Submitter : **Miss. Julie Rodda** **Date: 06/05/2006**

Organization : **Saint Joseph's Hospital**

Category : **Hospital**

Issue Areas/Comments

Background

Background

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

CMS-4105-P2-393-Attach-1.DOC

Attachment #393

611 St. Joseph's Avenue, Marshfield, WI 54449

May 8, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted Electronically: http://www.cms.hhs.gov/eRulemaking

RE: File Code CMS-4105-P

To Whom It May Concern:

The following comments are submitted by St. Joseph's Hospital, a 504-bed hospital located in Marshfield, Wisconsin. These comments are in response to the proposed rule regarding hospital discharge notices as published in the *Federal Register* on April 5, 2006. If you have any questions or concerns, please call any of the contacts listed at the end of this letter.

PROVISIONS OF THE PROPOSED RULE

Saint Joseph's Hospital (SJH) understands and thanks CMS for their efforts in trying to make sure the Medicare beneficiary is well informed of their rights. We do, however, have concerns in how a large facility such as Saint Joseph's Hospital will be able to administratively handle what this proposed rule would require.

The SJH Medicare population is 48% of the total number of inpatients per year. In 2005, this comes roughly to 9280 Medicare inpatient discharges for the year. Using the timeline (five minutes) as described on page 17056 of the April 5, 2006 *Federal Register*, this would be approximately 773 hours per year needed to meet the new regulation. This averages out to 25 notifications given per day.

If 2% of the Medicare population would choose to have an expedited review of their inpatient stay, SJH would have approximately 186 per year. According to the proposed rule this should take anywhere from 60 to 90 minutes to complete. For SJH this would amount to approximately 279 hours of time. In total our facility would spend approximately 1052 hours or approximately 3 hours per day with this proposed notification process.

Who Will Give the Discharge Notification? Due to the large number of patients who would have to receive this notice in our facility, we have looked at who would be the responsible group of people to handle the notification process. Those that were considered were Case Management and Nursing since both groups follow the patient closely throughout their stay.

IF Nursing were to Give the Discharge Notification:

As a healthcare facility, we have concerns of taking the nurse away from patient care to handle an administrative function. Even though having a lower ratio of patients per nurse (approximately 8 on average throughout the day) as compared to a case manager, there is still a concern that this would pull nursing away from performing nursing assessments, planning care, monitoring patient safety, following doctor's orders, administering medications, coordinating tests and procedures, and providing comfort measures as well as a multitude of other tasks/functions they need to perform with all patients they are caring for. Without performing this extra function, nurses already have a tight schedule to make sure patients are taken care of in a proper manner. What happens if a nurse is pulled into an emergency situation with one patient and the notification does not get administered as was intended? Does the patient then have to wait an extra day because the notification was not given the day previous? Many unforeseen situations could take place that could delay the discharge notification process.

At this hospital, the RN is the coordinator of care and the RN tries to have discharge be a focus as part of the Plan of Care and communicates the discharge plan ahead of time as it is communicated to the nurse. SJH feels that it would be wrong to make it a mandatory requirement.

As a facility, SJH feels nursing would be the instrumental people that would initiate the first stage of the notification process – thus creating another problem in how nursing will know the difference between the patients based on insurance. At SJH all patients are treated equally

with no consideration made to what type of insurance a patient has – patients are treated based on the illness they have. Administratively reports could be produced or charts flagged at the time of admission to show that this patient will need a notification of discharge, but again this would be a new process that is not currently done.

IF Case Managers were to Give the Discharge Notification:

Case Managers generally work with up to 25 patients on a given day. If Case Management were to handle this process, they would not be able to function in their other important duties such as discharge planning, utilization review, and coordination of care.

Time Consideration of Administering Discharge Notification We are concerned that CMS proposes that it would only take five minutes to give these notices. SJH feels this would be the very minimum amount of time that would be needed in order to provide this technical information to a laymen population. When working with the Medicare population, however, more time would also be needed for explanation of what they were getting and making sure it is understood. It would not be as simple as "popping in and out". Also, with knowledge of working with this population, there will be times when the process will be needed to be explained a second or third time as they may forget what had taken place. We estimate that it would average between 10 and 15 minutes to give these notices; some patients would be at the five minute mark, but some would need either a more thorough explanation or after explaining, family would have to be notified about the notification because the patient does not understand. Would family have to be explained this notification in person or could this be handled on the phone?

When thinking of time considerations one must look beyond the time that would have to be taken in explaining the form to the patient. Other items that should be looked at include filling out the paperwork and the availability of the patient.

Even though it will be a "generic form" there will be items that will need to be patient specific. Making sure all information is complete and correct could be time consuming since nursing will be filling out the paperwork and would be out of their normal nursing skills needed on the job.

There will also be times when the patient will be busy with other ancillary staff (such as physical therapy or speech therapy) or even just resting. On the day prior to discharge the

patient is usually feeling well and finishing up rehabilitation with PT/OT/Speech and also could be more active with visitors. Since a nurse takes care of multiple patients, coordinating when the nurse is ready and when the patient is available could be difficult. This could lead to delays in the patient receiving the notice and also make it more likely that throughout the day the notice might be forgotten by nursing. Shift changes could also play a role in this. When a new nurse arrives in the care of the patient, making sure this administrative duty is complete is not going to be top priority of information relayed in the care of the patient. This notification might be forgotten as the nurse leaving the shift may forget to relay that the current nurse still has to complete the form.

Physician Cooperation St. Joseph's Hospital has over 400 physicians that currently practice medicine in our facility and also is a teaching hospital with over 60 residents. With this large amount of physicians working with patients it often is difficult to coordinate things in a timely fashion. Since the physicians will not have direction by CMS to be doing this, it will be left up to our facility to educate all physicians involved, which could lead to costly delays in patient discharge due to a physician forgetting to improve his communication with nursing.

In theory it would be a normal occurrence for physicians to keep nursing informed as to the plan of care of a Medicare inpatient; informing them of patient discharge and disposition long before the actual day.

In reality, this does not occur often. Most nurses find out about discharge when the order is written or after the physician has seen the patient. Without making the physician in some way held responsible for this lack of communication and by again putting the burden on the hospitals to govern this, we feel cooperation from physicians will not be easy and very time consuming.

Discharge Possibility Only Realized by Physician on Date of Discharge Many times the physician will decide during rounds in the morning that the patient is ready for discharge; the day previous to this the patient would not have shown they were well enough for this and so no information that discharge was to occur the following day would be made in progress notes and/or related to nursing/case management. The patient, after receiving the discharge order, then goes through discharge instructions with the nurse and is released later that day.

With a normal inpatient stay it is often a communication from physician to nurse that the patient may go home the next day. But in some cases, there are going to be patients that do

not fit into the "norm" and would be suddenly well the next day without knowledge by the physician until they make rounds or are informed of their status by nursing.

Our concern at this point would be – how can we give the notification of discharge the day prior if it is not known to nursing or even to the physician? Would the hospital have to hold the patient *without* medical necessity until the next day because this notice was not given thereby increasing health care costs?

Does this not take the decision for discharge away from the physician/medical necessity and give it to an administrative function?

Discharge Cancelled Due to Change in Patient Condition Many times there are patients that are doing well one day and who looks as though they could possibly be discharged the following day. Overnight the patient deteriorates and when the physician sees the patient realizes that discharge will not happen as planned. The patient could go home the next day or maybe four days from then. If our hospital was following the discharge notification process, the patient would have received this notification when the patient was felt to be ready for discharge. What happens to this notification once it is realized that the patient is not ready for discharge? Will the notice have to be rescinded by the hospital? Will a new notification need to be done when it is felt the patient will be ready for discharge once again?

For some patients this could mean multiple notifications and nullifications. After a couple of notifications, it is our feeling that the patient would feel overwhelmed because each of the other times they received this notice their condition worsened to the point where discharge was impossible. Patients would have to be unnecessarily irritated when they are supposed to be focusing on getting healthy.

Retention of Discharge Notification According the proposed rule, the hospital would have to maintain a copy of the signed or annotated notice. SJH is concerned as to where the notice is to be retained. Would this have to become a part of the permanent record or would we be required to keep this under separate file? How would facilities keep this document that are paperless or at least trying to move toward that goal? This would have to be scanned into the computer system, which would add to the cost of the facility.

REGULATORY IMPACT

Costs to Provider CMS estimates that it would cost each provider approximately $7075 annually to complete the Discharge Notification process. With the information we have specific to our facility, we approximate that this would cost our facility $31,560.00 annually. This is a low estimate because we have used the same figure as CMS, which is $30 per hour. Since nursing would be doing a bulk of the notifications (which we estimated to be up to 15 minutes in total time), this could increase this amount significantly.

One factor to consider is that Case Managers (who are earning the same wage as a nurse) would be completing the second step requests from patients. They would provide at a minimum of 90 minutes for each of the estimated 186 second step reviews that we would have. SJH is asking CMS to reconsider their estimate in the time that would be provided in this case. It is not out of line to assume that the total time that would have to be given toward this could reach up to three hours.

Another factor in the cost to facilities is the time taken for copies and other secretarial items that may be completed by Health Unit Coordinators for the nurses and the secretary of Case Management. Since copies and/or scanning would have to be made for the patient, someone would have to make sure these are done.

Even though some patients may take less than 90 minutes to explain the paperwork to, the more common Medicare patient would need much more time in explanation. This would increase the estimated time needed to complete the second step in the process. Generally the elderly patient is not going to sign anything of this importance without reading line for line and without having family members in attendance. From experience, this is not a subject any family member or patient will take lightly and so therefore could easily lead to a very engaged discussion.

By calculating costs for the second stage of the notification using our estimate of 180 minutes, it would increase total cost for our facility from $31,560.00 to $39,930.00. As a whole, this proposed rule would cost all hospitals much more than estimated. Using the numbers in the proposed rule:

First Notice:

12,500,000 notices X 15 minutes X $30/hour = $93,750,000.00

Second Notice:

250,000 notices X 180 minutes X $30/hour = $22,500,000.00

Total Cost to Hospitals:

$93,750,000 + $22,500,000/6000 hospitals= $19,375.00 cost per hospital

This would be much more of a burden for hospitals than proposed by CMS. Saint Joseph's Hospital hopes that after further consideration is taken, that this proposed rule is not finalized. We definitely feel that rather than helping the patient and not adding much burden to the facilities this proposed rule would help a small percentage of patients, but add a very large administrative burden to our facility.

Our proposal to keep the Medicare population informed of their rights in regards to appealing discharges would be to strengthen the already existing document called the *Important Message from Medicare.* To "strengthen" the appeals information SJH suggests using a more distinct font to draw attention by the reader and either using the document at the time of admission or by giving it at the time of discharge.

Receiving the document at the time of admission would keep processes the same for hospital staff. SJH admission staff currently gives this document to the Medicare population and explains what is contained in it. Concern though would be that at the time of admission most patients are not paying attention to any paperwork that may be done, but would normally be more concerned about their health.

Alternatively if CMS still feels that the patient would better be served by receiving a notice at the time of discharge, the *Important Message from Medicare* could be revised so that it would be given as part of the discharge process on the day of discharge. This would then not create another administrative process, but would become part of the already existing discharge papers the nurse completes with the patient upon discharge and would be more reasonable for

staff to distribute then trying to get it to the patient as a single document the day prior to discharge. Upon receipt they would then have until Noon the following day to call for an appeal of the discharge decision. We feel that this would provide the Medicare population with the proper notification of their appeal rights and also not cause an administrative burden to the hospitals.

In closing we ask that CMS not implement this proposed rule to give discharge notification to all Medicare inpatients the day prior to discharge. As we have shown this will create a large administrative burden to hospitals and create yet another piece of paper that could be avoided by considering the options proposed above.

Sincerely yours,

St. Joseph's Hospital

And Representatives of St. Joseph's Hospital submitting these comments:

Julie Rodda

Julie Rodda, RHIT
Revenue Cycle/Reimbursement Coordinator
715-387-7164

Judy Gadke

Judy Gadke, RN
Case Management/Social Services
715-387-7890

Margaret Kennedy

Margaret Kennedy, RN
Case Management/Social Services
715-387-7890

Nancy Gilge

Nancy Gilge
Compliance/Audit Specialist
715-387-7484

Cheryl Meyer

Cheryl Meyer
Assistant Manager Patient Financial Services
715-387-7769

Judy Nowicki

Judy Nowicki, RN
Dir of Pt Care Serv/Med & Specialty Serv
715-387-7580

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

This proposed rule is redundant with current requirements, could result in unnecessary extensions to length of stay, and would be unduly burdensome on hospitals.
See Attachment.

CMS-4105-P2-394-Attach-1.DOC

Attachment #394

University of Iowa Health Care

University of Iowa Hospitals and Clinics

Hospital Administration
200 Hawkins Drive, 1353 JCP
Iowa City, Iowa 52242-1009
319-356-3155 ***Tel***
319-356-3862 ***Fax***
www.uihealthcare.com

June 5, 2006

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

Via electronic comment: http://www.cms.hhs.gov/eRulemaking

Attention: CMS–4105–P

Dear Dr. McClellan:

The University of Iowa Hospitals and Clinics (UIHC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled, *"Medicare Program; Notification Procedures for Hospital Discharges"* 71 Fed. Reg. 17052 (April 5, 2006). It is our opinion that this proposed rule is redundant with current requirements, could result in unnecessary extensions to length of stay, and would be unduly burdensome on hospitals.

Frequently hospitals do not know 24 hours in advance whether a patient will be discharged. Such decisions are often are made on the morning of the day of discharge, after the physician confirms that the patient's medical status no longer requires inpatient care, and may be reinforced by an event-free prior overnight period. This process is particularly common for the complex and severely ill patients treated in teaching hospitals like the UIHC, where a patient's health status can change quickly and whose discharge determination may require the concurrence of multiple treating physicians. Compliance with the "one-day prior" requirement could necessitate hospitals providing an extra day of inpatient care when beneficiaries would no longer need it. Not only would this outcome result in significant and unnecessary costs to hospitals, it would also be at odds with the desires of many beneficiaries who wish to expedite the discharge process. In addition, during times when our hospital is at full occupancy, this could also mean a delay for new patients being admitted.

The UIHC believes that the current process of providing the "Important Message from Medicare (IMM)" followed by a "hospital-issued notice of noncoverage (HINN)" if a beneficiary expresses dissatisfaction with an impending discharge sufficiently protects the rights of Medicare beneficiaries. We also respectfully disagree with CMS's five minute

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

The UIHC strongly encourages CMS to maintain the current process which already provides beneficiary notification procedures by means of the IMM notice and a detailed notice if the beneficiary expresses dissatisfaction with the discharge decision. In addition, we would support convening a national workgroup of affected parties if discharge planning issues need to be addressed.

Thank you for your consideration of these comments. Should you have any questions, please feel free to contact me at donna-katen-bahensky@uiowa.edu or (319) 356-3155.

Sincerely,

Donna Katen-Bahensky
Director and Chief Executive Officer

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

Organization : St. Margaret Mercy

Category : Hospital

Issue Areas/Comments

Background

Background

This would be a burden for our staff, since we do not work 7 days per week. We would have to hire additional staff, this would be a financial burden to the hospital.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

1.Physicians do not always know the date of discharge in advance. They rely on test results which may result in a discharge the same day. Providing a one day in advance discharge notice would result in our keeping a patient unnecessairily in order to comply with this regulation.
2. Families and patient's are not always cooperative in returning our phone calls. By requiring a signed notice, this would cause a delay in discharge.

Regulatory Impact

Regulatory Impact

Hospitals are not like hospice and home care agencies. Our relationship with patient's is short term, whereas the other agencies are long term. I do not see the need to give them an additional notice, since we work closely with them in regards to the discharge planning process.

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

Organization : **Hancock Medical Center**

Category : **Critical Access Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-396-Attach-1.DOC

June 5, 2006

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

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

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

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

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

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

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

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

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

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

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

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

Although the hospital is working closely with the physician and patient to monitor care and a pending discharge throughout the patient's stay, it is not possible to accurately

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

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

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

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

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

Susan Stevens, Director
Quality Resources Department

Attachment #396

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

(228)467-8739

Submitter : Mr. Scott Street

Date: 06/05/2006

Organization : Duncan Regional Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED LETTER

CMS-4105-P2-397-Attach-1.DOC

Attachment #397

June 5, 2006

Duncan Regional Hospital
P.O. Box 2000
Duncan, OK 73534

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 Duncan Regional Hospital in Duncan, Oklahoma appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients one day before their discharge. This new notice would be **in addition to** the following existing communications:

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

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

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

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

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

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

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

There are several problems with the proposed approach.

- *Physicians, not hospitals, make discharge decisions.*
- *It is virtually impossible to know with certainty the discharge date a day in advance.*
- *By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences*
- *To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care.*
  - *Our hospital is paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. We have approximately 2,214 Medicare hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would increase our cost of care for Medicare patients approximately$2,214,000.*
  - *Many patients would be compelled to stay in the hospital when they want and are medically able to go home.*
  - *For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.*

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

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

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

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

- *The estimated cost and burden of the proposal is grossly understated.*
  - CMS has not realistically estimated:
    - the time necessary to prepare and deliver the generic discharge notices,
    - time needed to explain the notice or why it must be signed,
    - the additional time required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent,
    - the manpower and capital costs to maintain hard copy files of the signed copy for our hospital's 2,214 Medicare admissions each year and to retain these hard copies for an indefinite period of time.
  - The most significant cost, however, is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge (as explained above). At a conservative estimate of $1,000 per day, we estimate the cost to our hospital at $2,214,000 per year.
  - Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals.

Duncan Regional Hospital recommends that the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.

- If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice.

- If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. More paperwork does nothing to improve care – it simply consumes resources that would be better devoted to direct patient care.

Duncan Regional Hospital appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me at 580-251-8555 or scott.street@duncanregional.com.

Sincerely,

Scott Street
President & CEO
Duncan Regional Hospital

Submitter : **Mr. Chrisopher Klang** **Date: 06/05/2006**

Organization : **JPS Health Network**

Category : **Hospital**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

June 5, 2006

JPS Health Network in Fort Worth, Texas (JPS), does not agree with this proposed rule. The burden to identify, collect and maintain the information is on backs of the hospitals. Consistent with complaints when this proposed rule was made previously, the administrative burden will result in additional costs without increase to reimbursement to cover this proposed obligation. The frontline staff that will communicate these proposed notices are first and foremost focused on patient care, determining, creating and explaining these proposed notices to the beneficiary s.

Another comment, the decision to discharge a patient is made by the patient s physician. Any concern the patient has should be between the patient and the physician. Requiring the hospital to be involved with discharge determination is not appropriate.

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

Organization : **American Academy of Family Physicians**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment.

CMS-4105-P2-399-Attach-1.DOC

VIA E-MAIL

June 5, 2006

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

Dear Dr. McClellan:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 94,000 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the proposed rule regarding "Medicare Program; Notification Procedures for Hospital Discharges" as published in the *Federal Register* on April 5, 2006. We are concerned that, although aimed at hospitals, this proposed rule may have a significant negative impact on physicians who treat Medicare patients in the hospital.

Currently, hospitals must provide Medicare beneficiaries with a general notice of appeal rights (referred to as the "Important Message from Medicare") at or about the time of the patient's admission. If a Medicare beneficiary expresses dissatisfaction with an impending hospital discharge, hospitals must also provide a hospital-issued notice of non-coverage to the beneficiary.

Under the proposed rule, CMS would establish a two-step notice process for hospital discharges that is similar to the process in effect in other settings, such as skilled nursing facilities. The first step would require hospitals to deliver, as soon as the discharge decision is made, a standardized, largely generic notice of non-coverage to each Medicare beneficiary whose physician concurs with the discharge decision. CMS considers delivery of the notice valid if it is delivered on the day before the planned discharge, contains all the necessary elements, and is signed and dated by the beneficiary (or beneficiary's representative) to indicate the he or she has received the notice and can comprehend its contents. The second step, which would occur only in those situations in which a beneficiary wishes to dispute the discharge, would require hospitals to issue a single, detailed notice of non-coverage. The proposed rule is not clear on whether or not CMS would eliminate the "Important Message from Medicare," and CMS invites comments on this and other aspects of its proposal.

Our concerns with this proposal relate to the first step in the proposed two-step process. First, it presumes that hospitals and physicians will always know the date of discharge a day in advance. That is not the case. Sometimes, patients are admitted and discharged on the same date. In this situation, it is impossible to provide the standardized notice of non-coverage the day before discharge. In other cases, a patient may be sufficiently well to be discharged earlier than expected. In such instances, the proposal would seem to require that the hospital keep the patient an extra day, just so it could provide the standardized notice a

day in advance of discharge. This makes no sense, either for the hospital or the physician who is responsible for the patient's care.

Another concern is the apparent redundancy between the proposed standardized notice and current "Important Message from Medicare." As noted in the proposed rule, both documents provide much the same information. We are not aware that the use of the "Important Message" has otherwise failed to provide Medicare beneficiaries or their representatives with the information that they need in this regard, and we see no need to provide them with two documents that say much the same thing, especially when the hospital stay is short. For example, as proposed, hospitals would be required to give beneficiaries both the "Import Message" and the standardized notice on the day of admission if the hospital expected the patient to be discharged the next day.

Finally, and most critically, this proposed rule presumes that hospitals will have active case management staff to handle all of this paperwork and that either the beneficiary will be competent to sign the standardized notice or that the personal representative will be readily available to do so. The reality is that in most small and rural community hospitals, active case management staff does not exist. As such, we anticipate that the burden of this paperwork will often fall to the attending physician, which in many cases will be our members. That burden will be exacerbated by the fact that many Medicare beneficiaries are not competent to sign such a document and their personal representatives will often not be readily accessible to the physician (e.g., because they live some distance away or have a schedule that makes them hard to reach).

Accordingly, we anticipate that this proposal may routinely extend the length of stay for many Medicare beneficiaries by at least one day, regardless of the severity of the cases involved. At a time when CMS is increasingly examining both hospital and physician quality, we are afraid such increasing lengths of stay will reflect negatively on our members and the hospitals that they serve.

For these reasons, we ask CMS to rescind its proposal requiring hospitals to provide a standardized notice of non-coverage the day before discharge and, instead, revise the current "Import Message" to include whatever information CMS believes is currently lacking in this regard. By revising the current "Important Message" and maintaining the requirement to provide it at or about the time of admission, CMS will maximize the opportunity beneficiaries have to discuss the eventual discharge with all concerned, including their family, primary physician and, perhaps, consultants. This approach ensures beneficiaries have adequate time to address discharge questions and issues without creating an additional burden for hospitals and physicians.

Thank you for your time and consideration of these comments.

Sincerely,

Mary E. Frank, M.D., FAAFP
Board Chair

Submitter : Mr. Daniel Byars **Date:** 06/05/2006

Organization : Centegra Norhtern Illinois Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

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

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

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

Submitter : **Ms. Helene Dujardin Dujardin** **Date: 06/05/2006**

Organization : **UMDNJ-University Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

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

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

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

Organization : **Managed Health Network**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

We submitted a similar attachment an hour ago, but we have made some minor changes...very minor! We wanted to resubmit regardless of the impact of the changes.
Thank You

See attachment (v2)

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

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

Submitter : Helene Dujardin

Organization : UMDNJ-University Hospital

Date: 06/05/2006

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-403-Attach-1.DOC

June 5, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-4105-P
PO Box 8010
Baltimore, MD 21244-1850

RE: CMS-4105-P

This letter on behalf of UMDNJ-University Hospital provides specific comments on the proposed rule and addresses the issue that the proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns. In addition, the hard copy signature and recordkeeping requirements are counter to hospital movement to electronic medical records.

Provisions of the Proposed Rule

There are several problems with the proposed approach. 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. 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. 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.

Collection of Information and Recordkeeping Requirements

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 estimated cost and burden of the proposal is understated. A realistic assessment must account for: 1) the time needed to explain the notice and why it must be signed, 2) the time needed to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent, and 3) the additional length of stay caused by the requirement to provide the notice the day before discharge after the discharge order is written "on the day before discharge" but after the discharge decision has been made.

We agree with the AHA recommendation 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.

We appreciate the opportunity to comment on this proposed rule.

Sincerely,

Helene K. Dujardin
Director of Business Development
UMDNJ-University Hospital
150 Bergen Street - D209
Newark, NJ, 07103

Submitter : **Mr. Roger Lamontagne** **Date: 06/05/2006**

Organization : **Harrington Memorial Hospital**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-404-Attach-1.DOC

June 5, 2006

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

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

Dear Dr. McClellan:

I appreciate 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. I am the Director of Social Services at Harrington Memorial Hospital in Southbridge, Massachusetts. Harrington Memorial Hospital is a 113-bed nonprofit community hospital. My responsibilities include the management of the discharge planning process for the hospital's inpatient population.

As the hospital's manager of the discharge planning process, I have been responsible for the implementation of effective post discharge planning for over 23 years. Our current discharge planning process begins on admission, and in some elective circumstances on pre-admission. The Important Message from Medicare is provided during patient admission and registration. Our hospital utilizes a nurse/social worker collaborative model to assess on admission the patient's current living situation and needed resources. We utilize a high-risk screening criteria to identify patients who are expected to need post discharge services and seek to ascertain the patient and family preferences to individualize the discharge plan. We do a comprehensive biopsychosocial assessment on all Medicare patients admitted to our hospital. All patients, family members and legal representatives are actively engaged to participate in the discharge planning process. We provide the patient and/or representative with a written discharge plan. We provide the patient and representative with written materials about available resource choices for post hospital services.

This proposed rule with its new notice of Medicare appeal rights would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date. The new notice would be in addition to the current written discharge plan and printed attachments that are presently provided to patients at Harrington Memorial Hospital. Our discharge planning

process also includes post discharge follow up monitoring to maintain a quality delivery of care.

The proposed rule seeks to have hospitals conform our comprehensive discharge planning process to a format that is being provided by home health agencies, skilled nursing facilities, outpatient rehabilitation facilities, and hospices. There has been no compelling case for the need to implement this change upon the acute care facilities. I do not believe these changes should occur without a more thorough and realistic examination of the process. 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.

The financial repercussions of the proposed rule will not be fully responded to in this letter. I will leave to others within the health care system to reply more fully. 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. Community hospitals operate on small margins, and mandating paper compliance without real added patient value is counterproductive to efficient stewardship of health care dollar.

I would recommend that if there are specific issues with the discharge planning process that need to be addressed, 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.
I appreciate the role of CMS in safeguarding patient rights. I believe we must protect patient rights while also stewarding government resources and ensuring that some patients do not take advantage of an opportunity to unnecessary extend a length of stay; thus, adding significant costs to Medicare without added value.

Sincerely,
Roger R. Lamontagne, MSW, LICSW, BCD
Director of Social Services

Submitter : Mr. Paul Sanders
Organization : Community Memorial Hospital
Date: 06/05/2006
Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P2-405-Attach-1.DOC

Attachment #405

Community Memorial Hospital
W180 N8085 Town Hall Road
Menomonee Falls, Wisconsin 53051

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

June 5, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am a <title> at <facility>, a <x bed>, <teaching, community, etc.> Hospital/Heatlhcare System located in <city, state>.

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

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

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

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

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

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

Sincerely,

Paul R. Sanders
VP Clinical Services

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

Organization : Advocate Trinity Hospital

Category : Nurse

Issue Areas/Comments

Background

Background

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. This can have a significant impact on throughput from the ED, beds may not be utilized efficiently therefore unnecessarily increasing lengths of stay and by decreasing available beds for admission.

GENERAL

GENERAL

There is a concern with available staffing to deliver a patient-specific generic notice to every Medicare patient seven days a week. Here at our organization the notices are delivered by the Care Managers. This delivery process takes longer than 5 minutes, on average 25 minutes this allows patient s to ask additional questions and review options. This time can possible be even longer for those patients requiring a translator, or when having to track down a family member for patient s who can not sign for themselves. There will be additional administrative requirements for the entire process including hard copy signature and record keeping requirements. Weekend staffing would be required to appropriately meet Medicare s proposed one-day notice requirement. When staff are working weekends the priority is reviewing for medical necessity and helping facilitate the weekend discharges.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS proposes to establish a two-step discharge notice similar to the process in effect for SNFs, HHAs, CORFs, and hospices. Hospitals differ from SNFs, HHAs, CORFs, and hospices, patients have a shorter length of stay. Because of a short length of stay many between 1-3 days, discharge planning in a hospital setting frequently begins at the time the Medicare beneficiary is admitted to the hospital. Hospital social work, discharge planning, and care management staff work closely with the physician throughout a patient s stay to convey to the patient length of stay expectations, to explore post-discharge options, and to assist with post-discharge arrangements.

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. Discharges would be delayed to meet the rule

Regulatory Impact

Regulatory Impact

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 Medicare program who are dissatisfied with a pending discharge. This 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.

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

Organization : Saint Margaret Mercy

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Inpatient stays have grown shorter over the past few years. Physicians base their decision to discharge on test results and patient condition. Sometimes, discharge cannot be anticipated much in advance. Physicians, case managers & nurses try to keep patients & families informed of the likely discharge date, but that is not always possible. At times, patients are mentally incompetent or families are difficult to reach or do not return our phone messages. This regulation would require us to keep patients hospitalized longer than necessary in order to provide the notice of proposed discharge and could expose patients to unnecessary germs. How would this process work for a patient who has surgery on a Friday and normally only has a two day length of stay? If a hospital does not staff their case management staff on Saturday, would the patient need to stay until Tuesday instead of going home on Sunday to recover at home?
I have many concerns about this proposed rule. Hospitals, physicians etc. are trying their best to keep patients informed...no one likes an unhappy patient. But this proposed regulation will hamper more than it will help the process.

Submitter : **Mrs. Phyllis Fritsch** **Date: 06/05/2006**

Organization : **Upland Hills Health, Inc.**

Category : **Hospital**

Issue Areas/Comments

Background

Background

To Whom It May Concern:

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

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

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

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

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

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

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

Organization : **Intermountain Healthcare**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

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

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

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

Organization : **Intermountain Healthcare**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-410-Attach-1.DOC

CMS-4105-P2 - Notification Procedures for Hospital Discharges

Provisions of the Proposed Rule

In response to the proposed rule above, please consider the following:

1. Acute care hospitals are distinctly different entities from HHAs, SNFs, CORFs, and hospices whose length of stay is significantly longer and the decision to "terminate services" is inherently different from the physician controlled acute care discharge process.

    - Coordination of efforts in the acute care setting to discern the exact discharge time would fall on the hospital organization, not the physician who has no formal accountability to comply.
    - There are too many variables surrounding the discharge process and the health status of patients in the acute care setting. This environment is much too complex to require the hospital to anticipate accurate discharge times and coordinate the discharge notification form. A change in the anticipated date of discharge could create multiple problems including rescinding methods and resources required, patient confusion, and a change in financial responsibility.
    - Given the current hospital environment of increasingly shorter lengths of stay (especially 1-2 day length of stay); this requirement is not practical in that the discharge notice would have to coordinated upon admission.
    - Acute care discharge decisions often occur "just in time" and the proposed process would impose unnecessary lengths of stay and increased costs.

2. Requiring a notice one day prior to discharge will be a significant burden to hospitals with no apparent benefit to beneficiaries. We believe that this process will:

    - Significantly increase administrative burden and unnecessary paperwork.
    - Make it difficult to track compliance and establish appropriate auditing processes.
    - Increase the complexity of the acute care process.
    - Create confusion to the beneficiary about discharge expectations and their potential risk of financial responsibility.

3. The current process of delivering "The Important Message From Medicare" upon admission and the Hospital Issued Notice of Non-Coverage (HINN) when beneficiaries disagree with a physician's order for discharge has proven sufficient to provide beneficiaries a clear understanding of their rights to appeal. The proposed rule would be a redundant and unnecessary administrative burden.

To require a discharge notification process for ALL beneficiaries, when the current processes sufficiently protect beneficiary rights, imposes an excessive burden on acute care providers, physicians, and beneficiaries.

Submitter : **Mrs. Jana Endicott** **Date: 06/05/2006**

Organization : **OakBend Medical Center**

Category : **Nurse**

Issue Areas/Comments

Background

Background

Regarding CMS-4105-P2
It is my humble opinion that adding this additional step would be extremely burdensome to all entities that are required to comply if this proposal is passed.

The burden to educate Medicare Beneficiaries falls to the entities that provide care to those individuals. When pts admit to our hospital they are provided with information regarding their rights as Medicare Beneficiaries.

As the Director of Case Management I am frequently ask to provide education and information to these individuals and their families during their hospital stay. Nearly all of those that I come into contact with have limited to no understanding how Medicare works and I have spent numerous hours educating these individuals.

I can only imagine how many more issues we would have if we had to go into every MCR pts room to tell them that the physician is planning on d/c'ing them within 24 hours and do they want to challenge this decision. Not to mention how hard it would be to pin a physician down on an exact d/c date.

I can guarantee that in most instances they or their families would choose to challenge the discharge because we have a large sub-group of the population that likes to makes others accountable and responsible for their issues. If they can get a hospital to take care of grandma, etc for a few more days that means that they don't have to be accountable and responsible for that care.

For anyone that has ever issued a HINN letter, they know how time consuming that process can be. The pts/families don't understand that the pt must continue to meet medical necessity criteria in order to stay in the hospital. All they understand is that the hospital is throwing them out!!!

They do not understand that the hospital is just complying with the rules and regulations that they are required to comply with if they want to continue to provide healthcare services to Medicare recipients.

It would require many man hours to implement this proposed process not to mention the impact that this change would have on the current staffing since case managers would be required to be onsite 7 days a week. Many facilities don't have the ability to provide this kind of coverage, not to mention the cost involved to do so.

What might start as a short 5 minute conversation will routinely turn into a 30-60 minute educational session because of the lack of knowledge that the pt/family has regarding how MCR works.

I don't think that this proposal would be a benefit for anyone involved. Especially the Medicare Recipients!!!

GENERAL

GENERAL

Please note comments entered in the Regulatory Impact box.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

I do not feel that this proposed rule should be passed and that Medicare recipients should not have to sort through yet another set of rules regarding their medical coverage.

Submitter : **Ms. Sherry Poplin** **Date: 06/05/2006**

Organization : **Stanly Regional Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

As a director of UR, Case Management, and Social Work Services with 20 years of hospital discharge planning experience, our department works proactively with patients to plan for their discharges. Throughout this process they have an opportunity to determine the most appropriate discharge plan. Patient's are provided information to choose services they may need for discharge. The current system of reimbursement in no way covers the expenses that our hospital incurs while dealing with patients whose needs are very complex, family situations are complicated, and resources may be limited.
The staff of our department have several concerns about the proposed revisions:

(1) Lengths of Stays will drastically increase due to the complexity of timing the notification of the patient or family with when the physician determines a patient is medically ready to go. Discharges are very complex due to various patient's needs. The need to notify a day prior to discharge is often not in the best interest of some patients, especially patients from SNF's who may be paying to hold a nursing home bed. Also, families who may be the care provider for dependant patients are often not readily accessible to sign a notice.

(2)The CMS proposed changes place an administrative burden on the hospital that greatly outweighs the benefits. The assumption that this process will only take 5 minutes appears to only consider the completion of the paperwork. When dealing with patients and families, particularly older persons, these types of notices often causes them confusion. With the number of Medicare patients that we see, we would struggle to be able to adequately provide the quality of time that this type of process would take. There are already too many processes that require we "get a notice signed" without taking into account what these processes do to our patients and families.

(3) We strongly believe that the 1 -2% extimation of beneficiaries that would request an expedited appeal is underestimated. Many families look for reasons for a family member not to be discharged because of their own acceptance of a patient's condition or need for nursing home care. This process would give further opportunity for them to remain in the hospital - all at the expense of the facility.

(4) We strongly believe in patient's rights. However, the extent to which this can be carried can be financially detrimental for many hospitals. As an acute care provider, we want to remain a viable option for our patients. This can only be done by ensuring our resources are utilized appropriately and efficiently.

Thank you for your review and consideration of our comments.

Patient and Family Services Department of Stanly Regional Medical Center - Albemarle, NC 28001

Sherry Poplin, MA, CSW, Director
Debbie Smith, RN, Case Manager
Carol Goodman, RN Case Manager
Beth Huneycutt, RN Case Manager
Anita Honeycutt, BSW
Teresa Brady, BSW
Sandy Atkinson, BA
Deanette Russell, RN Clinical Review
Gay Taylor, RN Clinical Review
Pam Howell, RN Clinical Review
Robin Mauldin, RN Clinical Review

Submitter : **Ms. eileen young** **Date: 06/05/2006**

Organization : **crozer keystone health system**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

The term hospital level of care has changed greatly over even the last ten years. Length of stay has decreased dramatically. Gone are the days, except maybe in rehab, that a physician determines a day or two in advance what day the patient will be discharged. The decision of hospital level of care versus discharge, especially at the end of a patient s stay, is often made on a day-by-day basis. This rule would, in effect, add a day of stay to every patient ready to go home to ensure compliance. The best thing for a patient who is clinically stable and ready for discharge is to be discharged, and NOT held for a "defined" 24-hour period to meet a rule.

Increasing the hospital length of stay to comply with the proposed rule will result in holding up placement of emergency admissions, overcrowdc din hospital E.D. s and cause unnecessary ambulance diversions. This proposal has the potential to add to the already difficult problems being faced in our hospital s emergency departments.

There are numerous situations where the patient is being discharged from an acute care hospital to another reimbursed level of care such as a psychiatric hospital, skilled nursing facility or even another acute care general hospital. It seems particularly problematic that this rule be applied in those situations. For example, do you really want a patient admitted status post suicide attempt to be kept in the acute care hospital an additional day after medical clearance rather than being transferred to the appropriate environment of an acute psychiatric unit?

The administrative burden has been underestimated in this proposed rule. Preparing, delivering, reading, explaining, and tracking the notices will require considerable more time than the estimated 5 minutes. In short, CMS has proposed a rule that creates another unfunded mandate for hospitals across the country.

Responsibility to deliver these notices will fall largely to bedside nurses who are one of the only members of the team present 24/7. Every time we add administrative burden to the nurse, it is time not spent with a patient.

In summary, CKHS believes the current process does inform and protect the patient against early or unsafe hospital discharge. Adding this additional step creates a cumbersome and confusing process for patients that will add a day of stay to each Medicare patient s stay. That added day will be uncompensated and exacerbate hospital overcrowding, wait times and divert. The additional administrative burden will fall on the bedside nurse and take time that should have been spent at the bedside.

CMS should consider convening a stakeholder group of the various constituencies to determine how best to address these concerns about discharge planning. The work of the stakeholder group could then be used to establish a demonstration project prior to implementation nationwide.

Crozer Keystone Health System appreciates the opportunity to provide this feedback to CMS.
We urge CMS to retain the current process with consideration given to modifying the current Important Message from Medicare to make it much more explicit about procedures available to patients who disagree with planned discharge from the hospital or a decision made by a Medicare Advantage plan for hospital non-coverage. At the very least we strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Should you have any questions regarding these comments, please feel free to contact me, at 610-338-8246 or by email at Eileen.young@crozer.org.

Respectfully,

Eileen E. Young, MSN, RN, CMAC
Assistant Vice President, Clinical Utilization/Outcomes
Crozer Keystone Health System
100 W. Sproul Road, HP II
Springfield, Pa. 19064

Regulatory Impact

Regulatory Impact

Crozer Keystone Health System welcomes this opportunity to comment on the proposed rule Medicare Program; Notification Procedures for Hospital Discharges, as published in the April 5, 2006, Federal Register.

It is evident in the design of this rule that there is a fundamental lack of understanding on how care is delivered in the hospital setting today. While the health system certainly understands the underlining concern for the beneficiaries well being and the need for them have a safe, appropriate transition on discharge from the hospital, there are many impractical and negative issues to the rule as published.

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

Some of the issues or concerns on the part of Crozer Keystone Health System include:

Hospitals are presently required to provide the Important Message from Medicare to patients upon hospital admission and a notice on how to request a review/determination when the patient disagrees with hospital discharge. This add an additional step. This now three-step process for Medicare beneficiaries where the average length of stay is less than six days is unreasonable. It is even more cumbersome, confusing and burdensome for patients in the hospital 72 hours or less. We believe the current process provides patients with the notice and protections they need regarding inappropriate or unprepared discharges. If CMS believe hospitals are not following the current rules and regulations, action should be taken against offending hospitals not add additional steps, burden and member confusion to the process for all.

Submitter :

Date: 06/06/2006

Organization :

Category : **Hospital**

Issue Areas/Comments

Background

Background

Requiring hospitals to provide each Medicare beneficiary with a standardized, generic discharge notice 1 day before discharge is, by itself, an extra amount of work to be done by "hospital staff". In these days of attempting to make work as efficient as possible, adding 1 more requirement with a specific anticipated deadline in anticipation that 1% of beneficiaries might request an expedited review, could be seen as an undue burden on hospital resources.

GENERAL

GENERAL

It does not make sense to add an additional burden to hospital staff. In these days of working to increase quality care for all patients, it makes sense to add requirements where there is a reasonable rationale - not just because other health care institutions are already required to do something!

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The idea that QIO staff who are not familiar with the patient, circumstances, or care required, could make a decision that is "better" for the patient than the physician and staff caring for the patient is insulting to hospital staff and physicians. When patients or family members have issue with discharge plans, the appropriate mechanism for addressing these is to have a discussion with the physician and care team involved with the patient.

Submitter : **Mrs. SUSAN NEDER** **Date: 06/06/2006**

Organization : **FLAGSTAFF MEDICAL CENTER**

Category : **Nurse**

Issue Areas/Comments

Background

Background

CMS proposed rule requiring a two-step discharge notice in hospital setting:
Prior to any discharge, the hospital must deliver a valid, generic notice to patient one day before discharge.

GENERAL

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See attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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

Regulatory Impact

Regulatory Impact

Sue Neder RN,OCN,CPUR
1 and half yrs. @ Flagstaff Medical Center as a Utilization RN.

CMS-4105-P2-415-Attach-1.DOC

Attachment #415

Flagstaff Medical Center

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

June 5, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am a RN at a hospital, a 250 bed, community, Hospital/Heatlhcare System located in Flagstaff, Arizona.

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

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

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.4 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

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

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

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

Sincerely,

Sue Neder RN, OCN, CPUR