Submitter : **Date: 05/08/2006**

Organization :

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I do not agree with the proposal to require all hospitals to give 24 hour notice prior to discharge. I am a social worker/case manager for a hospital and I do not feel that this is a reasonable proposal. First of all, with all of my other job duties, I do not foresee myself having time to give a written notice to a pt. prior to their discharge. (Case managers meet with all new pt.'s, review every chart on a daily basis, not to mention all of the issues involved in discharge planning.). Next, what if the pt. comes in on a Friday evening and discharges on Saturday or Sunday? There is only one member of case management that works on Saturday, and nobody on Sunday, so with all of the other important things (ie, setting up free meds, transportation, seeing the new pt.'s, etc...) I do not see how a discharge letter could be given. Also, if the pt. is here less than 24 hours, then what? Next, most Dr.'s do not even notify case management hours before their discharge, let alone 24 hours before their discharge. Also, what if the pt.'s condition changes rapidly over night, are we supposed to keep them in the hospital an extra day so that we can give them 24 hour notice? My next question is what if the patient refuses to sign the form stating that we are giving them 24 hour notice? Is the hospital bill going to be denied because of this? Some patient's already feel that they are being sent home to soon, so to give these pt.'s a letter stating that they will be discharged within 24 hours is just going to make them more angry. My understanding is that this letter needs to be administered to the pt. by 12:00pm, how is this going to happen when many Dr.'s do not even make rounds until late afternoon? Another question I have is does a copy of this letter need to be saved, and where will it be stored at? On the chart, medical records, etc..? Another question is what if the pt. is not alert and oriented? Can they stil sign this letter? If not, often times family members are not available at all times, so who would be responsible for signing this letter? Also, how can the hospital determine whether or not the pt. is capable of signing the form? Quite honestly I think this is quite a ridiculous proposal. Obviously the law makers are not members of a medical staff that works in a hospital. Some patients are already confused about Medicare and all of the changes that are being made, is it really necessary to confuse them even more? Supposedly it will only take 5 minutes to deliver this letter, I do not think that this is the case. There is no way that the letter can be explained and all of the pt.'s questions answered (you know they will have questions) in 5 minutes of less. If this proposal is to pass, I think hospitals will be losing a great deal of money and pt.'s will be provided with a headache prior to their discharge.

Submitter : **Kaaron Keene** **Date: 05/09/2006**

Organization : **Memorial Health Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I am very concerned about the proposed rule to require notice of non-coverage the day before hospital discharge. Hospital stays are very short these days (as a result of cost saving measures.) We often do not know that someone is ready for discharge until the day of discharge, because we are waiting for lab work, to see how pain is controlled, to evaluate physiologic response to our therapy, etc. If we have to issue a notice the day before discharge, we will certainly see a delay in getting people home. In the age of DRG's, it will add to health care expenditures, increase the cost shifting to non-government programs. It will directly increase CMS's costs for Critical Access Hospital care, and most likely fuel the fire of those who are critical of cost-based support for Critical Access hospitals. Our health care system in the rural areas is fragile. I am very concerned about adding one more layer of paperwork to a paper-heavy system.

Submitter : Mrs. Renee Leary, RN **Date:** 05/09/2006

Organization : Greater Baltimore Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I think this ruling will negatively impact all involved. The Hospitals will suffer because it has been very underestimated the amount of time it will require to issue this notice. I have issued similar notices in the past (Medicare Risk) and many elderly beneficiaries become alarmed or confused and require clarification and support which can easily take an extra 15 minutes. And the time spent tracking down and explaining to family/guardians? Hospitals will not allot extra staff so this will shift duties off of more important tasks with the beneficiary being the ultimate loser. Please rethink this and cancel the proposed ruling. It is a bureaucratic nightmare just waiting to happen. What a waste of paper too! Thank you.

Submitter : Ms. Kathy Tempel **Date:** 05/09/2006

Organization : Memorial Hospital, Jasper IN

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

The procedure outlined in teh Proposed Notification of Hospital Discharge seems excessively cumbersome and complicated. As I read this, the requirement would be to notify EACH CMS discharge AT LEAST 24 hours prior to the discharge, in order to 'think about the discharge decision and decide whether to pursue an expedited review'. Given the push for shorter length of stay and increased flexibility in discharge planning, this seems to place a new layer of challenge to care of patients. Nursing and Discharge staff currently stuggle to meet basic patient needs in an ever-increasing field of requirements. Patient safety being our primary concern, we often struggle to cover all of the needs of regulatory agencies as well as the patient need. The addition of another form to hand to each CMS patient while struggling to meet basic medical needs seems overwhelming. CMS patients are most often the elderly and will require an explanation of the form and their response to it. This will take away time & impact from the education we need to provide patients for the safety at home. Since the process seems confusing to me, I can only imagine what it will feel like to patients! I know what it will look like to our staff. As for Physicians - insisting that they be able to identify a firm discharge plan 24 hours in advance will stretch the already complicated day they have. The QIO will also feel the impact of this legislation - if nothing else due to the confusion that will follow the forms.

There seems to be no balancing benefit to the requirement - patients do have the opportunity currently to voice concern about their discharge plan. They do have input into when & how the discharge will occur. There are current regulations that require discharge plans to begin early in a stay and to involve the patient and family. There are requirements for staff to be devoted to discharge planning. I do not find an additional benefit to the proposal. Our Hospital will stuggle under the process outlined in the Proposed Rule and our patients will recieve no benefit. I beg a reconsideration of the requirement!

Kathy Tempel
Director Quality/Discharge Planning
Memorial Hospital, Jasper IN

Submitter : Mrs. Cam Christensen **Date:** 05/10/2006

Organization : Asante Health System

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-582-Attach-1.DOC

CMS-4105-P-582-Attach-2.DOC

Attachment #58

File Code - CMS – 4105-P
Medicare Program
Notification Procedures for Hospital Discharges

May 5, 2006

Proposed Rule Comment:

Once again, CMS is preparing to impose another unnecessary and burdensome requirement on hospitals, with their proposal to notify all Medicare beneficiaries in writing of impending discharge within 24 hours. To suggest that this process would only require 5 minutes per patient shows a complete lack of understanding of hospital operations. In addition, patients already receive the "Important Message from Medicare" on admission, which gives a detailed explanation of their right to appeal if they feel they are being asked to leave too soon. And it is inconceivable that preparation for the detailed termination notice would require 60 to 90 minutes. Is the QIO going to be available on weekends for case review?

CMS must understand that this action would require dedicated staff to follow up with each physician on a daily basis for an estimate of when he/she plans to discharge the patient. Since this function would likely fall to Case Management staff, just tracking alone would require additional FTE's, for the weekday and weekend. It isn't as though they are dealing with only a few physicians. There are hundreds of physicians on the medical staff that would require hounding on a daily basis. Actually, with complex cases where there is intense involvement by the hospital discharge planner, there is more predictability than on straightforward cases, where there is rapid response to treatment.

The suggestion that this hospital requirement would level the playing field, since Home Care Agencies and Skilled Nursing Facilities have similar notification requirements is completely absurd. Those agencies and facilities generally have a more predictable patient population and longer lengths of stay. When removing outliers, our Medicare inpatient length of stay is approximately 4 days. What about "inpatient only" procedures that only remain overnight or patients who meet InterQual acute criteria on admission but respond quickly to treatment? Why should they be given a 24-hour notice, when they meet InterQual discharge screen criteria? What happens when the anticipated discharge does not occur on that day? Does the patient get another 24 hour notice?

Instead of implementing a new and redundant process, it would seem prudent for CMS to pay attention to some other glaring Medicare problems, such as Observation Services, which cost hospitals an enormous amount to monitor for compliance. Fifty percent of the Utilization Management staff's time involves Observation tracking. Every time CMS issues a clarification of rules, the process gets worse, i.e., Condition Code 44. Before adding yet another barrier to efficient movement along the continuum of care, it would seem prudent to finally put this one to rest. That can be done by designating all admissions of 24 hours or less as Outpatient/Observation. Another murky area needing attention is self-administered drugs in the Outpatient/Observation setting. Part D didn't help Medicare beneficiaries in this instance.

It's incredible that CMS is proposing to add more red tape to already over-regulated/over-burdened hospitals. Physicians decide discharge, not hospital staff. As with Observation vs. Inpatient, the physician will have no financial incentive to comply. In addition to requiring additional staff to administer, this proposed rule will increase length of stay and inevitably lead to an increase in the cost of healthcare. Furthermore, it's preposterous to believe that hospitals would have the ability to comply with this requirement even a majority of the time.

Today's Medicare population is the most entitled and protected population in the nation. Please consider the ramifications of this proposal.

Submitter : Mrs. Cam Christensen **Date:** 05/10/2006

Organization : Asante Health System

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-592-Attach-1.DOC

Attachment #59-58 Duplicate

File Code - CMS – 4105-P
Medicare Program
Notification Procedures for Hospital Discharges

May 5, 2006

Proposed Rule Comment:

Once again, CMS is preparing to impose another unnecessary and burdensome requirement on hospitals, with their proposal to notify all Medicare beneficiaries in writing of impending discharge within 24 hours. To suggest that this process would only require 5 minutes per patient shows a complete lack of understanding of hospital operations. In addition, patients already receive the "Important Message from Medicare" on admission, which gives a detailed explanation of their right to appeal if they feel they are being asked to leave too soon. And it is inconceivable that preparation for the detailed termination notice would require 60 to 90 minutes. Is the QIO going to be available on weekends for case review?

CMS must understand that this action would require dedicated staff to follow up with each physician on a daily basis for an estimate of when he/she plans to discharge the patient. Since this function would likely fall to Case Management staff, just tracking alone would require additional FTE's, for the weekday and weekend. It isn't as though they are dealing with only a few physicians. There are hundreds of physicians on the medical staff that would require hounding on a daily basis. Actually, with complex cases where there is intense involvement by the hospital discharge planner, there is more predictability than on straightforward cases, where there is rapid response to treatment.

The suggestion that this hospital requirement would level the playing field, since Home Care Agencies and Skilled Nursing Facilities have similar notification requirements is completely absurd. Those agencies and facilities generally have a more predictable patient population and longer lengths of stay. When removing outliers, our Medicare inpatient length of stay is approximately 4 days. What about "inpatient only" procedures that only remain overnight or patients who meet InterQual acute criteria on admission but respond quickly to treatment? Why should they be given a 24-hour notice, when they meet InterQual discharge screen criteria? What happens when the anticipated discharge does not occur on that day? Does the patient get another 24 hour notice?

Instead of implementing a new and redundant process, it would seem prudent for CMS to pay attention to some other glaring Medicare problems, such as Observation Services, which cost hospitals an enormous amount to monitor for compliance. Fifty percent of the Utilization Management staff's time involves Observation tracking. Every time CMS issues a clarification of rules, the process gets worse, i.e., Condition Code 44. Before adding yet another barrier to efficient movement along the continuum of care, it would seem prudent to finally put this one to rest. That can be done by designating all admissions of 24 hours or less as Outpatient/Observation. Another murky area needing attention is self-administered drugs in the Outpatient/Observation setting. Part D didn't help Medicare beneficiaries in this instance.

It's incredible that CMS is proposing to add more red tape to already over-regulated/over-burdened hospitals. Physicians decide discharge, not hospital staff. As with Observation vs. Inpatient, the physician will have no financial incentive to comply. In addition to requiring additional staff to administer, this proposed rule will increase length of stay and inevitably lead to an increase in the cost of healthcare. Furthermore, it's preposterous to believe that hospitals would have the ability to comply with this requirement even a majority of the time.

Today's Medicare population is the most entitled and protected population in the nation. Please consider the ramifications of this proposal.

Submitter : Ms. patricia brady **Date:** 05/10/2006

Organization : grande ronde hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

'PROVISIONS OF THE PROPOSED RULE' There are so many concerning questions with this proposal. 1) The hospital acute care setting is in constant flex. Many times the physician isn't sure he plans to discharge the next day and may cancel an expected discharge due to new medical findings or may even make the final decision to discharge that day. 2) How would we manage the confused and the unavailable family members? 3) What occurs on weekends? Would beds be tied up waiting for the next business day when rulings can be made? This would impact staffing needs and bed availablity for other acutely ill patients. 4) The probability that you will see more patients/family members requesting reviews especially knowing their not financially responsible during the decision making time -- Some patients enjoy staying at the hospital and families want their family member here because of the safe/convenient care. CAH's would experience difficulties in providing care if there is an increase in patient lengths of stay based on this ruling. Having beds tied up while a patient awaits a ruling, when the physician has determined their stable and an alternative level of care is appropriate,limits care availablity for others within the community. 6) The elderly patient is already given so much information at discharge the confusion it will cause them seems unnecessary. I can not see this ruling benefiting anyone. Hospitals already have in place the use of HINN's and with a strong process in place regarding early discharge planning the patient/family should have plenty of time to discuss the plan of care and any concerns they may have with it. To apply a process like this to the hospital setting is wrong and although it has worked(to the best of its ability) in the different long-term settings, ie.HH and SNF's, I can not see its benefit here.

Submitter : **Mrs. Brandie Manuel** **Date: 05/12/2006**

Organization : **Grande Ronde Hospital**

Category : **Hospital**

Issue Areas/Comments

Background

Background

Medicare Program; Notification Procedures for Hospital Discharges

GENERAL

GENERAL

'Provisions of the Proposed Rule'--As a Certified Professional Utilization Review Nurse, as well as a Quality/Risk Manager in a CAH, I have serious concerns about the impact that this proposed ruling would have on our current discharge planning program. We have an effective Utilization Review Program and we work hand in hand with both the patients and the physicians from the time that the patient is admitted to facilitate a safe discharge plan. There are, however, some patients who enjoy the inpatient experience. These patients could potentially abuse this ruling to allow them a longer inpatient stay, regardless of how stable they might be for discharge.

I believe that the proposed ruling would open the door to what could potentially be a lengthy appeal process. This would, in turn, tie up a bed that is needed for another, more acutely ill patient. Health care is not predictable, and there are no guarantees regarding when a patient will be ready for discharge. A patient may be very ill one moment, and less than 24 hours later, be stable for discharge (or alternate level of care). Requiring this type of notification would only delay the process for an additional day. This seems counter-productive to keeping avoidable inpatient days to a minimum.

This process would allow for abuse of the system and could be highly unsafe if a new patient (who needs to be admitted) would need to be transferred out of the area due to lack of beds.

We currently issue HINN letters when necessary, and this is typically perceived as a negative experience by the patient and/or family. I fear that this proposed rule would generate negativity from our patients who would otherwise be happy with our discharge planning process. I strongly urge you to reconsider the proposed ruling and appreciate your time and consideration. Thank you.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The propsed rule sets forth new requirements for hospital discharge notices under both original Medicare and the Medicare Advantage program. This proposed rule would require hospitals to comply with a two-step notice process when discharging patients from teh hospital level of care that is similar to the notice requirements regarding service terminatoins applicable to home health agencies, skilled nursing facilities, comprehensive oupatient rehabilitation facilities, and hospices.

Submitter : **Mrs. Diana Jones** **Date: 05/12/2006**

Organization : **Grenada Lake Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-622-Attach-1.DOC

Attachment #62

glmc
Grenada Lake Medical Center
960 Avent Drive • Grenada, Mississippi 38901-5094
Phone (662) 227-7000

May 9, 2006

To Whom It May Concern:

Grenada Lake Medical Center would like to formally make comments concerning the proposal to implement Notification Procedures for Hospital Discharges, File Code CMS-4105-P. Because it would be difficult, costly, and time consuming, this procedure should not be implemented for the following reasons:

1. Short length of stays, especially one day stays, are virtually impossible to predict day of discharge and then provide advance notice to the patient.
2. Unexpected discharges due to late physician rounds, patient request to go home, and dramatic clinical improvement in a short period of time make prediction of discharge difficult.
3. Inability to determine if the patient's illness will improve to meet discharge screens by a certain date.
4. A high percentage of patients are discharged after business office and case manager hours and on weekends. Teaching other staff would be difficult and time consuming. Patient instruction after hours may not be accurate and effective.
5. Customer dissatisfaction has been noted with implementation of this process in other areas. Patients do not see this as a Medicare required form, but are unhappy with the provider and may lead to interference with care.

Respectfully,

Diana Jones, RNBSN
Director of Case Management

Submitter : **Ms. Kathryn Bennett** **Date: 05/15/2006**

Organization : **Bloomington Hospital**

Category : **Hospital**

Issue Areas/Comments

Background

Background

This rule will increase cost of healthcare throughout the nation, let alone the individual cost to the hospitals providing the care. It will increase the LOS for patients, increase their risk of a hospital-related injury, increase patient anxiety (as they do NOT understand the Medicare regulations, and will decrease throughput in already challenged facilities. It is next to impossible to predict a day ahead when many of these patients will be released. What about the MD who rounds at 7 PM? Who are hospitals supposed to make responsible for having patients sign this form and explain the meaning behind it? What if there is no one to sign? How many patients will ask for an immediate review when it is totally unnecessary, buying them an additional average of 3 days in the hospital? How many patients will stay an extra unnecessary day due to not being notified the day before? What about short stays? What about weekend stays? The cost that you predict to hospitals and the time involved is totally off the mark. We make numerous phone calls trying to track down family members of patients who can't sign for themselves. Even when they can't sign, they don't understand, so they want us to discuss with family members. I have tried for over a year to get a "pending discharge notification" process in place with NO LUCK! If we can't do this, then we'll not be able to predict discharges for the next day. Are you going to make us responsible for teaching physicians about this? Do you know how irate physicians will be when they have to round on their patients another day simply because we didn't get a form signed the day before? How much money will be spent by the QIOs to manage all of the requests they will get for continued stay reviews? What about all the employee time hospitals will spend in copying medical records, and the cost of paper and shipping the medical records, along with the cost of the additional days of care, including medications, just because a form wasn't signed--doesn't have anything at all to do with medical necessity, just getting a piece of paper signed.

GENERAL

GENERAL

I find this whole process to be ludicrous in a time when throughput is crucial, hospital costs are at an all-time high with no signs of slowing down, hospital stays are dangerous to patients and Medicare patients do not understand the Medicare regulations at all. Most of them have no idea what medical necessity means! Now we're going to encourage them to question the appropriateness of their discharge when they don't even begin to understand medical necessity. And the hospitals are going to have to bear the financial brunt of this regulation. Which means hospitals will raise their charges to commercial companies to help make up the loss. It is a huge, endless cycle of lunacy!! Why don't you try trialing this somewhere first before adopting this rule nationwide? Have you performed any trials? Instead of pushing for this, allow physicians to write orders to "Admit patient per case management protocol" so patients can get admitted to the correct status. A QIO in Florida trialed this with financial savings, decreased denials, and physician and hospital satisfaction. Even though this trial had very satifactory results, our QIO won't allow us to do this!! At the very least, I should think you would need to have a successful trial before even considering implementing a change like this.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Are there any exceptions to the rule?

Submitter : Mrs. Suzann Sullivan **Date:** 05/16/2006

Organization : Vernon Memorial Healthcare

Category : Hospital

Issue Areas/Comments

Background

Background

The regulatory impact that this rule would suggest is oposite of what we are trying to do in Health Care today. Instead of cutting costs this would increase costs. Aside from the estimated dollar amounts CMS has projected this to cost there would be additional monies in staff. In our rural facility we have one case manager. SHe is here M-F. We would need to arrange staffing to accomadate discharges planned on Saturday for Sunday. There are times when discharge plans are not known 24 hours in advance, or the plans are made in the evening prior to discharge. We would see delayed discharges due to waiting the 24 hour period to in which the patient received their notice. Patients would also have an additional aspect to worry about. If their discharge is delayed beyond the 24 hours, then what?
I feel the additional impact of this type of regulation is creating undo financial and staffing burdens on hospitals with limited resources. Please re-consider your regulation and how this might be accomplished in a different way.
Thank YOu,
Sue SUllivan
Vernon Memorial Healthcare
507 S.Main
Viroqua, WI 54665
608-637-4312
ssullivan@vmh.org

GENERAL

GENERAL

See Above

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The provisions of this regulation of providing all patients with notice of non-coverage the day before discharge is unrealistic. The provider does not always know for sure when a patient will be discharged. The discharge could be delayed beyond the 24 hour period. Some patients when discharge is determined the evening before would need to stay until that following evening, tying up a bed and costing more. Utilization of this process is poor. Most rural facilitites do not have the resources to provide for this around the call. If the patient appeals their rights, our medical records office is not here 24 hours a day to aquire, copy and send information. We would have to change current policy in order to have designation of who would be responsible to do this in their off hours and the case manager is not here.Completing a more detailed notice to the patient about our decision to discharge is giving the providers an additional tool to fill out. They would also not always be in the facility to do this. Then we get into faxing information back and forth which then becomes a time factor for both the providers office and the hospital staff involved.

I would like to ask that this regulation be reconsidered for the undo stress it will put upon facilities and providers. There has to be an easier way to occomplish this.
Thank You.
Sue SUllivan

Regulatory Impact

Regulatory Impact

We currently issue these letters of denial to Swingbed patients. We have a small population of swingbed patients. Due to our census and the type of swingbed patients we have, their discharges are pretty predictable. This is unlike in-patients.

Submitter : Dr. Ginger Williams **Date:** 05/17/2006

Organization : Oaklawn Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-652-Attach-1.DOC

CMS-4105-P

Comments

Date: May 13, 2006
Submitted by: Ginger Williams, MD, FACEP
Chief Medical Officer
Oaklawn Hospital
200 N. Madison
Marshall, MI 49068

BACKGROUND:

This section makes comment that "Currently, hospitals do not follow the same two-step discharge notice process that applies to HHAs, SNFs, CORFs, and hospices." There are several reasons hospitals should not follow the same two-step process as the other facility types mentioned.

1. The average length of stay for a patient in HHA, SNFs, CORFs and hospices is considerably longer than the average length of stay for a patient in an acute care hospital. For such extended stays, the ability to predict a discharge date with a 24-48 hour accuracy is reasonable.
2. In the acute care hospital setting, discharge is predicated upon meeting certain criteria which provide evidence that the patient is stable enough to be discharged. Commonly, the practitioner and the organization do not know 24 hours in advance if the patient will, indeed, meet those criteria. This rule, if enacted, will require the practitioner and facility to predict, at least 24 hours ahead of time, when a patient will meet these criteria.
3. There does not appear to be a provision for discharge of a patient who makes rapid, unexpected improvement. For example, should a patient suddenly "turn the corner", stop vomiting and tolerate sufficient fluids to be ready for discharge, all within a 12 hour period, would the hospital be in violation of this rule for allowing the patient to be discharged without the 24 hour minimum notice?

PROVISIONS OF THE PROPOSED RULE:

The proposed rule subsequently states, in this section and elsewhere, that this proposed process is "helpful to beneficiaries." Although this is not supported by any data, or defined in any significant detail, it appears that CMS is attempting to address a belief that beneficiaries are being prematurely discharged from acute care hospitals on a routine basis.

Although it appears that CMS is attempting to protect its beneficiaries by this proposed rule, it also seems to be alleging that the beneficiaries need to be protected from the hospitals caring for them. Absent any compelling evidence against the majority of hospitals in this regard, a blanket approach as proposed is unduly burdensome to both beneficiaries and providers.

Overall, it appears that the primary assumption leading to promulgation of this rule has not been validated. At a minimum, such validation has not been included within the body of the proposed rule.

As to the assertion that the process will be "helpful to beneficiaries", I believe the opposite may actually be the case, for the following reasons:

1) As noted above, these patients will be receiving notices of impending discharge before the physician, the patient or the hospital know if they will be stable enough for discharge the following day. Rather than being helpful, this has significant potential to create unnecessary anxiety for the patient and their family.
2) The alternative to trying to predict discharge readiness 24 hours in advance is to wait until the patient meets criteria for discharge and then issue the required notice. The patient would then remain in the hospital for 24 hours past the time they were actually ready for discharge. This has the potential to create the following problems:
   a) It places an undue financial burden on the facilities. 6000 affected facilities with an average cost of, conservatively, $2800/day for 10.9 million FFS discharges (as estimated in the proposed rule) amounts to roughly $5M per facility annually. Assuming the facility can predict readiness for discharge 24 hours in advance for 50% of the cases (leaving only half who would stay the extra day due to the required notice provision in the proposed rule), the burden is still $2.5M per facility per year.
   b) Most patients, once improved enough to go home, prefer not to stay in the hospital another day. Yet, the facility would be hesitant to discharge the patient less than 24 hours after the patient received their discharge notification out of concern for sanctions imposed because of violating this proposed rule.
   c) Retaining patients in the hospital for the sole purpose of meeting notice requirements creates a situation in which the inpatient bed occupied by that patient is not available for an acutely ill patient who needs inpatient care. Given the current crisis with overcrowding, enactment of this proposed rule has the potential to worsen access to care in many communities.

As an alternative to this proposed rule, I would recommend that CMS change the practice at the applicable QIO and MA organizations to allow for immediate review (i.e. within 2-3 hours of discharge notification to which the beneficiary objects) if the patient disagrees with a discharge decision. This process could be reflected and explained in the "Important Notice to Medicare Beneficiaries" received by each beneficiary at the time of admission. In this alternative, when a patient is notified of discharge, they would have the ability to request an immediate review by the appropriate organization, with the discharge pending while the QIO or MA organization reviews the request and makes a same-day determination of findings. This approach is helpful to Medicare beneficiaries, does not cause them undue anxiety, provides them protection against premature discharge and does not place undue burdens (as described both above and below) on the hospitals providing care to Medicare beneficiaries.

COLLECTION OF INFORMATION REQUIREMENTS:

This section states, "Since we have developed a standardized format for the notice, and the notice would be disseminated during the normal course of related business activities, we estimate that it would take hospitals 5 minutes to deliver each notice."

This analysis does not consider two issues which are likely to significantly increase this time burden on hospitals.

1. In the event the required notice is delivered to a patient who does not feel well enough yet to go home (which is common 24 hours prior to discharge), it is likely the patient will feel a sense of anxiety or fear over their impending discharge. Either the person delivering the notice, or someone else on staff at the hospital, should be prepared to dialogue with patients and their families in this situation. This will frequently (almost universally in patients receiving such notice for the first time) require longer than 5 minutes. A more reasonable estimate of actual time would be approximately 15 minutes, if this is done by the person delivering the notice; 20 minutes if personnel from another area need to be called in to speak with the patient/family. The total time burden to hospitals, then, is approximately triple the estimate in the proposed rule.
2. The proposed rule does not contain an estimate of the time required to determine, 24 hours ahead of time, when the patient will be discharged, in order to determine the correct day to provide the required notice. As mentioned previously, 24 hour advance knowledge of a patient's readiness for discharge is frequently not clear in an acute care admission. Most often, the necessary information to make this decision is not available until the day the patient is actually ready for discharge. Thus, developing processes to estimate when discharge-readiness will occur needs to be factored in to the analysis of the time requirement. A rough estimate would be 5 minutes of physician time, and 10-30 minutes of clinical staff time (reviewing results, assessing progress notes, contacting the physician, etc.).
3. Thus, the final estimate of the time burden would be roughly 5.5 million hours, as opposed to the 0.9 million hours estimated in the proposed rule.

Submitter : Mrs. Cleta Henry **Date: 05/17/2006**

Organization : Baptist Health Medical Center - NLR

Category : Hospital

Issue Areas/Comments

Regulatory Impact

Regulatory Impact

Question and Concern:
When discharge is not anticipated in advance of the physician order, will the rule require a 24 hour delay in discharge so that the notification of discharge may occur?

Since the QIO is not available for expedited review on weekend discharge disputes, will the advance notice be required for weekend discharges?

Submitter : **Ms. Christine Ludlum** **Date: 05/18/2006**

Organization : **Gratiot 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 : **Berta Cabrera** **Date: 05/18/2006**

Organization : **Mercy Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-682-Attach-1.DOC

Attachment 68

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MERCY Hospital

COMMENT LETTER

May 10, 2006

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

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

To Whom It May Concern:

Mercy Hospital welcomes the opportunity to provide the Department of Health and Human Services with our comments, concerns and recommendations on the proposed revisions to the Medicare Program Notification Procedures for Hospital Discharges, as published in 71 Fed. Reg. 65 (04/05/06).

Beneficiaries should know their rights as hospital patients. They should know what to expect as to a discharge plan and a discharge date. It is incumbent on the physicians and hospital discharge planning staff to discuss discharge plans with the patient from the time of admission and throughout the stay in order to prepare the patient, family and the continuity of healthcare providers of the post-discharge plan of care.

Your projection is that only 2% of recipients of the generic notice would require the Detailed Explanation of the Hospital Discharge Decision. This means that 98% of the patients who receive the generic notice would be in agreement with the discharge. It seems that staff time and salary dollars will be used for a program that only expects a 2% objection rate. Is this 2% a significantly different rate than that currently experienced when a Hospital Advanced Beneficiary Notices of Non-Coverage is issued?

The proposed rule would require hospitals to provide patients with the notice on the day prior to discharge. The hospital staff cannot determine when a patient will be discharged; that requires a physician order. Our concern with this section of the proposed rule is the timing of the notices. If a patient is discharged by their physician and is agreeable to the discharge, having to give a day's prior notice would unnecessarily add a day to the length of stay. This added day to the length of stay is not only a burdensome and clinically

unjustified expense to the hospital by having to provide care to a patient whose physician has medically cleared them for discharge but also ties up valuable acute care beds that are needed for the already overcrowded emergency department patients.

The proposed rule also estimates that it would take 5 minutes to deliver a notice. We believe that this is an unreasonable and unrealistic projection. Any time a healthcare provider walks into a patient room to discuss any type of "legal document" it takes a lot more than 5 minutes to explain it. Patients will have questions. Often, elderly patients are hesitant to sign anything without their next-of-kin's knowledge. The patients will ask that the next-of-kin be contacted which will take another significant amount of time to explain. In our area of the country, where many patients do not speak English, it will require translation of the notice into another language(s). This also will be a financial burden to the hospitals and will add to the projected 5 minutes.

This proposed rule will require that staff be available 24/7 to issue these notices in a timely manner. The staff that would normally b e i nvolved in this type of patient interaction is usually n ot available in the evenings a nd it is often at that time that physicians w ill give discharge o rders. T he p hysicians are t rying to discharge patients a s s oon as r esults f rom consultants, tests and other procedures are known. This could mean that it is an evening discharge and the patient is more than happy to be discharged. However, the requirement of giving prior day notices impacts the timeliness of the discharge as physicians may be required to hold that discharge order until morning.

We recommend that the current process of issuing HABN notices when the patient challenges their discharge order be maintained. It does not seem reasonable to establish a process that creates an unnecessary burden on hospitals to provide notices to all patients when only a 2% appeal rate is expected.

While w e support the Department of Health and Human Services goals of promoting and protecting the Medicare recipients' rights, we do not believe that this proposed rule will accomplish a significant benefit to the hospitalized patient. In fact, for many patients official notices are very threatening and creates more apprehension than relief.

Thank you for allowing us to share our concerns with you. If you have any questions please contact me at 305-285-2710 or via e-mail at bcabrera@mercymiami.org.

Sincerely,

Berta Cabrera
Director
Case Management Department

Submitter : Mr. Mike Glenn **Date:** 05/18/2006

Organization : Olympic Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-4105-P-692-Attach-1.DOC

Attachment #69

RESPONSE TO CMS-4105-P – PROPOSED RULE CHANGE

Date: May 18, 2006

Submitted by: Mike Glenn, Administrator

Organization: Olympic Medical Center

Category: Provisions of the Proposed Rule

Issue Areas/Comments: File Code CMS-4105-P

GENERAL

Olympic Medical Center would like to submit the following comments regarding the CMS Proposed Rule – CMS-4105-P - Notification Procedures for Hospital Discharges.

Requiring hospitals to provide ALL inpatient Medicare beneficiaries a standardized, generic notice of non-coverage the day before discharge would pose a significant administrative burden and have a significant financial impact on our hospital.

A beneficiary's length of stay in a hospital is much shorter than in a nursing home, home health agency, hospice, or outpatient rehabilitation facility. The decision for discharge is often not determined until the actual day of discharge. Physicians often must wait for lab/diagnostic results before deciding upon discharge. To delay discharge in order for the beneficiary to have at least one night to think about the discharge decision is not feasible. This may have the unintended consequence of unnecessarily extending the beneficiary's length of stay and thus incur increased hospital charges.

According to the proposed rule, this "standardized notice" actually would have to contain the beneficiary's name, the date covered services would end, and the date financial liability would begin. The estimation that it would take only five minutes to deliver a notice, we believe, is very under-estimated and unrealistic. To print out, complete, and deliver the form to the appropriate person (often not the patient), and explain it to the beneficiary, we believe, would take much longer than five minutes.

The per-notice cost estimate of $2.50 is too low and, once again, unrealistic. This estimate does not reflect the real time needed to prepare and deliver the notice and the formula does not include the manpower and cost to maintain hardcopy files. Using the estimations of five min/$2.50 per notice, based on our average yearly Medicare discharges, it would cost our hospital 257 man-hours and $7,710.00 per year to deliver these notices. Again, we believe this to be a very low estimate. Due to staff and resource considerations, this would put an undue burden on our small rural hospital.

We propose, instead, that the beneficiary be given, at the time of admission, a standardized generic notification that outlines his/her rights should a disagreement about discharge occur.

Thank you for reviewing our concerns.

Submitter : **Ms. Karrin Witte** **Date: 05/19/2006**

Organization : **Windom Area Hospital**

Category : **Nurse**

Issue Areas/Comments

Background

Background

This proposed procedure would be extremely difficult to do. There are times where the patient improves over 24 hours so they are discharged. This would actual lengthen the stay causing more of a cost issue. There are also times where the patient wants to go home. To comply with this rule, they would have to stay another 24 hours. I believe this ruling would cost Medicare more money, not less.

GENERAL

GENERAL

I work in a rural facility with mostly Medicare patients. This is adding more paper work to the already confusing paper work. It is time that patients take some responsibility for there care versus the hospital being responsible for it. If Medicare was less confusing this may be possible. Every rule and regulation added to Medicare causes more confusion for the patient.

Submitter : **Date: 05/19/2006**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

The comments for our facility are as follows. Providers rarely give orders 24 hours in advance, so we feel this proposal will do no good. When the patients do receive a notice of noncoverage, they never appeal their discharge. They don't understand what they are signing or the appeal process. Also, it just makes more paperwork for our staff. This will also result in more appeals and we feel that the appeals will not be done in time anyway. Our patients receive their discharge orders and are gone within a few hours. Further, most of our Medicare patients end up being swung anyway. We do not feel that there is enough time between when a patient receives orders and is dismissed, so we feel that this will result in patients leaving anyway or staying and having to pay for their care if the appeal is denied, which will result in upsetting the patients.

Submitter : Dr. **Date:** 05/19/2006

Organization : Dr.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I do not think it is a wise idea.

Submitter : Dr. Joseph Conner **Date:** 05/19/2006

Organization : Schneck Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-732-Attach-1.DOC

5/19/06

Dear Sir or Madam,

I am writing to voice my opposition to the proposal that patients receive written patient specific notice of discharge the day **before** scheduled discharge with the right to phone an 800 number and request additional stay in the hospital (CMS Docket # CMS-4105-P). My understanding is that then the hospital will be required to submit the patient's complete medical chart to Medicare for review and determination for readiness for discharge. This will be an administrative nightmare, will interfere with the doctor patient relationship, and greatly increase the length of stay, which is something physicians have been trying to moderate for years.

Thank you for your consideration in this matter.

Sincerely,

Joseph W. Conner, M.D.
President of the Medical Staff
Schneck Medical Center
411 West Tipton Street
Seymour, IN 47274

Submitter : Ms. Virginia Hendrickson **Date:** 05/19/2006

Organization : Legacy Health System

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am the Director of Social Services and Utilization Review for Legacy Health Systems, a five hospital system. I am concerned about the impact of implementing the notification for hospital discharge. Not all discharges are planned 24 hours in advance. Discharge planners are not involved with every Medicare patient in our hospitals. We are staffed to provide discharge planning to complex patients. Many Medicare patients are discharged without involvement from the Discharge Planners. The UR Analysts do Admission Reviews on patients to determine if they are in the correct patient status type, but do not follow all patients throughout their hospitalization. Giving a Medicare patient a notice, written in language that meets the requirements of the Medicare regulation, is not simple. Many patients/families will need to discuss the notice (as well they should). We are not staffed for this time consuming, customer service activity. I believe the estimate for the cost of implementing this regulation is not an accurate reflection of the labor hours that will be involved.

Submitter : **Dr. Bonnie Tesch** **Date: 05/21/2006**

Organization : **Advanced Healthcare**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

This regulation will be very costly to implement with limited benefit. It will delay many hospital discharge dates by 1 day and utilize hospital beds which could be better used by acutely sick individuals. I am in internist. Often, especialy with frail elderly patients, I do not know until the discharge day if a patient will be imporved enough to be discharged. It is a decision which I make with hte patient, their family and our discharge team. Requring one notification of discharge will delay many discahrges by 1 day.
Also much time and effort will be required to deliver these notices adn discuss them. This will be time taken away from more relavent care.
And this will only cost us 31.2 million dollars annually. With what benefit?

Submitter : **Mrs. Darlene Gondrella** **Date: 05/22/2006**

Organization : **West Jefferson Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P-762-Attach-1.DOC

Attachment #76

May 22, 2006

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

Re: Subject: CMS-4105-P Comments

To Whom It May Concern:

I am writing in opposition to CMS-4105-P.

As one of the few hospitals in the New Orleans area, West Jefferson Medical Center remained in operation before, during and after Hurricane Katrina. It's not bad enough that our indigent population is increasing, census is increasing, the complexity of the patients is increasing and the placement difficulties are extremely burdensome, and now CMS wants to propose a rule that would add yet another layer of complexity with no tangible benefit for the patient or the provider. What are you thinking?

Let me make a few notations re: the impact this proposal has on our healthcare system:

- This process will end up adding to the length of stay, thus increasing healthcare costs.
- It will further stretch the resources of all levels of the delivery system; physicians, nursing, discharge planning and case management.
- Would require at least 30 minutes per patient (not the proposed 5 minutes). We cannot just simply deliver a notice and walk away. This is the 65 and over population that we are speaking of. They will get confused and frightened, which could exacerbate their symptoms (possibly requiring additional treatment for chest pain and high blood pressure).
- Require additional time to track, document and audit compliance.
- Would force increased staffing (7 days/week) to be available to serve these notices. These individuals would have to understand the rationale for serving these letters and be an effective communicator to answer questions, while keeping the patient calm. This means you would need someone of a higher pay grade, which will ultimately drive up the price of healthcare.

Given the current healthcare system, with a nursing shortage (especially in the South, post-Katrina) and a baby boom influx, is it necessary to propose a process for a problem that does not exist--a process that will lead to confusion for the elderly and an administrative nightmare for hospitals? Will CMS have a 1-800 hotline that patients can call to get a full explanation of why they were served this letter, a hotline that will be answered timely, 24 hours per day?

Patients are familiar and comfortable with the process we currently use with the Hospital-Issued Notice of Non-coverage for those rare instances of dispute between the patient and hospital regarding discharge. Why confuse them? Hasn't the Prescription Drug—Medicare Part D confused them enough? In fact, Part D alone has resulted in increased resources as we are the ones who are answering their multiple questions.

I strongly oppose CMS-4105-P as it will create negative consumer perceptions, increased hospital staffing, rise in healthcare costs and, more importantly, will lead to an even more confused elderly population. Is this necessary when the current system seems to be working smoothly?

I urge you to dismiss this proposal immediately and focus your attention elsewhere.

Sincerely,

Darlene Gondrella,
Director, Case Management Dept.
West Jefferson Medical Center

Submitter : **Ms. Bonnie Arton** **Date: 05/22/2006**

Organization : **West Jefferson Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

I strongly feel that CMS-4105-P adds an unnecessary task to an industry that is already overburdened with needless bureacratic mandates. There can be no tangible benefit to such an exercise. Any JCAHO accredited facility has in place discharge planning and as such plans for the patient's flow through the healthcare system. If indeed there are facilities out there who are "throwing people out of the hospital with last minute notices",they should be dealt with directly. Imposing such requirements upon all facilities only added needless cost to a system that is already overpriced for most people.

Submitter : **Ms. Denise McMahan** **Date: 05/22/2006**

Organization : **Cuero Community Hospital**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I believe this proposed rule will place an additional financial burden on the hospitals. Currently we are able to discharge a patient the day they meet discharge criteria. However,with this new rule we will have to give notice to the patient and wait 24 hours to discharge the patient. This will add an additional day to the length of stay and increase the cost per patient.

Submitter : **Ms. Janet Gallaspy** **Date: 05/22/2006**

Organization : **Forrest General 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

Regulatory Impact

Regulatory Impact

See Attachment

CMS-4105-P-792-Attach-1.DOC

FORREST GENERAL HOSPITAL
Medical Excellence. Community Loyalty.

Attachment #79

May 22, 2006

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

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

Dear CMS,

The following comments are submitted by Forrest General Hospital, a county-owned, 2-hospital system that consists of a 429-bed acute care facility; a 95 bed acute care facility; an 88-bed chemical dependency and psychiatric unit; a 20-bed rehabilitation unit; an outpatient surgery facility; a home health service; and a variety of outpatient services including a Cancer Treatment Center. Forrest General Hospital appreciates this opportunity to provide feedback on the proposed CMS rule regarding hospital discharge notices as published in the *Federal Register* on April 5, 2006. If you have any questions regarding these comments, please see the contact information at the end of this letter.

BACKGROUND

In 2001, CMS proposed to "require hospitals to provide a notice of appeal rights and the reasons for the discharge to all hospital inpatients (including both original Medicare beneficiaries and MA enrollees) at least 1 day before the effective date of discharge." This proposal was opposed by hospitals then on the basis that a second, more detailed notice of appeal rights to all patients would impose a significant administrative burden on hospitals. Time has not changed this objection. Issuance of a discharge notification that includes appeal rights in addition to the "Important Message from Medicare" provided to all beneficiaries at admission and the Hospital-Issued Notice of Non-coverage (HINN) provided to beneficiaries who do not agree with an impending discharge will still impose a significant burden on hospitals. A discharge notification to all Medicare beneficiaries on the day prior to discharge would require additional staff and additional administrative and organizational processes to implement. We discuss these in detail further in the letter.

The current procedures seem appropriate. We would like to propose that CMS revise the current "Important Information from Medicare" form to include any additional information that may be needed to fully explain the patient's rights at discharge and the appeal process. The "Important Information from Medicare" notice provides beneficiaries with a review of their rights of appeal and the HINN provides specific appeal information to those few patients who object to discharge plans by their physician or by the hospital. The vast majority of patients require nothing more. Adding unnecessary steps to the discharge process is "overkill".

POST OFFICE BOX 16389
HATTIESBURG, MS 39404-6389
(601) 288-7000
www.forrestgeneral.com

PROVISIONS OF THE RULE

CMS proposes that the hospital be required to provide a standardized, "generic" discharge notification of non-coverage on the day before discharge to any Medicare beneficiary whose physician concurs with the discharge decision. For those beneficiaries who object to the discharge plans, CMS is proposing that the hospital then provide a detailed notice to the beneficiary once the QIO notifies the provider of the patient's request for an expedited review.

CMS's explanation of the process leaves several questions open which must be answered before going further with this proposal:

1. How will a hospital know of discharge plans a day in advance so that the hospital can meet the requirement to issue the discharge notification the day prior to discharge?

   The discharge date is controlled by the physician and is unknown to the hospital for many inpatients. Hospitals usually initiate discharge procedures themselves only when, a. the physician wishes to discharge the patient but the patient refuses to discharge or b. when the patient clinically no longer meets any continued stay criteria and the physician does not agree. The CMS proposal will require a hospital to know the planned discharge date in advance. This will require additional procedures, communications, reports, and staff to monitor and ensure the discharge date is known or approximated so that the notification can be issued in a timely manner. As usual, CMS has made no requirement of the physician to cooperate in this endeavor and the hospital is left with finding a way to achieve physician cooperation where the physician has neither associated benefit nor penalty.

2. What happens when the patient, because of change in clinical condition, doesn't go home on the planned discharge date?

   In acute care situations, the discharge plan changes rapidly as the patient's clinical condition improves or worsens. A patient who appears deathly ill today may be improved and ready to go home by tomorrow and a patient who appears ready for discharge in 24-hours may not be ready when tomorrow comes. If we give a notification today thinking the patient will discharge tomorrow but the patients worsens and does not discharge, does the hospital have to give another discharge notification on the day prior to the next planned discharge date? If so, we can foresee instances where the patient may receive several discharge notifications prior to actually being discharged which would confuse and worry the patient and add additional administrative burden to the hospital.

3. Instructions related to Home Health discharge notifications indicate that written notification must be provided to the patient if the discharge or termination of service date changes. Will this same provision apply to the hospital and require that the hospital amend the information provided earlier and then provide a written notification of the new termination date?

   Here again, if the patient does not discharge on the planned date after the generic discharge notification has been issued, the hospital will have to track, update, and issue another notification if the same rules apply to hospitals that now apply to home health and other providers.

4. Hospitals discharge patients at all hours of the day and on weekends. Are the QIOs going to be able to handle the increase in expedited review requests that will now come in on week-ends as well as weekdays?

   Many hospital departments do not operate on weekends and neither do QIOs for the most part. Providing a discharge notification on the day prior to discharge will require that

hospitals make provisions to issue notifications on weekends. If a notice is provided on a Saturday for a Sunday discharge, it will mean patients will be looking to notify the listed QIO on Saturday or Sunday that they want an expedited appeal. The hospital will also be required to provide staff for the QIO to notify of the appeal and staff to issue the detailed notice and copy and assemble the medical record to be sent to the QIO. This raises another question: How will the medical record be sent to the QIO on Sunday? Currently, in this area there are no mail services for Sunday delivery.

5. Why put a process in place to address 1% to 2% of the population that may disagree with, or not comply with, a discharge date ordered by the physician?

   The current process works well. The hospital, physician, and patient communicate regarding the patient's ever changing clinical status and make and amend discharge plans as needed. When a patient stays overlong based on an assessment by the physician or the hospital, the hospital takes steps to notify the patient of his rights and appeal processes and sets a date for termination of services at that point. The patient has the same ability to contact the QIO and request a review as they do with the new proposed process. The only real difference in the current and the proposed process is that the hospital is forced to provide unnecessary forms to 100% of the patients rather than deal with the 1% to 2% of patients who disagree with discharge plans. CMS indicates that these generic forms will be helpful to the patient but in reality they may do nothing but cause 98% of the patients to worry about an administrative form that really has no impact on their care or their financial liability in the long run.

6. How will 1-day and 2-day stays be handled?

   Forrest General FY 2005 data indicates that 29% of inpatients are discharged within 2 days of admission to inpatient care. This means that 29% of our patients will have just received the "Important Notice from Medicare" on admission. What value will this additional piece of paper provide to these short stay patients? 53% of Forest General hospitals are discharged by day 4 and the average inpatient length of stay is 4.6 days overall. Again, with the "Important Notice from Medicare" issued on admission and fresh in their minds, the additional piece of paper adds no value or new information to the patient's care or discharge planning.

7. What happens when the patient is incapable of understanding the generic notice and the hospital must contact the family or guardian to issue the generic discharge notice?

   It is not infrequent that discharge plans are finalized over the telephone with family or guardians for patients who are comatose or otherwise incapable of making decisions and are going to skilled nursing or swing bed facilities for continued care. Would documentation of acknowledgement of the notification over the telephone be adequate to issue the notification or would the hospital be required to send and receive back a signed form from the patient representative? Would the patient have to remain in the hospital until the signed form was received?

8. What happens when the hospital does not know the patient has Medicare insurance until after discharge and does the same process apply to patients who have Medicare as secondary insurer?

   In rare cases where the hospital does not get insurance information on a patient until after discharge will the hospital be found in non-compliance with the discharge notification if the notice is not issued? Does the hospital have to provide the generic notification for patients even when Medicare is the secondary insurer?

9. What about transfers to other hospitals?

   Will generic notifications be required prior to a transfer to another acute care hospital?

10. Other issues that need to be taken into account include the following:

    The discharge process for Medicare beneficiaries must be a different process than that for other payers. This may mean the clinical bedside staff would need to be aware of what insurance a patient has to ensure the correct process is implemented. Generally, in hospitals clinical staff are expected to provide quality care to the patient and the financial status of the patient is kept fairly opaque to the direct caregivers. Unless the process can be completely automated (doubtful), the caregivers will have to know that the patient is a Medicare patient and that a different discharge process must be instituted for this patient as opposed to other payer types.

    This process has the potential to increase the amount of time required by business office staff to prepare the claim for many Medicare beneficiaries. If there is a covered portion of the stay and a non-covered portion of the stay, this usually means a "split" claim and manual preparation is required.

    This process has the potential to require a full-time position to manage the process. The staff that prepares and delivers the notifications cannot be an entry level person since it will require someone with the ability to answer patient and physician questions and also communicate with the QIO.

REGULATORY IMPACT

CMS estimates a total cost of $7,075 per provider as regulatory impact of this proposal. Using CMS's estimated times and costs to deliver and manage the generic and detailed notices and Forrest General's Medicare discharge figures, Forrest General calculates the cost to the hospital to be $32,425 per year. Forrest General would issue an average of 26 generic notices per day and 0.5 detailed notices per day. We believe, however, that CMS has grossly underestimated the impact this new regulation will have on providers by underestimating the amount of time that delivery of the generic and detailed notices will take and ignoring other costs associated with the process.

CMS projects the generic notice will take no more than 5 minutes to deliver at a cost of $2.50 each. The "generic" notice is not truly generic and requires patient specific information to be entered which means the form must be manually prepared at many hospitals. If a hospital can program a form to generate from the computer system, this process would be done via the computer but this will save little in time over manually completing the form. Completing the form will take only a few minutes. The real time will come when the form is taken to the patient's room. A hospital employee cannot simply hand the form to the patient and walk out. The employee must explain the form, ascertain that the patient understands the forms, answer any questions the patient may have, and then obtain the patients signature. This scenario is the simplest version but even so, it would appear that 5 minutes is not realistic. If the patient is not in the room or the family or guardian is not in the room several trips to the room or phone calls may be required which would increase the time and expense to deliver the form.

Once the form has been signed, CMS requires that the form be stored on the patient's record. For hospitals that have moved to electronic medical records, this means the form must be imaged which takes another several minutes and increases the cost to the facility.

A copy of the form must be left with the patient and or family. For this the facility may either spend time copying the signed form or use expensive multi-copy forms which may or may not produce good copies. Either way, producing a copy to leave with the family and a copy to store on the medical record increases the time and cost to the facility.

CMS estimates that 2% of Medicare beneficiaries would require a detailed notification and that it will take approximately 60 to 90 minutes to fill out and deliver the detailed notice and make the supporting documentation available to the QIO. Experience with HINN processes in the past indicate to us that this detailed notification process will probably take much longer than CMS estimates. Situations where the patient and/or family do not agree with an impending discharge are very emotional for the patient and family. A simple explanation of the form and obtaining a quick signature is not the norm in these situations. The patient and family will consult with other family members who are not present via telephone or will want to wait for other family members to arrive. They will want to read every line of the form, ask questions about the form, ask questions about the appeal process, and then, frequently, they will refuse to sign the form.

CMS has left out of estimates the time required to coordinate and explain the required processes to the patient's physician. The physician must be kept informed and his cooperation is required since the QIO will wish to speak with the physician regarding the patient's readiness for discharge.

Then there is readying the supporting documentation to be sent to the QIO. Most often, these stays will be a longer length of stay which requires copying of pages and pages of medical record, or for hospitals who have converted to electronic medical records, printing of pages and pages of record. Once the medical record has been reproduced it must be packaged for immediate pick-up and overnight delivery to the QIO.

With the above information in mind Forrest General estimates that a minimum of 10 minutes is required to deliver the generic discharge notice and that some deliveries may take as much as 30 minutes of time. We also estimate the time for delivery and management of a detailed notice to be at least 120 to 180 minutes instead of the 60 to 90 minutes estimated by CMS. With these time estimates, Forrest General's specific cost estimate would be $64,850 and the average total cost per provider would be $14,150 rather than $7,075. The total cost for 6,000 hospitals would be approximately $85 million rather than $42.5 million.

In closing, we ask that CMS not implement this requirement to issue a generic notice of non-coverage on the day prior to discharge to all Medicare beneficiaries whose physician agrees with the discharge decision. We hold that the generic notification is unnecessary and will prove to be an administrative burden to Forrest General and to other hospitals.

Sincerely,

Forrest General Hospital
Janet V. Gallaspy, BS, RN, CPUR, CPC-H
Medical Auditor, Corporate Compliance
E-mail: jgallaspy@forrestgeneral.com
Telephone: 601-288-4462
Fax: 601-288-4469

OTHER HOSPITAL REPRESENTATIVES SUBMITTING THESE COMMENTS:

Ms Ora Lee Shaheed
Vice President of Patient Care Services

Dr. William H. Peters
Vice President of Medical Affairs

Ms. Beth Peyton
Director of Patient Care Services

Ms Linda Haywood
Director of Health Information Services

Mr. Scott Smith
Director of Patient Accounts

Ms. Robin Strickland
Director of Registration

Ms. Pat Snead
Director of Forrest General Home Care

Mr. Don Bullock
Corporate Compliance Officer

Ms. Josie McKorkle
Assistant Director of HIM - Utilization Management

Submitter : **Mr. Gene Wright** **Date: 05/23/2006**

Organization : **Upson Regional Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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

To Whom It May Concern:

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

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

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

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

Sincerely,
Gene B. Wright, CEO
Upson Regional Medical Center

Submitter : Dr. Steven Calkin **Date:** 05/23/2006

Organization : POH Medical Center

Category : Physician

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Two concerns: Will physicians and hospitals need to renotify patients on the intent to discharge 24 hours in advance of every decision to discharge? Unlike SNFs, CORFs et. al., a decision to discharge is not always equivalent to a discontinuation of benefits. A discharge from an inpatient setting is often predicated on how the patient is doing at the time of discharge. Example: I evaluate a patient on Tuesday and plan for a discharge the next day, only to discover the patient isn't ready for discharge afterall. Now we are on a day to day discharge readiness approach. Each and every day, the patient may be ready to be discharged tomorrow. Is a notice required each and every time?
Secondly, our hospital has several levels of care. We often discharge from our acute care beds into rehab beds, or psych beds. Is the intent then to issue a notice each time such a discharge occurs? Benefits aren't necessarily being terminated, just reapplied to another level of care.
I propose one such notice, if in fact any of this is necessary at all, and such a generally generic Notice could also be issued at the time of admission with information indicating that the intent to discharge on or about the geometric mean LOS for the admitting DRG. most hospitals have access to that info, and most hospitals certainly try to target such lengths of stay so as to most efficiently utilize resources. the notification will still serve to inform beneficiaries of their appeal rights, and no hospital is going to put someone on thestreet who is challenging the decision to discharge.

Submitter : Dr. Craig Horton **Date:** 05/23/2006

Organization : Meadows Regional Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Notification Procedures for Hospital Discharges (CMS-4105-P).

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

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

Submitter : **Ms. Nancy Payne** **Date: 05/23/2006**

Organization : **Allina Hospitals and Clinics**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-832-Attach-1.DOC

Attachment #83

Formatted: Right

Allina Hospitals & Clinics
Regulatory Affairs
PO Box 43 Mail Route 10105
Minneapolis, MN 55440-0043

ALLINA.
Hospitals & Clinics

May 23, 2006

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

Re: 42 CFR Parts 405, 412, and 489, Medicare Program: Notification Procedures for Hospital Discharges, April 5, 2006, Federal Register.

Dear Dr. McClellan;

I appreciate the opportunity to comment on the proposed new requirements for hospital discharge notices under both the Medicare and the Medicare Advantage program, on behalf of Allina Hospitals & Clinics. Allina Hospitals & Clinics is a family of hospitals, clinics and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, medical transportation, pharmacy, durable medical equipment, home care, hospice and palliative care services. Allina serves communities throughout Minnesota and western Wisconsin.

We vehemently oppose the new requirements and respectfully request that CMS does not implement this proposed two step notification procedure for Medicare or Medicare Advantage beneficiaries being discharged from the inpatient setting. These requirements create significant and unnecessary administrative burden for the stated sole purpose of standardization. This procedure may work well in Home Care, SNF's and CORF's where patients are longer term, have a more predictable course of treatment and discharges are planned well in advance, but it will demand much more resource in the inpatient world where discharge decisions may be made hours prior to the patient leaving the hospital. Further discussion of our reasons for opposition is included below.

PROVISIONS OF THE PROPOSED RULE

The proposed two step notification procedure poses a significant administrative burden in both delivering and explaining the form that takes away from time better spent on providing care to the patient. This process is unnecessary for both fee for service and managed care Medicare. This procedure will create more confusion for beneficiaries rather than clarification.

Please recognize that the timing of the discharge decision is in the hands of the physician. Their rounding schedules, access to diagnostic testing results, collaboration with their peers and numerous other factors influence their ability to make this decision. While we do our best to plan, the dynamic nature of acute inpatient care and our dependence on physicians prohibits our ability to consistently know 24 hours in advance that a patient will be discharged, thus making compliance with this procedure nearly impossible.

We challenge the estimated 5 minutes that CMS notes it would take to deliver the notice. If getting the signature were the only thing required, that may be true, but having the patient understand what is being presented and why, will require significant time. The vulnerability of the Medicare population requires that we work with family representatives on a regular basis and we are not always able to talk with them about the discharge a full 24 hours prior to the discharge. The need to coordinate the discharge process with interpreters, family members and the multiple providers involved in the care make it extremely difficult to give this notice within 24 hours of the day of discharge.

We estimate that just delivering a notice at the low end of time is 15-20 minutes with the more complex situations taking up to 2 hours. This does not factor in the shift in nursing time away from direct care to complete an unnecessary paperwork task, nor the additional hours of coverage that will be required for Social Workers and Case Managers in order to meet the 24 hour timeline.

CMS estimates that only 2% of the beneficiaries have an interest in appeal. We fail to see any advantage to implementing a process for the greater number of beneficiaries that will only address the issues of the small portion of the 2% that may actually follow through on an appeal. We believe that very few beneficiaries have any interest in disputing their hospital discharge and concur with the CMS data quoted. The down side of this requirement far outweighs the slight benefit of a standardized approach.

We strongly believe that all beneficiaries need to be informed of their Medicare appeal rights when admitted as inpatients to hospitals but feel that it is unnecessarily burdensome to require hospitals to provide notification a second time one day before discharge. We believe that the current process of notification at admission, furnishing the Important Message from Medicare which explains the beneficiary's appeal rights is sufficient. We oppose the burden you move to the provider to communicate more effectively with beneficiaries on this issue. We would support continuing with the current process of issuing the Important Message from Medicare document at admission and the utilization of the HINN or NODMAR to patients covered under original Medicare when they indicate disagreement with the discharge decision.

We are gravely concerned that CMS would move the burden of notification to Medicare Advantage (MA) enrollees from the MA Organizations to the hospitals. We believe that it continues to be appropriate to place this responsibility on the MA Organizations, given their financial liability for continued care. We believe that by interjecting the hospital in the relationship between the MA Organization and their enrollee, you will exacerbate disputes and put the hospital in a position of explaining the MA Organization's decisions to discontinue inpatient coverage. This is not right.

We request that CMS increase its educational and outreach efforts to enhance beneficiary understanding of the notice they receive. Hospitals should not be relied upon to provide all of the education necessary for a beneficiary to understand their rights.

Allina appreciates the opportunity to provide comments on the proposed new requirements for hospital discharge notices under both the Medicare and the Medicare Advantage program. We hope that CMS will consider our strong opposition and recognize the significant burden of hospitals of this change. We hope that CMS will recognize that the same concerns that stopped implementation of this change in 2003 still hold true in 2006. If you have any questions, please feel free to contact me at 612-775-9744. We look forward to seeing the final rule.

Sincerely,

SENT ELECTRONICALLY

Nancy Payne, RN, MA
Director of Regulatory Affairs
Allina Hospitals and Clinics

Submitter : **Mrs. Linda Hogel** **Date: 05/23/2006**

Organization : **TriHealth**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

"see attachment"

CMS-4105-P-842-Attach-1.DOC

May 23, 2006

RE: CMS-4105-P
RIN 0938-AN85

BACKGROUND

The proposed CMS 2-step process requiring facilities to notify every Medicare beneficiary the day before discharge of his or her Medicare rights is costly, impractical and most importantly unnecessary.

- The current process of issuing a Hospital-Issued Notice of Non-coverage adequately provides the Medicare beneficiary with their appeal rights and allows them to express dissatisfaction with an impending discharge when necessary. The Medicare Advantage plans are required to issue the Notice of Discharge and Medicare Appeal Rights when a beneficiary disagrees with the discharge decision. These two processes along with the Important Message from Medicare letter given at the time of admission are sufficient. Providing a notice the day before discharge spelling out the same information as the Important Message letter, HINN or NODMAR is re-work and inefficient use of staff time.

PROVISIONS OF THE PROPOSED RULE

The process of issuing a notice to all Medicare beneficiaries offers no benefit to the patient. In reality, this may add more confusion to the already complex and difficult to understand health care system for Medicare beneficiaries.

- The ALOS for Medicare is 5 days. Based upon a work team we put in place for patient flow, the decision to actually discharge the patient is typically not known until the actual day of discharge. You may anticipate a discharge, but in reality have no way of knowing. Hospitals will be immediately be non-compliant with this ruling, because a letter many times will not have been given within the time constraints indicated in this proposal. The attending MD often preliminarily plans for discharge on the next day but then may round later in the same day and discharge the patient. This means that we would be giving the letter on the same day of discharge. This is a common occurrence in our facilities and has increased with hospitalists following the patient.
- There are very few instances in our facilities in which a patient expresses concern over being discharged too soon. Giving all patients a personal letter and requesting a signed acknowledgement of receipt, for the few instances of a perceived problem adds an administrative cost and is unnecessary.
- Application of the same rules across all provider settings offers no advantage to the patient since the level of care and LOS vary greatly between each of these settings.

COST

The time estimate is 5 minutes to deliver the letter. However, more questions, issues may need to be addressed with the patient and the actual average may extend beyond 10 minutes. There is no accounting for the administrative time and burden placed upon a facility to identify the Medicare patient, and then try and estimate the day before discharge. This adds significant cost, time and burden to the facility at an estimate of 30 minutes per patient which is >$30,000. It may also take 2-3 attempts to deliver the letter, especially when dealing with the Medicare representative and not the patient themselves. In addition, we would be forced to develop a monitoring and audit process to assure compliance, which then requires man-hours at a cost to the organization with no return or additional benefit to the patient.

The 2-step process may make sense for Medicare patients in SNF, HHA, or CORF because typically those patients are actively receiving service and care for weeks as opposed to the few days in the acute care setting.

Sincerely,

Linda Hogel RN
TriHealth
513-569-6583

Submitter : Nena Jones **Date:** 05/23/2006

Organization : Grande Ronde Hospital

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 : Nena Jones **Date: 05/23/2006**

Organization : Grande Ronde Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Regarding file code CMS-4105-P:

The nature of acute care is that people get ill quickly and sometimes get well as quickly.

This proposed rule is unnecessary and destined to prolong hospital stays. The intent to notify a patient of planned discharge and Medicare coverage ending, so they can file a Q10 review is lovely and could occur in a much less onerous way. A one day stay for antibiotics and inhalation therapy for pneumonia/COPD exacerbation - is it okay to notify the person an admission? If this is okay, then why is it not okay to notify every person on admission of their right to file a Q10 review if they disagree with the planned discharge? How will Medicare meet the increased cost of providing reviews on weekends or do we just stop discharging patients on the weekend? What about the nursing home patient unable to speak for themselves, with a delineated plan and expectations worked out with the nursing home and their Health Care POA, who we are able to transfer back to the nursing home?

In this world where we stack up patients in the Emergency Department waiting for beds does it make sense to prolong the stays of persons who meet criteria for discharge? If the problem is patient being discharged before meeting criteria, then address the real problem, not this back door attempt to throw paperwork at the problem and call it solved.

We need real world answers which expediate and simplify, we don't need more layers of complexity. Please reconsider implementing this rule.

Thank you,
Nena Jones

Submitter : Mr. Scott McCorkle **Date:** 05/24/2006

Organization : Monongahela Valley Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-872-Attach-1.DOC

May 24, 2006

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

Dear Sir/Madam:

Monongahela Valley Hospital would like to take this opportunity to comment on the proposed Notification Procedures for Hospital Discharges regulations. We believe that the regulations, as proposed, will create additional unnecessary paperwork and confusion to a process that is already in place. A more appropriate means to achieving compliance with notifying beneficiaries would be enforcement of the current regulations. Outlined below are our comments on the proposed rule:

BACKGROUND

1. Many times a patient's discharge is not known until the evening before or the actual day of discharge pending test or lab results, etc. This would require the hospital to keep the patient an additional day to meet the proposed requirement of notification the day before discharge.
2. The discharge of a patient is dependent upon the physician writing a discharge order. Physicians routinely are treating patients that have multiple co-morbidities and chronic diseases. Physicians and hospital staff are always working to achieve certain parameters that need to be met or under control with patients to warrant discharge from the hospital. As outlined in #1 above, many times the physician will wait for test or lab test results prior to deciding whether or not a patient is stable for discharge. Many times this could be the day of discharge. As such, patients will not be discharged for 24 hours after the physician writes to discharge the patient.
3. As part of the discharge planning process, several calls can be placed to various SNFs looking for a bed. A call could be received by the hospital from a SNF stating a bed is available today. This would limit the transfer of these patients to a SNF for an additional 24 hours.
4. The potential for adding additional paperwork responsibilities to the nursing staff and taking them away from actual patient care exists.
5. The estimated time period for completing the paperwork at 5 minutes and the cost associated with implementing and management of the process is highly underestimated.
6. Holding patients in a bed for an additional day not only adds costs by increasing length of stay, but also has a domino effect on other departments within the hospital. (Emergency room overcrowding, placement of emergency admissions, ambulance diversions, etc.)
7. Increased length of stay results in decreased revenue to the hospital.
8. The hospital is being asked to provide the notice of non-coverage to beneficiaries for decisions that are made by a managed care plan. In addition, the physician may not

feel that the patient can be discharged at that time. It should be the responsibility of the managed care plan to deliver the notice of non-coverage and not the hospital. Once the patient is capable of being discharged, the hospital would then have to issue a second notice to the patient. This process will be very confusing to the patient.

9. Requiring the hospital to add it's logo to the forms is misleading. It is not the hospital, but the managed care company, that makes the decision for non-coverage.

We have complied with providing the "Important Message from Medicare" to all inpatients at the time of admission and a "Hospital-Issued Notice of Non-Coverage" (HINN) to any Medicare beneficiary that expresses dissatisfaction with an impending hospital discharge without any questions or unresolved issues from our patients. We believe that enforcement of the current regulations, and not additional regulations, is the more appropriate means for compliance.

Sincerely,

Scott A. McCorkle
Director of Corporate Compliance
Monongahela Valley Hospital

cc: Donna Ramusivich, Senior Vice President
Chris Baloh, Director of Human Services
Joanne Barber, Director of Utilization Review

Submitter : **Mrs. Patricia Robinson** **Date: 05/24/2006**

Organization : **Kingman Regional Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

The issuance of the letter works for SNFS and Home Health, because they are planned carefully, looking at the guidelines and the patient's condition. However, in the acute care setting, it is difficult to predict on which day the discharge will occur. We do not usually know 48 hours in advance. We more often know within 24 hours. Some physicians are good about documenting and others are not. A lot depends on whether the patient is stable for discharge and that isn't always determined until the day of discharge. The Committe thought at best, that compliance would be much better if it was given 24 hours before discharge. This would encourage the physicians to not only communicate the planned discharge to the patient/family, but give staff adequate time to complete and execute the discharge plan. If this proposal is passed for the 48 hour limit, it would in deed create a burden for many rural hospitals.

Regulatory Impact

Regulatory Impact

I am Manager of the Case Management Dept.which consists of Utilization Mgt. and Social Services at a 213 bed hospital. I took this proposal to our MR/UR Committee. These were the comments.

Submitter : Mrs. Sara Snyder **Date:** 05/24/2006

Organization : Baptist St. Anthony's Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

It is clear that a notice would be presented to a beneficiary by a SNU or home health because these agencies can be certain of a discharge date. In the hospital seting, patient acuity changes, sometimes quickly, and a discharge date cannot always be determined in advance.
Furthermore, presenting notices to each beneficiary requires a great ammount of time from personnel, which is already limited. If the beneficiary does appeal, it would require even more time to provide clinical reviews to CMS.
As a Case Manager and Reistered Nurse, I do not support this proposal.

Submitter : **Dr. Paul Spilseth** **Date: 05/25/2006**

Organization : **Lakeview Hospital**

Category : **Physician**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

To: Centers for Department of Health and Human Services May 24, 2006
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD, 21244-1850

Re: Proposed Rule: Notification Procedures for Hospital Discharges

Provisions of proposed rule

Comments:

The proposed rule to establish a two step notice of discharge process in order to align acute hospitals with those of SNF, HHA, CORFs and hospices is somewhat unrealistic. The treatment provided and length of stays in an acute care setting differ significantly from those agencies, therefore you are not comparing like indices.

Due to our relatively short length of stays, the decision to discharge a patient from the hospital is often made that day. Requiring a notice to be given the day before in order to allow a beneficiary at least one night to think about the discharge could indeed increase cost and add unnecessary days.

Additionally, the proposed process is somewhat redundant in that every Medicare beneficiary is already given a copy of his or her rights upon admission. If the intent is to improve awareness, would it not be more reasonable to require that notice be made more high profile in order to increase understanding of appeal rights?

We at Lakeview Hospital feel that providing the right care, at the right time and in the right place is a priority. We strive to provide the necessary information and tools to our patients in order to empower them to make the best decisions possible regarding their plan of care. While we appreciate the spirit with which this proposal was created, it would appear to add another layer to an already complicated process without significant benefit to beneficiaries or providers.

Thank you.
Paul Spilseth
Medical Director
Lakeview Hospital

Submitter : **Dr. Paul Spilseth** **Date: 05/25/2006**

Organization : **Lakeview Hospital**

Category : **Physician**

Issue Areas/Comments

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

CMS-4105-P-912-Attach-1.DOC

Attachment #91

LAKEVIEW
HOSPITAL
A member of Lakeview Health
927 West Churchill Street
Stillwater, Minnesota 55082

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

May 24, 2006

Re: Proposed Rule: Notification Procedures for Hospital Discharges

"Provisions of proposed rule"

Comments:

The proposed rule to establish a "two step notice of discharge" process in order to align acute hospitals with those of SNF, HHA, CORFs and hospices is somewhat unrealistic. The treatment provided and length of stays in an acute care setting differ significantly from those agencies, therefore you are not comparing like indices.

Due to our relatively short length of stays, the decision to discharge a patient from the hospital is often made that day. Requiring a notice to be given the day before in order to allow a beneficiary "at least one night to think about the discharge" could indeed increase cost and add unnecessary days.

Additionally, the proposed process is somewhat redundant in that every Medicare beneficiary is already given a copy of his or her rights upon admission. If the intent is to improve awareness, would it not be more reasonable to require **that** notice be made more high profile in order to increase understanding of appeal rights?

We at Lakeview Hospital feel that providing the right care, at the right time and in the right place is a priority. We strive to provide the necessary information and tools to our patients in order to empower them to make the best decisions possible regarding their plan of care. While we appreciate the spirit with which this proposal was created, it would appear to add another layer to an already complicated process without significant benefit to beneficiaries or providers.

Thank you.

Submitter : Dr. James Hackett **Date:** 05/25/2006

Organization : Advanced Healthcare, S.C.

Category : Physician

Issue Areas/Comments

Background

Background

The implementation of the proposed rule would require a lengthening of the patient's hospital stay without medical benefit. Current medical practice allows for efficient and "just in time" discharges often within a 12-24 hour period one the patient achieves discharge criteria. Prior notification and allowance of time to contest routine discharges would result in unnecessary lengthening of stay.

GENERAL

GENERAL

Please be aware that there are processes already in place in most hospitals where contested discharge is addressed by Ethics and Quality Assurance committees. The proposed rule with further interfere with hospitals and staff already strapped for time and resources. This rule should be revised or discarded.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The provisions are ambiguous in that there is mention of the "Quality Improvement Organization" as playing a role in determining discharge. For 90+% of my hospital discharges, there is no QIO involvement. Only when a patient or family is recalcitrant or has exceeded medical benefits and will not consent to being discharged, does this QIO become involved. The proposed rule suggests that ALL discharges will be required to be notified 24 hours in advance of discharge. I would accept the rule if it applied ONLY to the patients who were being notified that continued stay would be non-covered.

Regulatory Impact

Regulatory Impact

The initial implementation of this rule was intended for ancillary providers in chronic, subacute, or rehabilitation environments. In the modern hospital where time and efficiency are precious comodities, there is no need or desire to initiate a procedure which will delay or complicate the otherwise orderly discharge of patients who have reached maximum benefit of inpatient care.

Submitter : **Ms. Hilda Gonzalez** **Date: 05/25/2006**

Organization : **Pan American Hospital**

Category : **Hospital**

Issue Areas/Comments

Regulatory Impact

Regulatory Impact

Pan American Hospital opposes this proposal requiring hospitals to deliver a second, more detailed notice of appeal rights to all patients the first being the "Important Message from medicare" which is a standard notice issued at or about the time of the patient's admission. This would pose a significant administrative burden.

Submitter : **Mrs. Gretcha Estenson** **Date: 05/25/2006**

Organization : **Rogue Valley Medical Center**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-4105-P Comments

The proposal to establish a two-step notice process for acute hospital discharges similar to the process in effect for service termination in home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospice services again demonstrates the lack of operational knowledge by those involved in rule-making.

The first problem with this proposal should be obvious. Hospital lengths of stay are significantly lower that any of the other service providers bound by this rule. In fact if this rule were to become final, hospitals will be issuing the notice at time of admission in many cases.

Secondly, with decreases in Medicaid funding, patients and families have fewer resources available for support in the home and community. Therefore, even with a physician s determination that the patient is medically stable and ready for a lower level of care, and a safe discharge plan, there is an overall reluctance to leave the hospital setting after an appropriate short length of stay. I believe that the proposed notice will create yet another barrier to timely discharge, as more than the CMS projected 2 percent of affected beneficiaries will request unnecessary reviews, which will ultimately result in an overall increase in length of stay. Are the QIO s staffed to handle this increase?

Third, I believe that the estimation of administrative time required to implement the proposed change is vastly understated. We are dealing with an elderly population; and it is irresponsible to think that we could just spend 5 minutes dropping off a notice of discharge. The notice should come with an explanation and a time to answer questions. Many of our elderly patients are already confused about the entire healthcare process. Adding another document is not going to make it anymore understandable.

Finally, there are additional concerns such as the collaboration with the physician in the timing of discharge. Physicians frequently are awaiting test results and upon receipt of those results might discharge a patient on the day of discharge. The implementation of this proposed rule would definitely require additional staffing. I cannot see that the cost would translate into any added value for the beneficiaries or the providers.

Respectfully,

Gretcha Estenson, RN, BSN, CCM
Manager, RVMC Resource Management

Submitter : **Mrs. Tammy Owenby** **Date: 05/29/2006**

Organization : **Tanner Health System**

Category : **Hospital**

Issue Areas/Comments

Background

Background

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

To Whom It May Concern:

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

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

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

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

Sincerely,

Tammy Owenby

Submitter :

Date: 05/30/2006

Organization :

Category : **Individual**

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.