stay depends on medical necessity. If a patient cannot be safely treated as an outpatient, the attending physician will admit this patient to acute care. Once that physician determines acute care is no longer necessary, medical necessity ceases and a patient's objection to the impending discharge is irrelevant. Unfortunately, we have some patients, including Medicare beneficiaries, who like to stay in the hospital and will appeal the notice simply to delay their discharge. We also have family members who will appeal discharges because it will lengthen the family's "break" from caring for the patient in the home setting.

Acute care is quite different from skilled care or home health services. Acute patients require ever changing treatment, and predicting a patient's discharge would be impossible. If a physician is waiting on good lab results the next morning and receives them, the patient would be discharged home. A physician cannot guess the results ahead of time. Delivering the 24 hour notice upon receipt of good lab results would again lengthen the patient's stay, which could inadvertently expose the patient to additional illnesses in the hospital setting.

In our small hospital setting, I would not be able to deliver the proposed notices. We do not have true case management, and our UR Coordinator works the same days/hours that I work. Our nursing staff would be forced to deliver these notices, which would take valuable time away from direct patient care.

One suggestion that may actually assist Medicare beneficiaries in understanding their rights is this: Include a specific insert in beneficiaries Medicare handbook that highlights the important rights when a beneficiary is admitted to and discharged from a hospital setting. This would clarify the beneficiary's rights during a time when the beneficiary is ill and does not feel like learning about his or her Medicare rights. It would also be a quick reference in what beneficiaries feel is a "maze" of paperwork they receive via mail.

I thank you for considering all angles of the implementation of the proposed rule CMS-4105-P.

Sincerely,

K. Nickelson, LMSW

Submitter : Mr. Michael Rogers **Date:** 06/05/2006

Organization : MedStar Health, Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-362-Attach-1.DOC

MedStar Health

Michael C. Rogers
Executive Vice President
Corporate Services

June 5, 2006

VIA Electronic Transmission to www.cms.hhs.gov/eRulemaking

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-4105-P

RE: Medicare Program: Notification Procedures for Hospital Discharges; Proposed Rule: CMS-4105-P

Dear Dr. McClellan:

These comments on the above referenced proposed rule are submitted on behalf of MedStar Health and its affiliated organizations which include, among others, the Washington Hospital Center, Georgetown University Hospital and the National Rehabilitation Hospital located in the District of Columbia, and Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital in Maryland. MedStar Health is a private, non-profit organization with over 100,000 Medicare hospital inpatient discharges annually.

MedStar Health would like to focus comments on the impact of the 24 hour advance notice requirement of the proposed rule, and the regulatory impact that will result. The case management professionals at our hospitals believe that the 24 hour notice requirement will result in a large number of additional and mostly unnecessary patient days. The 24 hour requirement will also require far more additional staff time than CMS has anticipated. There are also significant downstream impacts affecting patient access. As a result, we believe that CMS has underestimated the regulatory impact on hospitals. We therefore suggest that the 24 hour requirement be eliminated or modified as described below.

24-Hour Provision of the Proposed Rule Will Result in Additional, Unnecessary Patient Days

The most significant concern from an operational/patient care point of view is the 24 hour notification requirement prior to discharge for the delivery of the generic notice. The 24 hour advance notice requirement provision requires that hospital staff accurately predict an acute care discharge 24 hours in advance so that the generic notice can be delivered one day prior. This prediction requirement in an acute care setting is very difficult, and will necessarily result in unanticipated discharges that do happen and thus must be delayed. Acute care hospitalization has a less predictable treatment course than other patient care facilities. While anticipating the date of discharge may be fairly routine for many uncomplicated surgical patients, it is very difficult for most

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phone: 410 772 6820 • *fax:* 410 715 3905 • *e mail:* michaet.c.rogers@medstar.net

of our medical patients and our complicated surgical patients. Our hospital staff conservatively estimate that it can accurately predict the discharges 24 hours in advance for most of the uncomplicated surgical patients, and about 40% of medical patients and the more complicated surgical patients. Given our mix of patients, this means that 25% of our Medicare discharges would not be accurately predicted, possibly as many as 50% by other estimates.

This will result in additional patient days that may not be medically necessary. For example, a physician decides that a patient can go home today, but this was not anticipated yesterday as a discharge by staff. Because the patient was not given the generic notice one day prior to discharge, the notice is given today, and patient must wait until tomorrow to be discharged. **Our hospitals conservatively estimate that this could apply to 20% of all Medicare discharges. This would result in about 22,000 additional patient days annually, just in our seven hospitals.** The cost of these patient days could be devastating.

In addition, coordination issues with the QIO will contribute to additional delays. The QIO has not traditionally been open on nights and weekends. An appeal of a discharge decision filed near the end of the 24 hour period might not be heard until the following day. If that is near the end of the day, it could add more than one day to the length of stay. Similarly, a Friday or Saturday appeal may not be heard by the QIO until Monday, increasing length of stay by more than one day. To minimize the impact on extended stays, the QIO would have to be available on evenings and weekends.

24-Hour Provision of the Proposed Rule Will Require Additional FTEs

As a result of the 24 hour requirement, additional staff time will be needed to handle the process and related paperwork, including tracking the planned and unplanned discharges, physician and staff education, and compliance monitoring. In addition, because discharges are difficult to predict, some anticipated discharges may not happen, and the generic notices that were delivered will have to be retracted. For example, a discharge is expected for the following day, and the Medicare notice is delivered to the patient. The patient's status changes, and the discharge is delayed. Because the patient will likely be concerned about payment for services being cut off, staff will visit the patient, retract the notice, and answer questions as needed to minimize patient anxiety. Our hospitals estimate that this could apply to 5% of all Medicare discharges. Multiple notices provided to patients within a very short time frame will require careful follow-up. Many hospitals will not be able to impose these requirements on already overburdened nursing staff, and will instead use dedicated staff for the notifications as well as the administrative duties. **For the larger hospitals with a significant Medicare population, we estimate two dedicated FTEs will be needed.**

Other factors support our belief that dedicated FTEs will be required rather than marginal nurse staff time, as long as the 24 hour requirement remains part of this proposal. We believe that a number of patients will require more staff time than that estimated, such as patients with dementia, those that do not have family to help with explanations, and those that request additional information before making a decision about an appeal. In addition to the 2% of patients that will appeal the discharge decision, another 2% might request additional information but not follow up with an appeal. Finally, our hospital staff believe that the estimate of 2% appeals, while reasonable, is conservative, and could be as high as 4%.

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24-Hour Provision of the Proposed Rule Will Impact Patient Access

Another important concern is the downstream impact of these extra patient days on access to other services. One major reason for emergency department overcrowding is the lack of inpatient beds during peak census times. Thus, admissions from the emergency department will be affected by the additional Medicare patient days, and ambulance diversions could increase. Also, discharge planning is often time sensitive and will be impacted by this requirement. Because there is often a narrow window of opportunity for placement of the elderly in other settings such as skilled nursing facilities, discharges delayed by a day or more may disrupt these placements, affecting the hospitals, our patients and their families, as well as the availability of those placements. Long term care facilities will simply take another patient off their waiting list.

Regulatory Impact

CMS bases its estimate of the regulatory impact on hospitals on these assumptions: (a) 5 minutes for delivering the generic notice to all Medicare discharges, (b) 90 minutes to fill out and deliver a detailed notice to (c) two percent of the beneficiaries and enrollees that will appeal or ask for additional information, (d) at a cost of $30 per hour incremental staff time, and (e) 6,000 affected hospitals. The result is a national impact of about $42,500,000. However, the regulatory impact is far greater than CMS suggests, when considering the effect of the additional patient days from the 24 hour notice requirement, and the dedicated staff that would be required in many hospitals. At MedStar Health's six acute general hospitals alone, 12 dedicated FTEs and 22,000 additional patient days at $1,000 per day is well over $22 million. Nationally, based on a conservative estimate that one FTE per hospital in 6,000 affected hospitals would be needed (two in larger hospitals, while in smaller hospitals the CMS assumption using marginal nursing time for administering these notices might be appropriate), shows that the CMS estimate of $42.5 million is grossly underestimated. Adding the impact of the additional patient days incurred for 20% of 12.5 million discharges, at a cost of $1,000 per day, would be staggering.

Recommendation

MedStar Health recommends that the 24 hour advance notification requirement be eliminated, and the generic notice delivered in another way. The 24 hour advance notification requirement could be eliminated if the generic notice can be delivered in another way to inform beneficiaries of their rights in a more appropriate setting. Elderly patients, often on pain medication and other drugs in the 24 hour period prior to discharge from an acute hospital stay, may actually be unfairly burdened with the timing of this information. Medicare should instead consider delivering this information well in advance through one or more means. A reminder could be provided at the time of admission, at the same time as the "Important Message from Medicare", with a discharge sheet reviewing their appeal rights and responsibilities, with names of people to contact once the discharge notice is provided, and informing them that they may have only a short time to decide on the appeal. Having patients or family sign for the receipt of the this information would ensure that the message was delivered. Given the usually short time frame of hospital admission, there is considerable benefit to consolidating messages. A public educational campaign directed to all beneficiaries that focuses on the rights of beneficiaries upon discharge could also prepare beneficiaries by

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notifying them of their rights at a time more conducive to understanding and discussion with family. Alternatively, a four hour advance notice rather than the 24 hour advance notice requirement, combined with the notice on admission, could help reduce the negative impact of the proposed rule.

MedStar Health believes that another method of informing beneficiaries of their rights would continue to address a beneficiary's need to be informed about appeal rights, in a more appropriate manner and time, and avoid the burdens on hospitals, patients and their families imposed by the proposed approach. Providing for the unique needs of hospitalized patients, keeping their length of stay as short as possible, and informing them well in advance of their discharge rights at admission rather than waiting until just before discharge, is more helpful to beneficiaries than is providing uniformity in process between hospitalized patients and other provider types.

Sincerely,

Michael C. Rogers
Executive Vice President, Corporate Services

cc: Kenneth A. Samet
Michael J. Curran
Lawrence M. Beck
James F. Caldas
Joy M. Drass, M.D.
Edward A. Eckenhoff
Joseph M. Oddis
Harrison J. Rider, III
Carl J. Schindelar

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Submitter : Ms. Laura Jensen **Date:** 06/05/2006

Organization : St. Croix Regional Medical Center

Category : Critical Access Hospital

Issue Areas/Comments

GENERAL

GENERAL

The proposed rule requiring a one day notification for discharge seems to be unreasonable and impractical. Acute care patients freqently have medical conditions that can change rapidly, making it difficult to predict discharge with certainty one day in advance. Typically we begin working on discharge plans very soon after admission and work very diligently on involving the patient and family in the formation of tentative discharge plans. Our average LOS is 2.5 days and this seems to be an unnecessary step. I also feel that the time estimates are severely understated. Thank you very much for your careful consideration on this important matter.

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

Organization : **Trinity Health**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached

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

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

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

Submitter : **Mrs. Sharon Johnson** **Date: 06/05/2006**

Organization : **Western State Hospital**

Category : **Psychiatric Hospital**

Issue Areas/Comments

GENERAL

GENERAL

To Whom It May Concern,

Members of our Utilization Review Committee have reviewed the proposed ruling and have discussed it during a regularly scheduled Medicare Compliance Meeting.

It is our opinion that the proposed ruling would have no significant meaning or serve any purpose for the patient population we service within our state psychiatric facility. The proposed ruling as drafted appears to be appropriate for medical acute care units and psychiatric units in private pay settings. Consideration has not been given to the levels of care and type of population served by a state psychiatric facility. A Medicare pay patient is provided with an "Important Message from Medicare" upon admission, which clearly outlines their appeal rights. Additionally, a HINN is provided to the patient when the level of service no longer meets the Medicare guidelines/criteria. Requiring a two step procedure seems redundant and unnecessary in our hospital setting.

Thank you for allowing me to comment.

Submitter : Mr. David Burd **Date:** 06/05/2006

Organization : Nebraska Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-366-Attach-1.DOC

NHA Nebraska Hospital Association

June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

On behalf of the Nebraska Hospital Association (NHA), its 85 member hospitals, and the 36,000 individuals we employ, I appreciate the opportunity to comment on the proposed rule concerning the notification procedures for hospital discharges. The proposed rule would require hospitals "to provide a standardized notice on the day before the planned discharge from any inpatient hospital stay." This new notice would be in addition to the Important Message from Medicare (IMM) given at admission, which already provides an explanation of Medicare discharge appeal rights.

The NHA believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. The NHA does not believe CMS should proceed with these changes without conducting a more extensive analysis of the current processes. A stronger case justifying the need for the proposed changes should be developed before proceeding.

This letter includes our comments on several issues contained within the proposed rule.

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

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

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

Background
Hospitals are already following a two-step process for notifying Medicare beneficiaries of their appeal rights by providing the IMM at admission and a detailed notice when a beneficiary believes he or she is being asked to leave the hospital too soon. This new notice would create a three-step process. For an average Medicare length of stay in Nebraska of 5.3 days, a three-step process is unreasonable. Congress required the IMM so that beneficiaries would know their discharge rights at admission and in anticipation of "quicker and sicker" discharges under the inpatient prospective payment system (IPPS) – an expectation that did not materialize. Furthermore, the timing for hospital discharges and, therefore, the potential subject of an appeal or Quality Improvement Organization (QIO) review, generally concerns the length of the beneficiary's stay related to medical necessity, not availability of hospital benefits.

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

There are several problems with the proposed approach.

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

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

- By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer

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

To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost eighty thousand hospital admissions in Nebraska a year, an extra inpatient day for each admission at an approximate cost of $1,780 per day would impose a significant burden on hospitals. Many patients would be compelled to stay in the hospital when they are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty.

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

Collection of Information and Recordkeeping Requirements
The notice's language and the process for preparing, delivering and documenting receipt are problematic. Some of the troubling requirements include:

- At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless. The proposal would require that the beneficiary or a representative sign a copy of the discharge notice documenting its receipt and their understanding of it. The hospital would be required to maintain a hard copy, with no provision included for electronic alternatives.

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

likely encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based on medical necessity.

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

- The estimated cost and burden of the proposal is greatly understated. The proposed rule states "we estimate that it would take hospitals 5 minutes to deliver each notice." However, this does not include the time needed to explain the notice or why it must be signed. It also does not reflect the additional time and effort required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent. Nor does it reflect the manpower and capital costs to maintain hard copy files of the signed copy for eighty thousand or more admissions a year for an indefinite period of time. The most significant cost, however, is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge. Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals for the reasons cited above.

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

The NHA appreciates the opportunity to comment on this proposed rule. To discuss any questions, please contact David Burd, Director of Finance, at (402) 458-4904.

Sincerely,

Laura J. Redoutey

Laura J. Redoutey, FACHE
President

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

Organization : IPRO

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-367-Attach-1.DOC

#367

IPRO Experts in Defining and Improving the Quality of Health Care

VIA ELECTRONIC MAIL

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

<http://www.cms.hhs.gov/eRulemaking>

Re: Proposed Rule Regarding Notification Procedures for Hospital Discharges

Dear Mr. McClellan:

We are writing in response to the Proposed Rule (PR) published by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, regarding the Medicare Program; Notification Procedures for Hospital Discharges (71 Fed. Reg. 17052-17062, April 5, 2006). IPRO is the health care review and quality improvement organization that serves as the Medicare Quality Improvement Organization (QIO) for the State of New York. We are concerned in particular with two aspects of the regulation: accomplishing the transition to the new requirements without undue disruption and the means of delivery of the notice. Our comments follow.

PROVISIONS OF THE PROPOSED RULE:

We appreciate the agency's goal of seeking to design a hospital notice procedure that satisfies the beneficiary's need for information about his or her appeal rights without imposing unnecessary burden on the hospital. Nonetheless, the requirements would create some additional burdens for hospitals, by imposing upon them a new task that they do not currently perform, *i.e.*, the issuance of the detailed notice. The PR would also increase staffing and coverage requirements for both hospitals and QIOs on the weekends because of the need to process appeals seven days a week, requiring additional rotating staff. Staffing needs will also increase, although it is not clear to what extent, due to a projected increase in the number of appeals that will be filed.

We respectfully request that CMS acknowledge the magnitude of these changes by allowing ample lead time for hospital and beneficiary training and for staffing adjustments at both hospitals and QIOs. We suggest that an effective date at a minimum, at least three months after issue of the Final Rule would be warranted. We

IPRO

note that the QIOs are uniquely situated to assist in training the hospitals and beneficiaries because of the relationships they have developed with hospitals within their geographic area and their past performance of beneficiary outreach under the QIO program. Of course, all additional effort under the QIO contracts should be appropriately funded.

As a preliminary matter, we are concerned about the interplay between the new requirements and some of the current requirements. Please confirm that we are correct in our interpretation that there is no change in the appeals process for admission denials. Please clarify whether the current requirement for a hospital to send a QIO a copy of a Hospital-Issued Notice of Noncoverage within three days of issue will be eliminated.

Section 402.1205 (b)(1) would require hospitals to deliver the notice on the day before discharge. We submit that a hospital should be permitted to issue the discharge notice sooner when possible, up to three days before the end of Medicare-covered services.

Section 402.1205 (b)(3) would require actual physical delivery of the generic notice of non-coverage to the beneficiary or its representative. Experience has shown that in some cases, when the beneficiary's representative is disinclined to receive actual notice, it may be difficult and labor-intensive to ensure that the notice is actually delivered. The regulation should recognize and address this difficulty by defining what will constitute reasonable and sufficient attempts at actual delivery or by permitting actual or constructive delivery. This could be done by recognizing that where a hospital has made reasonable attempt to deliver the notice, actual delivery will be presumed. We suggest that the acceptable methods for delivery of the notice to the beneficiary's personal representative should be expanded to recognize additional means of delivery such as express mail (*i.e.*, Federal Express) and facsimile, as long as there is documentation in writing of the transmission.

We appreciate your consideration of these comments.

Very truly yours,

/s/

Andrea Goldstein
Vice President, Medicare/Federal Health Care Assessment

Submitter : Dr. Michael Unger **Date:** 06/05/2006

Organization : Community Memorial Hospital

Category : Physician

Issue Areas/Comments

Background

Background

The Regulatory Implications are significant for both physicians as well as hospitals. Firstly, this will actually increase overall costs as physicians will not be able to discharge patients when the decision is appropriately made on a clinical basis typically currently the same day as the decision is made. Therefore, the vast majority of patients will be forced to sit an additional 12 to 24 hours in the hospital to fulfill the regulatory requirements. Patient dissatisfaction will like increase.
Secondly there are already adequate mechanisms in place to allow patients the opportunity to dispute an anticipated discharge with their physicians as well as the hospital. The benefit of an additional 12 to 24 hours to "think about it" is clearly not balanced by the likely increased costs and need for more bureaucacy to implement and manage these proposed changes which we (Government, Providers and Patients)would have to bear.
Thirdly, I believe that the estimates regarding time and expense on the part of hospitals to enact this proposed rule change are at best very conservative and likely not accurate. This will greatly increase costs to hospitals already under stress with decreasing reimbursements from payors including Medicare.

GENERAL

GENERAL

As noted above...If this proposed rule is enacted, patient and physician dissatisfaction will increase. In addition, the cost of providing care will likely increase significantly. Please do NOT enact this proposal.

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Submitter : Ms. Amy Shideler **Date:** 06/05/2006

Organization : The Toledo Hospital

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

While I think the patients and family have a right to notification of discharge and reasons associated with that, I do feel that the method of notification maybe combursome in actual practice. During most hospitalizations, it is difficult to determine the course of stay based on the human factor associated to illness. Discussion of discharge with a patient begins during the initial intereaction with families/patients as is the role of discharge planning social workers. Most patients do not want to be in the hospital and therefore are often pursuing discharge as soon as they are admitted. There are some patients and families who are going to want to stay longer in the medical setting than most and for them they will likely benefit from home care, rehab services, or ECF.

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : **Ms. Teena Keiser** **Date: 06/05/2006**

Organization : **UnitedHealth Group**

Category : **Health Plan or 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 : Mr. Ronald Grousky **Date:** 06/05/2006

Organization : Mayo Clinic

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-373-Attach-1.PDF

Attachment
#373

MAYO CLINIC

June 5, 2006

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

RE: Medicare Program; Notification Procedures for Hospital Discharges

Dear Dr. McClellan:

We appreciate the opportunity to comment on this proposed rule.

We oppose the addition of a Discharge Notice to inform patients of their appeal rights because it duplicates the information patients already receive in the Important Message from Medicare (IM). Thus, it does not provide any additional benefit and would likely cause unnecessary anxiety to patients. In addition to being redundant, the proposed requirement is overly burdensome to hospitals. We believe the cost would be significantly greater than the cost estimate in the Proposed Rule. The Proposed Rule estimates five minutes to deliver the Discharge Notice; a more realistic estimate is at least 30 minutes, to allow time for staff to explain the Notice and to obtain the patient's signature. There would be additional time and cost associated with filing and retaining the signed document, submitting medical records (by fax or courier), and coordinating subsequent communications between the hospital, the QIO, the patient and the physician. Lastly, we feel the Discharge Notice, proposed as "Notice of Hospital Non-Coverage," will cause unnecessary anxiety to patients about whether Medicare will pay for their entire hospitalization or not.

As an alternative, we recommend that CMS consider some improvements to the current process, in order to standardize and increase efficiency. A more favorable option might be to expand the use of the IM to include Medicare Advantage patients and implement a standard detailed notice of non-coverage (one similar to the Proposed Detailed Notice). We believe patients and hospitals would benefit from the use of a single standard notice, replacing the various Hospital-Issued Notice of Non-coverage (HINN) letters currently used when patients dispute a discharge decision. The use of a single notice, by both original Medicare and the Medicare Advantage plans, would increase the likelihood of patients' understanding of the contents of the notice and provide some administrative relief to providers.

In the event that the Discharge Notice Procedure must be implemented, we offer these suggestions for your consideration.

- We are concerned about the impact the Discharge Notice process could have on hospital operations. It seems likely that this could increase lengths of stay, thereby limiting bed availability to incoming patients. Increased lengths of stay would result from patients waiting until noon the next day to initiate a review, or, from the time needed for the exchange of information between the hospital and the QIO. We recommend that patients be encouraged to request a review as soon as possible. When the Discharge Notice is given early in the day, the patients' timeframe for requesting a review should be the same day or an earlier time on the next day, 10:00 a.m., rather than noon the next day. In addition, the QIOs may need to offer expanded service hours and days, to assure timely responses to patient requests.

- The Proposed Rule requires that the Discharge Notice be given one day prior to the planned discharge date. There must be recognition that the decision to discharge cannot always made prior to the day of discharge. Any notification rules must accommodate this reality. That is, patients should not remain in the hospital unnecessarily (past the point of medical necessity), due to discharge notice rules.

- The Discharge Notice should not be required for lengths of stay less than five (5) days. Our rationale is that the IM at admission should suffice for short stays, and, that additional notice should only be required for longer stays.

- The language of the Notice should be changed to avoid confusion between non-coverage of the entire hospitalization and non-coverage from a certain point in time, if the QIO agrees with the hospital and/or physician.

- Lastly, we note that vendor software supporting bed occupancy in hospitals may need to be modified to support these requirements. Bed management software usually allows for tracking of "today's" discharges, but not for tracking "tomorrow's" discharges. Large hospitals will likely need automated support for the Discharge Notice process. Sufficient time for the necessary software changes must be allowed between final rule publication and implementation dates.

Thank you for your consideration of our comments. If you would like to discuss them, please contact Lynette Beck at 507-284-1935.

Sincerely,

Ronald W. Grousky
Director
Medicare Strategy Unit
Mayo Clinic

Submitter : Mr. Kurt E. Johnson **Date:** 06/05/2006

Organization : Ingalls Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-374-Attach-1.DOC

INGALLS HEALTH SYSTEM

Ingalls

ONE INGALLS DRIVE
Harvey, IL 60426
(708) 333-2333

Attachment #374

June 5, 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

We are writing on behalf of Ingalls Memorial Hospital ("Ingalls") and its Medical Staff. Ingalls is a 563-bed general acute care hospital located in Harvey, Illinois, with an organized Medical Staff of approximately 425 physicians. 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. Ingalls appreciates and understands the CMS quest for uniformity, as

well as the legitimate desire to fully protect the rights of the Medicare beneficiaries, and we agree with these goals; however, we think the CMS rule could be designed in a manner as to achieve the same goals (uniformity and notice) while not unnecessarily extending length of stay and over-burdening staff. Of great concern to Ingalls (as a hospital with approximately 45% Medicare patients) is the potential, due primarily to social and family issues, for patients and family members to "game" the system and extend their stay in the hospital a day or longer because they have no disincentive not to do so.

Background

Ingalls Current Process

Ingalls currently delivers the "Important Message from Medicare" to all Medicare beneficiaries at the time of admission, and provides a hospital-issued notice of non-coverage (HINN) to beneficiaries in the original Medicare program who are dissatisfied with a pending discharge. For 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.

Comments

The current process was designed to inform beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services. Congress specifically required the "Important Message from Medicare" to ensure that Medicare beneficiaries know their discharge rights, and it has worked well.

Individual patient discharge decisions are made by the attending physician responsible for the patient's care, but 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. At times, the physician is reluctant to discharge a patient, or the patient's family is reluctant to make a decision regarding post-acute care. Sometimes putting a mother or father into a long term care facility can be a traumatic experience. Decisions get delayed due to social and family factors. The HINN has been effective in prompting action by both the physician and the patient's family in certain circumstances. We are extremely concerned that the new rule will provide the opportunity to buy time and delay discharge when no legitimate basis for appeal exists. We see such delays happen all the time now, and we are concerned the proposed process would only increase such delays.

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 reasons that beneficiaries in an inpatient hospital setting should have the "same notice of appeals 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). **Discharge could be delayed at least one full day just to give the notice.**

Comments

The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not well suited for the acute care hospital setting. The current process, however, does work well, and CMS has offered no compelling reason, other than uniformity, for standardizing the process. 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.

Acute care hospitals have a short length of stay, which continues to decline. Because of a short length of stay, discharge planning in a hospital setting frequently begins at the time the Medicare beneficiary is admitted; however the actual discharge time is sometimes not known until the day of discharge, due to lab test results or other factors that change rather quickly.

The proposed discharge notice process is not consistent with the timing of physician decision-making and with hospital operations. The generic notice erroneously indicates that the hospital 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 has determined that Medicare coverage for the

hospitalization "should end." The language is potentially misleading, so that the patient could assume the hospital has made the discharge decision, not the physician. 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 could 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. 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. It is not possible to accurately identify the date of discharge one day in advance for every Medicare patient (and remember 45% of our patients are Medicare beneficiaries).

The proposed generic discharge notice invites longer lengths of stay, thus consuming valuable hospital resources. 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 a possible financial penalty to the patient, 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 when a difficult social, or personal situation exists.

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.

Recommendations

First, Ingalls asks that CMS not implement the proposed discharge notice procedures as currently described. Before making any changes to current hospital procedures for notifying Medicare beneficiaries of their appeal rights, CMS needs to better understand hospital operations and the burden the proposed requirements may impose on hospitals in increased length of stay.

Ingalls would be happy to participate in 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, operations and beneficiary rights.

Sincerely,

Kurt E. Johnson
President and Chief Executive Officer

Dr. Bohdan Iwanetz
President of the Ingalls Memorial Hospital Medical Staff

cc: American Hospital Association
Illinois Hospital Association

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-375-Attach-1.PDF

Attachment #375

Finance

23400 Michigan Ave.
Suite 900
Dearborn, Michigan
48124

313.586.5303

Oakwood

June 1, 2006

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

Re: ***Medicare Proposed Discharge Notice***
CMS-4105-P

Dear Dr. McClellan:

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

Background

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

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

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

Intent of the Proposed Rule

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

Increased Administrative Burden

The proposed policy would create an additional administrative burden for OHI to develop a process for determining the discharge date and communicating it to the patient, physicians, and discharge planning staff. In its estimated regulatory impact, the CMS only included the time it would take to deliver a notice to each inpatient, estimating this would take 5 minutes per patient and 60-90 minutes for each patient that appeals the discharge decision. The CMS estimate does not include time required to prepare the notice, explain the notice or why beneficiaries have to sign for it. In addition, it does not reflect the staff time and capital costs incurred by hospitals to maintain hard copy files containing the signed copies for all Medicare admissions. There are approximately 25,700 Medicare inpatient discharges throughout OHI on an annual basis.

Predictability of Discharge Date

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

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

Discharge Decision

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

Timing of Notice

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

Impact on Hospital Length of Stay (LOS)

If OHI kept 10 percent of its estimated 25,700 annual Medicare patients an additional day and 2 percent of Medicare patients an additional 3 days due to appeals, OHI would experience an increase in length of stay of 4,112 days, with no additional Medicare payment. In its proposal, the CMS failed to consider the potential impact on LOS, and additional cost to hospitals, which is a significant concern. During a time when over 50 percent of Michigan hospitals already lose money providing care to Medicare beneficiaries, an increase in LOS would further threaten the financial viability of OHI and patient access to care. In addition, this notice could impact quality outcome reporting, public reporting and potentially pay-for-performance reimbursement since it would increase the length of stay.

Electronic Health Records

The proposed policy would require manual signatures by Medicare beneficiaries or their representatives, documenting its receipt and their understanding of it. This requirement is contrary to the CMS' desired movement to electronic health records. The paperwork clearance package submitted by the CMS to the Office of Management and Budget (OMB) indicates that it must be provided and maintained in hard copy and that they are not making any provision for electronic alternatives.

Summary

In conclusion, OHI strongly opposes this policy due to its significant impact on hospitals and Medicare beneficiaries. As indicated above, **OHI cannot support the proposed policy due to the:**

- impact on hospital length of stay which will have a negative financial impact for hospitals and likely result in bed shortage issues for hospitals where occupancy levels are high
- increased administrative burden on hospitals
- inability to predict discharge date 24 hours in advance, prior to having patient test results and monitoring the patient's specific medical condition and response to treatment
- fact that the physician, **not the hospital**, is solely responsible for the discharge decision
- confusion it will cause for Medicare beneficiaries, which will increase distrust
- fact that it is contrary to the CMS' desired movement to electronic health records

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

Again, OHI appreciates this opportunity to provide comments to the CMS regarding this proposed discharge notice. We believe that, with the incorporation of our suggested recommendations, Medicare beneficiaries will be able to receive the information they need regarding their discharge from the inpatient hospital setting without undue administrative burden or the potential increase to a patients' length of stay. If you have questions on this comment letter, please contact me at (313) 586-5303.

Sincerely,

Robert Plaskey
Corporate Director, Reimbursement

Submitter : Mrs. kathleen linkiewicz **Date:** 06/05/2006

Organization : saint margaret mercy hospital

Category : Nurse

Issue Areas/Comments

Background

Background

This will be a financial burden for the hospital due to the need to increase staffing the casemanagement/discharge planning department 7 days a week to meet this requirement.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

hospitals have short term relationships with patients compared to homecare or hospice agency. This notice is not realistic nor needed in the inpt hospital setting since we work with our patients and families from point of entry in the hospital setting.
-Physicians do not alway know when they are going to d/c a patient-this is at times determined by labs results or last minute plans with family or patient.
-Patient and families are not always cooperative with discharge planning like not return calls or refuse to leave, by asking the hospital to issue these letters could result in delayed discharge when patient is medically ready.

Submitter : Ms. Olivia Wong Kubasik **Date:** 06/05/2006

Organization : District of Columbia Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-377-Attach-1.DOC

Attachment #377

DCHA
District of Columbia
Hospital Association

1250 Eye Street, NW • Suite 700 • Washington, DC 20005-3930
Tel: (Office) 202/289-4925 • (Cell) 202/528-2721 • Fax: 202/371-8151 • E-mail: okubasik@dcha.org • Web: www.dcha.org

June 5, 2006

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

Dear Sir/Madam:

CMS has proposed regulations calling for all original Medicare and Medicare Advantage patients to get a "generic hospital discharge notice" that should be issued the day before discharge and that informs the patient/family that Medicare benefits will be terminated for the current hospital stay on the following day. If the patient or family representative does not believe that the patient is ready for discharge, the patient/family can appeal the discharge decision to the QIO. The discharge and therefore financial liability will be delayed until the QIO's decision is made.

As with the proposed rule issued in the Federal Register on January 24, 2001 (66 FR 7593), we anticipate this new requirement will be a significant administrative burden on hospitals in a health care environment that has many situations that can make determining a definitive date of discharge extremely difficult. Our hospitals are encouraged to use InterQual's Acute Level of Care Criteria to evaluate the patient's clinical presentation, monitoring and therapeutic services, and clinical stability appropriate for discharge. We are frequently unable to anticipate 24 hours in advance of when the patients will be clinically appropriate for discharge from an acute care setting. Some of our hospitals estimate that they would not be able to predict at least 20% of their daily Medicare discharges. If this resulted in 10 to 20 patients not being discharged and we conservatively estimated an additional costs at $1,000/day per patient, the lost revenue and additional costs to our DC hospitals would be in the millions of dollars. With many of these hospitals are already on the margin financially, this can have a devastating impact.

Below are some examples where it may be difficult for our hospitals to comply with the requirements of this proposed rule. We would like to get further clarification on what will be the expectation by hospitals in these circumstances realizing that many of these examples present an additional financial cost that hospitals will incur as a result.

Example #1: An elderly patient, who just had a total hip replacement 3 days ago, is scheduled for discharge tomorrow. Someone is going to deliver a "generic hospital discharge notice" that as of tomorrow Medicare would no longer cover the patient's hospital stay but, if the patient does not believe he/she is ready for discharge, the patient can appeal the decision to the local QIO. If patient appeals decision, discharge could be delayed 2 days. If the patient were to go to a rehabilitation facility, those plans, too, would be put on hold. The hospital would incur the additional cost of this additional patient day.

Example #2: A patient received notice yesterday that physician planned to discharge patient today. Yesterday, the patient received the notice. Today patient had a temperature and physician now does not want to discharge patient. In this circumstance, it is unclear what the process would be for informing the patient of the retracted notice.
In addition, the notice will need to be re-issued later when patient again to be discharged. All of this will need documentation by a hospital staff person.

Example #3:
Most patients who are hospitalized for uncomplicated surgical procedures are generally prepared for the discharge date and would not contest the discharge.

However, it is very difficult to predict the exact discharge date for most of our medical patients and our complicated surgical patients. An example of this would be a patient with severe congestive heart failure requiring careful fluid management. A discharge decision is difficult because of the precariousness of fluid balance. A physician may be very concerned and decides to add another drug and monitor the patient over night because the physician is unsure if the patient can go home. But when the physician comes in the next day and decides that the patient can indeed go home, the patient is covered by Medicare and has to get notice one day prior to discharge. So, the notice is given and patient stays an extra day per Medicare protocol.

Example #4: A patient comes to the hospital from a nursing home and has dementia. The family will have to be contacted about the discharge notice that is not a problem if they are involved, but many of these patients' families are difficult to contact.

Example #5: In situations where patients are scheduled for 1-2 stay hospitalizations, there is a lack of clarity in whether or not hospitals will need to provide these patients notices upon admission?

The District hospitals have a large Medicare population. With tens of thousands of Medicare patients that are treated annually, each one of these patients will need a notice of discharge letter 24 hours in advance. Evening, weekend and holiday discharges will be especially problematic because of lower staffing levels. The hospital will need to

engage additional staff to keep up with the notices - neither Nursing nor Clinical Resource Management/Social Work departments will be able to support this volume with deliveries and subsequent appeals and retractions. In addition to the extra time it will take to deliver each notice, explain each notice, and obtain a signature on each notice (taking at least 15 – 30 minutes per notice depending on the patient's capabilities), it will take as much time to explain the advance notice process to each physician for each notice.

We also anticipate that with a new Medicare regulation, we will be monitored so during the first year our hospitals will expect to be audited with reports to which, if compliance is found lacking, will require additional response and documentation.

There has been some discussion among our hospitals about alternatives that would be less burdensome on hospitals such as having patients sign the "Important Message from Medicare" information or another way of delivering this notification upon admission or another consistent point in the patient care process.

Here are some additional areas to consider that were submitted by various member hospitals:

1. What impact will a two-step notification process have on a patient in observation status, but then converts to an acute care admission by the second day? Will an additional day be added to facilitate a notice 24 hours prior to discharge? (Example: a Laminectomy was required).
2. Some surgical patients with relatively short length of stays (joint replacement) are often receiving pain medication 24 hours prior to discharge. What degree of understanding/comprehension is feasible for such surgical patients? Family and or POAs are often involved but not available at the time when the notice should be delivered.
3. This process and information is too complicated for the elderly patient. They are just trying to comprehend the New Medicare D benefit. Consider a simpler approach: Medicare patients could receive, at the time of admission, a discharge sheet reviewing their "rights".
4. Require all Medicare participating physicians to have an information packet that describes their rights and the function of the QIO.
5. Could Medicare provide public service announcements that focus on beneficiary rights rather than handing them letters?
6. During a health care provider current and projected shortage, who will be realistically available to distribute these notices 7 days a week?
7. How do we handle the case in which the patient is ready for discharge and return to a nursing facility, however a bed is not available at the facility when the 24 hour notice of discharge is to be given?
8. With the addition of this notice and additional steps in the discharge process, there is concern over a greater chance for process breakdown.
9. What educational tools are available to convince the physicians to communicate to the patient and hospital staff 24 hours in advance of a discharge?
10. Will this process not ultimately penalize the hospitals, as they will need to delay many discharges by a day in order to provide 24 hour notices?

Thank you for the opportunity to provide these comments. If you would like to discuss these comments with us further, please feel free to contact me at (202) 289-4925 or by email at okubasik@dcha.org.

Sincerely,

Olivia Wong Kubasik

Olivia Wong Kubasik
Vice President for Policy Development
District of Columbia Hospital Association

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

Organization : **DMC-Huron Valley Sinai Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

The Proposed rule (66 FR 7593) should not be made final. It does not meet the goals set forth to increase beneficiary inofrmation while not overburdening hospitals. In practice, it does not provide any additional information or substantive improvement in the information already recieved by Medicare beneficiary's on admission, regarding their rights to appeal. It creates a real financial and administrative burden for hospitals and may potentially adversley effect the satisfaction and confidence Medicare beneficiary's have in their health care institution.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The proposed rule (66- FR 7591) establishes a 2-step process for hospital discharges similar to that used by HHA s, SNF s, CORF s and hospices for upon termination of Medicare covered services, with the assumption that this would be helpful to beneficiaries and provide for expeditious review to which Medicare beneficiaries are entitled. The proposal requires hospitals deliver a standardized, largely generic notice of non-coverage to each Medicare beneficiary whose physician concurs with discharge on the day before the planned date of discharge, to allow the beneficiary at least one night to consider the discharge plan and need to appeal it.

The stated goal of this proposed rule is to design hospital notice procedures that balance a beneficiary s need to be informed about his or her right s without imposing unnecessary burden on hospitals. As described, the proposed 2-step notice process would pose financial and administrative burdens for hospitals and does not provide additional information on appeal rights or more expeditious review by the QIO for Medicare beneficiaries. It is just a repetitious notification process that will service to create barriers between hospital personnel and Medicare beneficiaries pending discharge. The proposed rule fails to meet its goal on both counts.

Current processes provide detailed notice of appeal rights to beneficiaries upon admission. Contained within this notice is information the beneficiary needs to know to appeal care and coverage decisions. The proposed 2nd notice adds no new information. Further, processes exist for patients to appeal discharge decisions via HINN and NODMAR. The proposed procedure offers no new information to beneficiary. It serves only to remind them of appeal rights at the time of discharge.

In hospital settings, length of stay is often shorter than three days. In fact, Medicare encourages expeditious discharges. Under the provisions set forth in this proposed rule, the patient could potentially receive and admission notice of rights and a discharge notice of appeal rights in the same day. The administrative challenges of this proposal make that a likely scenario. The potential to add days to an inpatient stay due to difficulties in patient comprehension of these rights, finding family members to communicate with, and individuals who will use this process as a stall tactic to avoid discharge are great and would be financially burdensome to hospitals. Customer satisfaction will likely suffer as a result of this process, indirect costs and increased staffing requirements will increase as well.

In conclusion, this proposed rule will prove to be over burdensome administratively and financially for hospitals and frustrating for both hospital personnel and Medicare beneficiaries that do not understand the language or the purpose of the notice.

Regulatory Impact

Regulatory Impact

The April 4, 2003 final rule (68-FR 16652) published in the Federal Register, required Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF), to comply with a 2 step process for notification of termination of Medicare covered services.
When covered services in the aforementioned organizations, it represents the end of supervised care and evaluation options for Medicare beneficiaries. The requirement for notification of termination of services in this instance, provides an opportunity for the beneficiary to have the readiness for termination of service re-evaluated based on the input of the beneficiary and care provider.
Discharge from a hospital setting does not present this circumstance. When a Medicare beneficiary is discharged, or when termination of covered services occurs, the option for continued evaluation and treatment exists with the organization listed above. The requirement for a second notice of appeal rights does not serve the same purpose in the hospital setting as it does with HHA s, SNF s, CORF s or hospice care, because the opportunity to continued care provision exists. Further, there is an existing first notice of appeal and requirements for issuance of Hospital Issued notice of Non-coverage (HINN) and Notice of Discharge and Medicare Appeal Rights of Non-coverage (NODMAR) for use by beneficiaries that disagree with discharge decisions. Therefore, the addition of the second mandatory notification will be extraordinarily burdensome on hospitals administratively, increase length of stay and nor provide commensurate assistance to Medicare beneficiaries to make this process meaningful.

Submitter : Pamela Greenberg **Date:** 06/05/2006

Organization : American Managed Behavioral Healthcare Association

Category : Health Plan or 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 : Mrs. LYNN HERNDON **Date:** 06/05/2006

Organization : COBB MEMORIAL HOSPITAL

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

JUST DO NOT UNDERSTAND WHY THIS WOULD BE BENEFICIAL TO ANYONE, JUST ANOTHER FORM TO BE DEALT WITH; ARE THERE PROBLEMS WITH PATIENTS BEING DISCHARGED FROM ACUTE INPATIENT HOSPITALS TOO SOON? (? ONLY IN THE BEGINNING OF "DRG" ERA). THIS SOUNDS LIKE ANOTHER FORM FOR THE
GERIATRIC POPULATION TO SIGN WHICH IN NO WAY WILL IMPROVE THE QUALITY OF CARE THEY RECEIVE.

Submitter : Ms. Teena Keiser **Date:** 06/05/2006

Organization : UnitedHealth Group

Category : Health Plan or Association

Issue Areas/Comments

Background

Background

Subject: CMS Proposed Rule regarding a two-step notification process for hospital discharges that is similar to the notice requirements in effect for service terminations in HHAs, SNFs and CORFs.

I. General Concern with Required Notice
Citation: Section 422.620; Notifying Enrollees of Discharge from Hospital Level of Care; 71 FR 17060.

Issue: We believe that implementing the same discharge notification process for SNFs/HHAs/CORFs and hospitals seems inappropriate because generally an acute hospital stay is much shorter than a SNF stay and the discharge day is much less predictable than the day of termination of services from a SNF.

Recommendation: We agree that enrollees should be advised of their appeal rights when admitted as inpatients to a hospital. However, because the notices are largely duplicative, we recommend that at the time of admission to the hospital provide every enrollee with a combined Important Message from Medicare and Generic Notice rather than providing them with the proposed Generic Notice the day before discharge. We believe issuing one combined notice would be less confusing to enrollees and administratively and financially less burdensome for hospitals, physicians and Medicare Advantage Organizations (MAOs).

The combined Notice could be a CMS standard Notice modified to include more specific information such as the enrollee's discharge and appeal rights, process, timelines and the local QIO to contact if they wish to appeal. CMS could require that this Notice and process be reviewed with the enrollee (or representative) at admission to ensure enrollee comprehension before signing and dating. A copy of the notice would be given to the enrollee and/or representative for their future reference. If the enrollee wanted to appeal the discharge decision, they could refer to the appeals information provided in Notice given at admission.

Rationale: Because the SNF environment is more planned and predictable than the acute hospital setting it's easier to plan and prepare for the delivery of the Notice of Medicare Non- Coverage (NOMNC) in the SNF setting than it would be in the hospital setting. Issuing the proposed Generic Notice the day before discharge will unnecessarily extend the hospital stay an extra day because physicians generally decide to discharge the same day the patient leaves the hospital because they often must wait for morning lab tests, radiology and procedure results to ensure the patient is medically stable for discharge. In addition, usually an acute stay is much shorter than a SNF stay so it would be more confusing to enrollees to receive two notices within days of each other.

The current hospital notification process for Medicare Advantage enrollees who disagree with a discharge decision, gives adequate notice to the enrollee because they must receive the Notice of Discharge and Medicare Appeal Rights (NODMAR) by 6:00 pm and appeal to the QIO by noon the next day.

GENERAL

GENERAL

See attachment (could not attach so divided content between comment areas)

VI. Concern that Clear, Detailed and Consistent Guidance be Provided by CMS
Citation: Section 422.622(c); Notification responsibilities of the MA organization; 71 FR 17061.

Issue: We believe that implementing the same notification process for SNFs/HHAs/CORFS and hospitals requires clear, detailed and consistent guidance from CMS on an ongoing basis.

Recommendation: CMS provide clear, detailed and consistent guidance on an ongoing basis and monitor QIO s education programs to assure they reflect regulatory requirements. In addition, we would recommend that CMS increase enforcement efforts to hold providers accountable for delivery of the notices.

Rationale: Based on our experience in implementing the two-step notification process in SNFs, there have been different interpretations of regulatory requirements between MAOs, some SNFs and some QIOs. We are concerned that this will also occur under the proposed rules and will result in additional administrative burden to MAOs, hospitals, physicians and QIOs in revisiting the requirements. The areas of CMS clarification and enforcement include in SNFs include:

1) Responsibility of SNFs to delivery the notice;

2) Discharge Day aka Last Covered Day aka Effective Date on NOMNC for the Fast Track Appeals (Grijalva) process Effective Date is a Medicare Covered Day for service only and not a day paid for by Medicare since Medicare does not pay for the day of discharge; and

3) The delivery date of the NOMNC can be counted as day one of the two day notification requirement provided that the provider (SNF) can carry out valid delivery of the NOMNC by close of business (typically 4:30 pm) at least two calendar days in advance of the service ending. CMS is in general agreement that delivery of the advance termination by close of business will provide sufficient time for an enrollee to appeal by noon of the next day, however as some QIOs and SNFs are interpreting a day to mean 24 hours thus requiring an additional day of notification.

In addition, in some cases the QIO makes a decision on the available information without waiting for the MAO to deliver the Detailed Explanation of Non-Coverage (DENC), so the MAO spends time preparing and delivering the DENC when it's not considered in the QIO's decision. In addition, QIOs are not always available to review cases, especially on weekends, resulting in longer decision making timeframes and additional financial burden for MAOs.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

II. Concern with Administrative and Financial Burden
Citation: Section 422.620; Notifying Enrollees of Discharge from Hospital Level of Care; 71 FR 17060.

Issue: We believe that CMS is underestimating the additional administrative burden and financial liability of implementing the two-step notification process.

Recommendation: We recommend that CMS conduct a study to determine the actual administrative and financial burden incurred by the two step notification process currently in place for terminations in SNFs/HHAs, and CORFs, especially the impact for SNF terminations.

Rationale: Based on our experience with the two-step notification process for terminations in SNFs, the delivery of the Generic Notice in hospitals will be significantly more burdensome and time consuming than the CMS estimated timeframe of five minutes. The CMS estimate does not reflect time spent educating hospitals and physicians about CMS requirements and MAO expectations; explanation of the Notice to enrollees and/or representative; valid delivery of the notice when the representative is unavailable to sign or when the enrollee has no appointed representative; maintaining copies in the files for all discharges; and MAO monitoring to assure that notices have been delivered appropriately and timely by the providers.

Although the hospital is responsible for delivering the notices, the MAO is still financially responsible in the event the hospital does not issue a valid timely notice. Since the cost of bed days in the acute setting is far more costly than SNF bed days, we are very concerned with the additional financial burden that MAOs may have to incur if the proposed rule is implemented.

CMS estimates that only 2 percent of original Medicare beneficiaries and 1 percent of Medicare Advantage enrollees will actually file an appeal with the QIO. We are concerned that this is an under estimation because issuing the Generic Notice for every discharge will create doubt in the mind of the enrollee that their discharge is appropriate and may result in unnecessary appeals being filed.

MAOs will be required to issue an increased number of Detailed Explanation of Hospital Non-Coverage notices upon notification from the QIO that a member filed an appeal. This requirement would be challenging and financially burdensome for MAOs who do not conduct concurrent review. To comply with the requirement, the MAO would need a staff to conduct a "focused review" for each appeal filed.

In addition, based on our experience, enrollees generally do not want to go to a SNF and prefer to stay in the acute setting. Enrollees who appeal will remain in the acute setting longer thereby taking up acute beds when it is not medically necessary for them to be in an acute bed. Should enrollees who are scheduled to go to a SNF following their acute inpatient stay, decide to appeal to the QIO, there is the potential to lose their SNF bed while waiting on the QIO decision.

Regulatory Impact

Regulatory Impact

III. Concern with Valid Delivery to Enrollee s Representative
Citation: Section 422.620(b)(3); When delivery of notice is valid; 71 FR 17061.

Issue: The proposed rules requires that for the Generic Notice to be valid, the enrollee or representative must sign and date to indicate that he/she has received it and comprehends the content. However, when an enrollee is incompetent and the responsible party is not available to sign the Generic Notice it could cause an extended hospital length of stay.

Recommendation: The enrollee's representative is more likely to be with the enrollee at the time of admission to the hospital than at the proposed time of delivery of the Generic Notice. Therefore, we recommend combining the Important Message from Medicare and Generic Notice and issuing at admission, rather than providing the proposed Generic Notice the day before discharge. This way, the enrollee and representative are aware of their discharge and appeal rights from the time of admission. If there is no appointed representative to act for the enrollee, the hospital can then pursue the appropriate legal avenues to determine an appropriate representative before the discharge date.

Rationale: The proposed rule is not clear on what is considered a valid delivery when the enrollee is incompetent and the representative must sign the notice. Based on our experience with the two-step notification process in SNFs, it is administratively burdensome to meet current CMS requirements when the enrollee is incompetent and the representative must sign and date the notice. Often times the representative is not available in-person or by phone and the notification must be sent by certified mail. In this case, the notice is only considered valid when the signed notice or return certified mail receipt is received. This process can cause unnecessary delays in termination of services. In addition, if there is no one to act on the enrollee's behalf, a public guardianship agency has to be assigned to represent the enrollee. The length of time to appoint a representative could cause an extended stay in the hospital setting when it s not medically appropriate.

Submitter : **Joseph Parker** **Date: 06/05/2006**

Organization : **Georgia Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-4105-P2-382-Attach-1.DOC

Attachment #382

June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

The Georgia Hospital Association (GHA), on behalf of our approximately 170 member hospitals, appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

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

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

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

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

Georgia Hospital Association
1675 Terrell Mill Road, Marietta, Georgia 30067 / Phone: 770-249-4500 / Fax: 770-955-5801 / http://www.gha.org

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

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

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

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

There are several problems with the proposed approach.

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

- *It is virtually impossible to know with certainty the discharge date a day in advance.* Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. That determination is based on test

results and clinical indicators, such as whether a patient is free of fever. Patients generally know their expected day of discharge (often from before admission in the case of elective admissions), which is then adjusted as necessary to reflect their condition during the discharge planning process. There may be an expected discharge date of Thursday for example, but if the patient develops a fever the evening before, the discharge date will be postponed until that fever is gone.

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

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

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

Collection of Information and Recordkeeping Requirements

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

- *At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless.* The proposal would require that the beneficiary or a representative sign a copy of the discharge notice documenting its

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

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

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

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

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

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

GHA appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. If you have any questions, please contact Karen Waters at 770 249-4540.

Sincerely,

Joseph A. Parker
President

Submitter : elsa cortez **Date:** 06/05/2006

Organization : St. Margaret Mercy

Category : Social Worker

Issue Areas/Comments

Background

Background

Our department would have to hire staff to work 7 days a week.This would be a financial burden on our hospital.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Physicians do not always know ahead of time when a discharge will be. This could result in patients staying longer in the hospital.
Families are not always cooperative. They do not always return call timely so if we had to meet with them to sign this notice, it could again result in a delay of discharge.

Regulatory Impact

Regulatory Impact

Hospitals have short term relationships with their patients, unlike home care agencies who have up to 60 days. We do not see a need to give them a notice. We work closely with them on a discharge plan and they are kept informed.

Submitter : **Miss. Maya Cashman** **Date: 06/05/2006**

Organization : **Managed Health Network**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attchment

CMS-4105-P2-384-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

To Whom It May Concern:

I am writing on behalf of the Managed Health Network (MHN) to comment on the proposed rule for the Medicare Program Notification Procedures for Hospital Discharges (CMS-4105-P). MHN provides a comprehensive employee assistance program to several companies, as well as behavioral health and substance use service coverage for Health Net, Employer Groups, Trust and Welfare, Commercial, and Medicare Advantage members.

In the Proposed Two-Step Notice Process in the proposed rule it states "The notice processes as specified in Sec. 405.1208, addresses the situation where the hospital requests a Quality Improvement Organization (QIO) review because the physician does not concur with the discharge decision, would remain unchanged." MHN suggests that the Centers for Medicare & Medicaid Services (CMS) extend this right to request a QIO to a Medicare Advantage (MA) organization in 42 CFR 422.622 when the physician does not concur with the discharge determination made by the MA organization. <u>This language should be binding on all QIOs and not be applied at their discretion.</u>

Medicare Advantage (MA) plans were developed to provide quality health care to Medicare enrollees while at the same time controlling the out of pocket expenses for enrollees and costs for CMS. To create an efficient product, the Medicare Advantage organizations develop a provider network comprised of providers that meet strict credentialing requirements. MA plans develop and/or use nationally recognized medical necessity guidelines to evaluate the enrollee's need for and response to treatment. These guidelines are used to make benefit determinations to ensure the enrollee is receiving treatment at the appropriate level of care. However, 42 CFR 422.620(b) impedes the MA plan from performing these functions and the process is further complicated if the treatment relates to behavioral health needs.

42 CFR 422.620(b) requires that before discharging an individual or changing the level of care in an inpatient hospital setting, the MA organization must obtain the concurrence of the physician who is responsible for the enrollee's inpatient care. This provision restricts the MA organization's ability to manage the enrollee's benefits. If the patient is admitted for treatment related to a behavioral health need, there is no prescribed regimen.

Treatment for behavioral health needs usually involves varying sequences of treatment and drug dosages. Additionally, in behavioral health, the physician and facility are paid on a per diem basis, not a DRG basis; therefore, there is no incentive on the part of the physician to discharge the patient.

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

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

Thank you for your consideration of MHN's request and if you need additional information please feel free to call me at (510) 620-6122.

Sincerely,

Maya Cashman
QI Compliance Manager
Managed Health Network

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

If discharge notices are required to be presented to every Medicare and MA patient within 1 day of patient discharge, the patient s length of stay will be increased due to this notice not being given to the patient within the allotted time period for the following reasons:

7 Discharge pending test results
7 Nursing home bed availability
7 Transport availability
7 Physician rounding patterns

In addition, implementation of this process will necessitate additional visits by the case managers to the patients and their families for delivery of this notice. This process will be additional time dedicated to the discharge planning process due to additional questions being asked and discussions being held with the patient and family members. This will also cause an increased in the overall hospital length of stay due to more critical issues not being addressed for other patients.

Additional questions from this ruling are as follows:

7 How would this process be handled for the patient who is not competent or coherent to understand this discharge notice and who has no one responsible for them?
7 How would this process be handled for the patient who has a 1 day stay?
7 How would this process be handled for patients who are placed in an observation status?

Continuance of the current process and procedure would be our preference .

Submitter : Ann Guild **Date:** 06/05/2006

Organization : Illinois Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

Background

Background

Duplicative, costly and burdensome in acute care setting.

GENERAL

GENERAL

See attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Required notification of patient of discharge decision 24 hours prior to discharge.
Additional beneficiary notice of discharge appeal rights.

Regulatory Impact

Regulatory Impact

Rule ignores current discharge processes in hospitals.

CMS-4105-P2-386-Attach-1.DOC

June 5, 2006

Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850
(comments submitted electronically)

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

Dear Dr. McClellan:

On behalf of our 189 member hospitals and health systems in Illinois who would be affected, I appreciate the opportunity to comment on the proposed rule that will require hospitals to provide discharge notice to patients 24 hours prior to discharge along with additional notice, beyond what is currently required, on beneficiary appeal rights.

First, I'd like to comment that we are in complete concurrence with the comments made by the American Hospital Association and intend this letter to support the concerns that have been raised by the AHA and many others.

First, I'd like to address the discharge planning process that hospitals currently engage in. The proposed rule would require hospitals to notify the beneficiary of non-coverage and the hospital's decision to discharge on the day before the planned discharge. The physician, not the hospital, discharges the patient. The physician does not concur with a hospital's decision. The hospital makes no decision. It is the physician who writes the discharge order.

Operationally, the proposed rule imposes new requirements that are redundant and unnecessary. Hospitals already provide information to beneficiaries upon admission about their discharge appeal rights. And in fact, particularly for elective admissions, patients are usually informed of the anticipated date and time of their discharge upon admission.

While a physician may tell a patient that he or she may be discharged the next day, a conversation no hospital employee may be privy to, the actual discharge order is typically written on the day of discharge. Often the final decision will be made based on final test results and will take into account any changes in the patient's condition from the prior day.

Illinois hospitals already give patients notice of their anticipated date of discharge <u>at least</u> 24 hours prior to the discharge. If a patient can be informed of a likely discharge date prior to 24 hours in advance, There need not be a rule that would either prevent this or require duplicative notices and resulting duplicative paperwork? How does this benefit the patient? Or if the discharge notice occurs later or is appealed, there is the potential that the patient may stay in the hospital unnecessarily and that another patient who needs to be admitted cannot be.

One stated CMS rationale for this new requirement is that it mirrors requirements in post acute care settings. While this approach may seem logical from the perspective of promoting consistency across levels of care, it will be burdensome in the acute care setting and will not add value for the patient. On average, patients stay less than 5 days in the acute care setting. And during the entire stay, nurses, discharge planners, social workers and others are engaged in helping patients and their families make appropriate plans to implement the discharge order when it is signed. This added step is unnecessary and far more burdensome in the hospital setting.

Second, I'd like to comment on the paperwork requirements. While hospitals are being encouraged to move to electronic health records, the federal government should not be imposing new paperwork requirements. We believe the cost of additional paperwork is significantly under-estimated, not only from the perspective of the paperwork itself, but from the perspective of encouraging appeals that would not otherwise have been made and that will likely unnecessarily lengthen a patient's stay. When a patient is informed of appeal rights, the information provided should recognize that discharge decisions are clinical decisions made by the physician based on the patient"s condition. Financial liability issues should not be presented alone.

Recommendation: Given the serious concerns raised by IHA and others, and the fact that the proposed rule does not appear to recognize current practices nor does it appear to solve any real problem, IHA recommends that this proposed rule be withdrawn. The hospital community would be more than willing to assist CMS to convene a national workgroup that can inform future proposed regulations. If there are problems with the discharge planning process that need to be addressed via regulation, the problems need to be more clearly articulated and the solutions need to minimize burdens on hospitals while ensuring that patients are appropriately informed of discharge decisions and their rights as Medicare beneficiaries. On the surface, the proposed rule may seem simple, but there are burdensome and unintended consequences that need to be addressed before any regulatory changes are made.

Once again, I appreciate the opportunity to comment. If you have questions or need more clarification, I can be reached at 630-276-5496 or via e-mail at aguild@ihastaff.org. Or you can contact Kathleen Pankau, Staff Counsel, at 630-276-5598 or via e-mail at kpankau@ihastaff.org

Sincerely,

Ann Guild
Vice President

Submitter : Mrs. Amy Menconi **Date:** 06/05/2006

Organization : St. Margaret Mercy

Category : Social Worker

Issue Areas/Comments

Background

Background

It would be a burden on our hospital to staff our department 7 days a week in order to issue these notices to Medicare patients'

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Physicians do not always know in advance the discharge date. They rely on results of testes that are not always available at all times until the day the pt can be discharged.
Families and patients are not alwats cooperative. They do not always return our phone calls. If we have to meet with them for a signature on the notice this can delay discharge.

Submitter : lisa davis **Date:** 06/05/2006

Organization : St. Margaret Mercy-North Campus

Category : Social Worker

Issue Areas/Comments

Background

Background

It would be a burden on the hospital to staff our department 7 days a week in order to issue these notices to medicare patients.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Physicians do not always know in advance the discharge date. They rely on results of tests that are not always available at all times until the actual day the patient can be dc'd.
Families and patients are not always cooperative, they do not always return our phone calls so if we have to meet with them for a signature on the notice this could delay d/c.

Submitter : **Mr. Barry Eads** **Date: 06/05/2006**

Organization : **Fayette Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P2-389-Attach-1.DOC

Attachment #389

FAYETTE MEDICAL CENTER-DCH
1653 Temple Ave North
Fayette, Alabama 35555
205-932-1164

June 5, 2006

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

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

To Whom It May Concern:

On behalf of Fayette Medical Center in Fayette, Alabama, I welcome this opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with our comments, concerns, and suggestions on the proposed new rule regarding discharge notification procedures.

Fayette Medical Center supports CMS' efforts to ensure that Medicare beneficiaries are kept informed of their care planning, including planned discharge date. Currently, every patient begins the process of discharge planning at the time of admission; more intense discharge planning services are coordinated by a case manager based on need as determined through a medical-social screening. Our process involves the patient and their decision-maker giving them choices for providers of post acute care services. Patients are given ample opportunity to change their minds, revise discharge plans, disagree with planned discharges and request appeals through our QIO.

The proposed rule will place an administrative burden on the hospital that outweighs any benefit and is likely to become a patient dissatisfier. Our assessment is based on specific concerns discussed below.

Many times the patient's decision-maker is not available which could easily cause a one day delay in issuing the generic notice.

Ensuring that patients and/or their representatives understand their appeal rights is a very complicated process. 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 await a response from the QIO. The patient assumes no financial responsibility until the QIO responds.

Reflecting back to the "Important Message About Medicare Rights" of September 2000, HCFA revised its estimate of the costs borne by hospitals to issue the notice for inpatient stay. The new cost estimate totaled more than $170 million - a seven-fold increase from HCFA's original estimate of $24 million, cited in the April 12 *Federal Register* notice. Similar costs will be associated with this proposed rule and the burden and expense of compliance must be borne solely by hospitals, not the health plans. Responsibility will be shifted to hospitals, but resources for this activity will have to be diverted from already stretched resources for patient care. Further, the current environment in which paperwork and documentation demands continue to increase contributes greatly to clinical staff dissatisfaction with working in the health care field.

While this new requirement to administer the written notification of discharge may appear minor to CMS, to hospitals, it is yet another requirement that takes time and resources away from direct patient care. We maintain that any perceived benefit from administering this notice during the course of an inpatient stay is not justified by the very real increase in costs. We propose that the Medicare program share appeal rights information with beneficiaries through the Medicare handbook, and hospitals reinforce knowledge and understanding of those rights when a discharge is in dispute. Otherwise, hospitals should be required to continue to distribute the "Hospital Issued Notice of Non Coverage", as they have done for years, when continued stay is inappropriate and unnecessary.

CMS also fails to include a cost estimate for storing the forms. Whether stored on paper, microfiche or by computer, significant administrative costs are associated with storage.

Fayette Medical Center is supportive of CMS's role in safeguarding patient rights. It is understandable that CMS wishes to ensure these rights are upheld. But, as Medicare shifts much more of these administrative functions to providers compared to the private payers, CMS has an obligation to energetically pursue efficient administrative approaches. Hospitals cannot afford to continue diverting so many resources to paperwork, rather than patient care. We must be responsible stewards of the very limited resources we have while ensuring that patients do not take advantage of a new opportunity to unnecessarily extend a hospital length of stay.

Fayette Medical Center appreciates the opportunity to submit these comments. If you have any questions regarding our comments, please contact me, Barry Eads-Director, Quality Management.

Sincerely,

Barry Eads, R.N.
Director-Quality Management
Fayette Medical Center
1653 Temple Avenue North
Fayette, Alabama 35555
205-932-1164

Submitter : Ms. Carol Grant

Date: 06/05/2006

Organization : Palmetto Health

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

seee 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 : Mary Ninos **Date:** 06/05/2006

Organization : Coventry Health Care, Inc

Category : Health Plan or Association

Issue Areas/Comments

Background

Background

CMS should consider including the cost of preparing multiple copies which will have to be prepared in advance if the requirement is to provide notice 24 hrs prior to discharge due to the quick turn around on some discharges -
Also consider including the time and cost of oversight of hospital delegated distribution process by MA plans which is a requirement for all MA delegated processes.

GENERAL

GENERAL

For contractual reasons in a managed care arrangement some hospital days may be non-covered, however the patient/member is "held harmless" and these notices would not and should not apply to these situations and should not be delivered by the hospital.

The QIO should use some known and published standardards of care such as InterQual Criteria, in reviewing cases for hospital care.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Part 22 - Medicare Advantage program, 422.620(a)(2)(b)(1)Timing of the notice: While services in a SNF, CORF or HH setting are planned and allocated in advance - hospital services are based on the acute condition of the patient and while discharges may be anticipated they are often not known until the DOD. We would recommend more flexibility around the timing of the notice to accomodate this aspect of hospital care

Submitter : Mr. Robert Granger **Date:** 06/05/2006

Organization : St. Francis Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment: Letter

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

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