54

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

June 2, 2006

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

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

Dear Dr. McClellan:

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

The NDHA does not believe CMS should proceed with this process without further examination. Does CMS fully understand how patient care decisions are made in the hospital setting and how the discharge planning process works? This proposed rule making will impact hospitals financially and operationally.

Not only is this a concern for our hospitals, but the Medicare beneficiaries may doubt whether the discharge planning is appropriate. It is possible that such a process could increase the number of appeals, perhaps unwarranted, at the hospitals expense, and delay the admission of other patients.

Physicians make the decisions regarding discharges. Hospitals cannot discharge a patient without a physicians order. After the order our hospitals follow a discharge planning process that is governed by Medicare Conditions of Participation.

The discharge decision is generally not made until morning rounds the day of the discharge. Therefore, requiring a notice on the day before discharge means the hospital would need to keep the patient an extra day. In some instances the discharge may be ordered the night before. However, CMS' proposal requires the notice be delivered "by the close of business" which is defined as the end of the administrative day.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

The extra day does not result in additional compensation because hospitals are paid a set amount for an admission. Also, there may be patients waiting to be admitted and their admission could be delayed.

The federal government is urging hospitals to create electronic health records for all patients. The hard copy notice requirement does not meet the paperless process hospitals are working towards.

NDHA recommends that CMS withdraw the proposal and retain the current requirements. If there are issues and concerns that need to be addressed, additional consideration and suggestions need to be discussed in a work group that includes hospitals and physicians.

NDHA appreciates your consideration regarding the issues and concerns with the proposed rule.

Sincerely,

Arnold R. Thomas
President

cc: Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
CMS – 4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

cc: Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
ATTN: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

LOWER
BUCKS
HOSPITAL

Saving Lives, Every Day

We thank you for allowing us to respond to the proposed rule in "Medicare Program: Notification Procedures for Hospital Discharges".

Lower Bucks Hospital is a small community hospital that is licensed for 190 beds but with an average daily census of 100. We are located in Southeastern Pennsylvania and basically serve a community of blue collar and senior populations. We have a very high volume of Medicare and Medicare Advantage patients.

For Fiscal year 2005 /2006 (through May 31, 2006) the Emergency Room has treated and released approximately 2900 Medicare patients and approximately 3000 Medicare patients were admitted through the Emergency Room . Inpatient statistics through April of fiscal year 2006 include total discharges of 3,167 (45.7%), 16,629 patient days(52.9% of all patient days) and length of stay of 5.30 for Medicare and 5.15 for Managed Care Medicare.

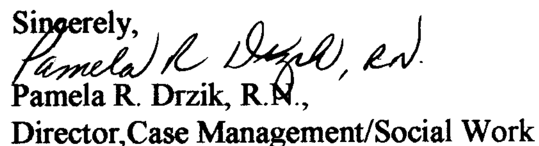
The requirement that we comply with issuance of Notice of Non Coverage twenty four (24) hours prior t o discharge would cause an increase in the length of stay and cause increased amounts of congestion in an already overburdened Emergency Room. We are not always aware of the discharge date until the Physicians have written the order. If we attempted to serve the notice based on progress notes we could possibly end up giving more than one notice due to ever changing patient status. This would cause unnecessary confusion for the patients, their families and caregivers and facilities with available beds for transfers to be received.

An average daily census of 100 justifies a Case Management staff of 4.5 Registered Nurses and 2 Social Workers with one secretary and one Director. To comply with the proposed rule increases in staff would be required. The financial burden to a small community hospital already struggling with reduced reimbursement would be a very large one.

We agree with the suggestions submitted by The Hospital Association of Pennsylvania and the Delaware Valley Healthcare Council that would require the Medicare Advantage plans to be responsible for the issuance of the Notice to their customers. The notice could also be presented on admission as part of the "Important Message from Medicare" that would be revised to include much more specific details of procedures available to patients. We would also like to suggest that the requirement be modified with a specific length of stay (over 6or 7 days) so that patients with short duration stays would not be affected by this ruling.

We urge you to consider the day to day functions of all hospital services and departments and all that encompasses before making your final ruling

Sincerely,



Pamela R. Drzik, R.N.,
Director,Case Management/Social Work

Lower Bucks Hospital • 501 Bath Road • Bristol, Pennsylvania 19007
215.785.9200 • www.LowerBucksHospital.org

56

May 30, 2006

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

Subject: CMS-4105-P Comments

We have reviewed CMS-4105-P, the Proposed Medicare Discharge Notice Changes, at the Hospital's May 16, 2006 Utilization Review Committee Meeting.

The Committee strongly opposes the proposal for the following reason. Projected discharge dates are tentative based on a patients changing condition. Providing a written notice of discharge 24 hours prior to actual discharge, will obligate a hospital to either discharge a patient prematurely or hold a patient unnecessarily.

We hope this helps in your decision.

Very truly yours,

James Mowery, M.D.
Acting Chairman, Utilization Review Committee

Cc: CMS Website - www.CMS.HHS.Goiv/Erulemaking.com

S7

June 5, 2006

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

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. As the director of Case Management at **Northwestern Memorial Hospital**, which is a 744 bed hospital in Chicago, Illinois, I am responsible for ensuring discharge planning to the approximately 45,202 patients who are admitted yearly.

The CMS proposed change places an administrative burden on the hospital coupled with the real possibility that many discharges will be delayed due to procedural issues. Your estimates that the process will take 5 minutes to deliver the generic notice and have it signed are misguided. If a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the appropriate signature. My recommendation is to allow telephonic notification to the decision maker when the decision maker is not the patient.

Our current discharge planning practice begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. At Northwestern Memorial, we are committed to involving patients and families in care planning and discharge planning. Patients are kept apprised of the anticipated discharge date and are provided choices regarding post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

Your proposed rule requiring a "day's notice" poses an unnecessary financial burden on the hospital. In our hospital, the average LOS is 4.85 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it sometimes becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12 noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00 p.m. that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients have short stays, I recommend that the generic notice be required only for patients who have been hospitalized for 3 days or more.

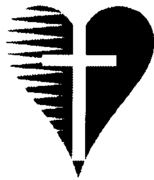
Your estimate that approximately 1 – 2% of beneficiaries will request an expedited appeal is an underestimate of both volume and potential burden. My recommendation would be for CMS to institute this rule only on a temporary basis to judge the actual impact on hospitals. If the percentage is significantly higher, as I would expect from experience, and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expected results, and indeed, the increased costs (administrative and LOS) do not justify the means.

Thank you for this opportunity to comment.

Sincerely,

Marcia Colone, Ph.D., LCSW, ACM

58



St. Francis Hospital & Health Center
BLUE ISLAND

June 5, 2006

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

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

We are writing in response to the above referenced notice of proposed rulemaking establishing new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs which will introduce a two-step notice process. We are very concerned about the significant administrative and financial burdens this new process would place on the hospital. In addition to the above stated issues we have concerns about patient throughput challenges on our limited resources; causing probable delays in available rooms for treating other patient's who need acute care services. Also we do not see any significant added value to the patient, family or hospital with the implementation of this new burdensome process.

We believe the proposed discharge notice process is inappropriate for an acute care environment. The proposed process will cause unwarranted appeals, longer lengths of stay and much greater consumption of staff resources to work through length of stay issues with patients and family members.

We ask that careful reconsideration be given to the implementation of this process as it is projected to be difficult to implement in the organization and will be very costly to our organization. Currently we are providing the notice "Important Message from Medicare" which outlines the beneficiary's discharge and appeal rights. We believe the implementation of this new process will be redundant.

We appreciate the opportunity you have provided us with in order to comment on this new proposal and we hope that you will reconsider your actions regarding this matter.

Sincerely:

Catherine Brunson Young, MBA, MHA, BA, CPHQ, CPUR, RM, ICP
Interim Director Care Management &
Elizabeth Hills, Director Patient Financial Services

59

Saint Raphael Healthcare System

Sponsored by The Sisters of Charity of Saint Elizabeth

1450 Chapel Street
New Haven, Connecticut 06511

David W. Benfer, FACHE
President and Chief Executive Officer
Saint Raphael Healthcare System and
Hospital of Saint Raphael
(203) 789-3020 Fax: (203) 867-5235

June 2, 2006

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

Re: Medicare Program: Notification Procedures for Hospital Discharges, Proposed Rule CMS-4105-P

Dear Dr. McClellan:

On behalf of the Hospital of Saint Raphael, we appreciate the opportunity to comment on the Centers of Medicare and Medicaid Services' (CMS) proposed rule regarding Notification Procedures for Hospital Discharges, as published in the April 5, 2006 Federal Register. <u>We do not believe CMS should proceed with the proposed rule</u>. We are particularly concerned about adding another component to the discharge process when Medicare patients are already given the "Important Message from Medicare (IMM)" at the time of admission, and the delay in discharging Medicare patients, who no longer need hospital care, will result in longer delays for other patients who await admission.

The proposed "notice of non-coverage" refers to hospitals making discharge decisions -- physicians, not hospitals, make discharge decisions. Physicians usually write discharge orders in the morning once lab test results are received, after they have completed rounds, and once they have determined that the patient no longer needs hospital-level care. Patients have a general idea when they will be discharged, however, the discharge order cannot be written until the physician confirms that it is "medically-appropriate" for the patient to be discharged. Most patients look forward to being discharged from the hospital. This additional discharge notice, however, will require hospitals to keep patients an extra day when the patients are medically able to go home or to a sub-acute facility.

<u>Delivering a notice of non-coverage to every Medicare beneficiary on the day before planned discharge (or on the same day of admission in some cases) will cause confusion and will result in Medicare beneficiaries questioning whether the planned discharge is appropriate -- this will</u>

result in an extra day of patient care when the patient no longer needs hospital care. This will cause delays for other patients who need inpatient care. Patients waiting in emergency rooms for inpatient beds will be faced with even longer delays. In addition, the discharge delays will be at the expense of the hospitals. At the Hospital of Saint Raphael, we are currently facing a $7.6 million loss for this fiscal year. Most of the loss can be attributed to Medicare/Medicaid underpayments and uncompensated care.

In addition, the language in the proposed discharge notice repeatedly stresses that the beneficiary can stay in the hospital during an appeal without any financial liability, no matter what the outcome of the review. This would encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based upon medical necessity. This will add to our deteriorating financial condition. Providing more paperwork to Medicare beneficiaries consumes more resources and takes away from direct patient care.

We recommend that CMS withdraw the proposed rule and retain the current notification requirements. If there are specific issues with the discharge planning process that need to be addressed, we recommend, along with the American Hospital Association (AHA), that CMS convene a national workgroup comprised of hospital, physician, beneficiary, and CMS representatives to ensure a full understanding of how current and proposed procedures affect our patients.

We are concerned about the financial implications for the Hospital of Saint Raphael, but we are also concerned about the additional length-of-stay caused by the requirement to provide a notice after the discharge order is written and how that will affect patients waiting admission.

Thank you for the opportunity to comment on the proposed Hospital Discharge Notice rule. If you have any questions, please don't hesitate to contact me at 203-789-3020 or via e-mail at dbenfer@srhs.org.

Very truly yours,

David W. Benfer, FACHE
President and CEO

60

Aurora Health Care

Govt & Community Relations
Forest Home Center
3305 West Forest Home Avenue
P. O. Box 343910
Milwaukee, WI 53234-3910

T (414) 647-3072
F (414) 671-8751
www.AuroraHealthCare.org

June 2, 2006

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

Re: CMS-4105-P

Dear Dr. McClellan:

Aurora Health Care wishes to comment of the Federal Register dated April 5, 2006 regarding the proposed notification procedures for hospital discharges. Aurora Health Care owns and operates the following acute care hospitals:

Aurora St. Luke's Medical Center	Provider # 52-0138
Aurora Sinai Medical Center	Provider # 52-0064
Aurora BayCare Medical Center	Provider # 52-0193
Aurora Medical Center -Manitowoc County	Provider # 52-0034
Aurora Medical Center – Kenosha	Provider # 52-0189
Aurora Medical Center – Washington County	Provider # 52-0038
Aurora Medical Center – Oshkosh	Provider # 52-0198
Aurora Medical Center – Sheboygan County	Provider # 52-0035
Aurora Lakeland Medical Center	Provider # 52-0102
Memorial Hospital of Burlington	Provider # 52-0059
West Allis Memorial Hospital	Provider # 52-0139

In particular, we would like to comment on the difficulties the proposed advance discharge notification would present to the patient's hospital(s) and staff.

"Provisions of the Proposed Rule"

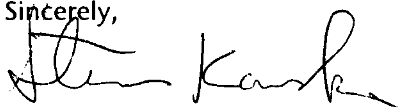
Aurora Health Care is concerned about the proposed 24-hour advance notification before inpatient hospital discharge. This advance notification requirement will present confusion between staff and physician, and extra cost for the hospital, federal government, and physicians. Specifically, our concerns are as follows:

- A discharge is between the patient and their physician. Usually the hospital has little or no input into this process. The hospital should not be held responsible for discharging a patient, something that the physician controls.
- Patient discharge is usually dependant upon the results of testing. This proposed notification requirement inconveniences the patient when results indicate that a hospital stay is no longer warranted, but the patient has to stay longer due to advance notification requirements.
- Short lengths of stay – It seems very confusing to the patient, physician, and staff when you would have to admit and give notice that the patient will be discharged in the same day, when the expected length of stay is only 1 to 2 days.
- The proposed rule would result in patient dissatisfaction when the discharge is governed by regulations, and not the patient's physician.
- Possible extended length of stay due to appeal results in unnecessary extra costs.
- Hospital will incur additional administrative costs putting together additional information needed when the patient appeals their discharge. This would include weekend coverage for patient care staff to work on appeals.
- The Quality Improvement Organization (QIO) will incur additional staffing costs due to the appeals they will have to review.
- The QIO would have to have weekend coverage to review appealed discharges that are on Thursday or Friday.
- The patient may be confused by their regulatory right to appeal their discharge. Not sure what they can base their appeal on, or how to appeal. Family members will have to get involved when patient is not competent to understand his or her rights. This results in further dissatisfaction and inconvenience to the patient and family.
- Hospital has to spend unnecessary time being a liaison between the Medicare Advantage HMO, the hospital, and the patient, when the hospital may not have any input into the discharge decision process.
- Hospital is dependant upon the Medicare Advantage HMO to deliver the detailed appeal notice to the patient. Hospital may be at financial risk for something it has no control over.
- Patient and family may not be cooperative and use this appeal procedure to keep the patient in the hospital for convenience, and not medical necessity. The hospital would incur additional costs holding this type of patient until the appeal is cleared.
- Unlike skilled nursing or home health, which has the same notification requirement, the predictability of a hospital discharge is not as easy and can lead to additional unnecessary expense.
- Physicians will be burdened with the additional expense of making additional patient rounds, and decreased productivity.
- There is no conclusive data produced by CMS to warrant that such a system is necessary, and that the present system is not working.
- This proposed notification requirement takes valuable time away from nursing staff who should be planning and providing patient care instead of filling out additional paperwork.
- The patient caregiver will not have any physician orders when the patient is appealing the discharge, and they are still in the hospital. The physician has already discharged the patient and pre-discharge orders will no longer be valid. This will cause extreme confusion for nursing staff especially if the physician cannot be located.
- Patient appeal rights already available through Hospital Issue Notification of Non-coverage (HINN). Medicare beneficiaries already have a right to refuse discharge and appeal continued

coverage for hospitalization through the QIO on a concurrent basis. This provision already provides the beneficiary with up to three additional days of hospitalization whether the patient appeals or not. Other payors have their own process for expedited appeals as well.

Aurora Health Care would like to thank CMS for the opportunity to comment on this proposed discharge notification provision. Should you have any questions regarding these comments, please feel free to give me a call at 414-647-3429.

Sincerely,



Steve Kowske
Regulatory and Reimbursement Manager
Aurora Health Care

61

DUKE UNIVERSITY HOSPITAL
DUKE UNIVERSITY HEALTH SYSTEM

June 2, 2006

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

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

Dear Dr. McClellan:

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

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

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

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

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

Box 3647 DUMC • Durham, NC 27710 • Phone (919) 668-2483 • Fax (919) 668-0251

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

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

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

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

There are several problems with the proposed approach.

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

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

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

- By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences. The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost 13 million hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would impose a significant burden on hospitals. And for many patients, they would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

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

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

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

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

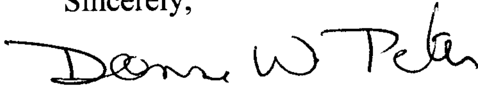
- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons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

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

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

Duke University Hospital appreciates the opportunity to comment on this proposed rule. To discuss any questions or reactions to our comments, please contact Donna Peter, director of patient resource management, at (919) 668-5062 or peter028@mc.duke.edu.

Sincerely,



Donna Peter, MSN
Director, Patient Resource Management
Duke University Hospital

cc: Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
Attn: CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

Foote Hospital

205 N. East Avenue / Jackson, Michigan 49201

Sheila Gomez, LMSW, ACSW
Manager
Case Management Department
Tel. 517-788-4800 Ext. 5359
Sheila.Gomez@wafoote.org

May 30, 2006

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

Submitted electronically to http://www.cms.hhs.gov/eRulemaking

I am writing in response to the Centers for Medicare and Medicaid Services proposal concerning notification procedures for hospital discharges (File Code CMS-4105-P) that will require hospitals to notify patients of their discharge date one day prior to discharge, and will allow patients to appeal the discharge decision. Thank you for the opportunity to provide comments on this CMS proposal.

Regarding Provisions of the Proposed Rule:
The proposed hospital discharge notification process does not consider how hospital discharge decisions are currently made. As early in an admission as possible, an estimated discharge date is determined to support discharge planning. Whether a patient is discharged on that date or not is determined by his/her physician, based on daily rounds and on the patient's recovery progression. Throughout the hospital stay, physicians, nurses and case managers talk to patients and families about the anticipated discharge date and adjustments that need to be made as circumstances change. The discharge date is finalized when the physician has deemed that the patient is clinically stable for discharge and any needed after-care services (e.g., nursing home) are available. The date is confirmed in the physician's written discharge order that is typically completed the morning of the discharge. Requiring that a pre-discharge notice be provided after a confirmed discharge (as opposed to a tentative/conditional discharge), but 24 hours before the actual discharge will add a day to many Medicare admissions.

At W. A. Foote Memorial Hospital, a non-profit community hospital in Jackson, Michigan, there is a significant percentage of patients where we cannot determine that a patient is ready for discharge until the day of discharge. Examples are provided in the addendum to this letter. This means our hospital could be required to keep the patient an extra day to allow 24 hours after giving the discharge notice. For those patients that appeal the decision, this has an even greater impact on hospital length of stay.

If the purpose of this proposal is to notify the patient of his/her appeal rights, this is done upon hospital admission. If the purpose is to give a patient advance notice of his/her expected discharge, this already occurs in the discharge planning process. If the purpose is to notify a patient when he/she becomes financial liable, if he/she wants to stay beyond the need for acute inpatient care, there is a hospital process to establish liability and for the patient to appeal.

The time and cost to administer the notice 24 hours prior to discharge is underestimated (e.g., this does not include the time to respond to patient questions, salary of case managers, 24 hour availability of such staff, cost of educational materials) in the proposal. In addition, the extra expenses to hospitals due to the impact on length of stay, without additional Medicare payment, needs to be considered.

In conclusion, there already exist several regulations (e.g., Social Security Act 1861 Discharge Planning; Medicare Conditions of Participation pertaining to utilization review, discharge planning and patient rights) that if applied appropriately, address the issue of patient discharge planning adequately.

Thank you in advance for the opportunity to submit these comments. If you have any questions about these, please contact me at the address/email above.

Sincerely,

Sheila Gomez, LMSW, ACSW

Addendum

Examples of patient conditions that may require discharge decision to be finalized on the day of discharge include:

1. If a patient has a pending culture due to an infectious disease, the culture will require a designated period of time to incubate in order to determine sensitivity to specific antibiotics. Most physicians will require at least one dose to be administered to observe reactions to the medication once the appropriate sensitivity to the microbe is determined; the observation time is patient-specific.
2. Many patients on oxygen therapy cannot be appropriately weaned from their oxygen abruptly when on high volumes of Fi02; this requires daily evaluations once a determination has been made that it is clinically safe to wean the oxygen or appropriate to prescribe home oxygen.
3. Patients receiving pain medications must be weaned to avoid complications of withdrawal from narcotics; this requires day-to-day evaluations and each individual cannot be expected to respond with the same predictability.
4. Patients not receiving oral intake after surgery or procedures may require gradual initiation to full liquids and solids. The progression of diet tolerance is not always the same for each patient.
5. Patients receiving IV steroid therapy will often require tapering doses to oral steroids; this may require short-term use of insulin or oral agents to control blood sugars. However, it is not possible to predict how a patient will respond once the tapering starts; therefore it is not possible to send him/her home without proper evaluation. The time frame varies for each patient.
6. Patients requiring placement at a SNF, LTACH or acute rehabilitation program in a hospital facility: discharge will depend on the acceptance of the patient by that facility and the determination may not be made 24 hours in advance. In addition a 24-hour discharge notification process would place a burden on the receiving facility.
7. New Medicare prescription coverage may or may not cover IV medications. Infusion therapy companies often require 24-48 hours to obtain prior authorization of the medication(s).

63

Temple University Health System

Howard R. Grant, J.D., M.D.

Chief Medical Officer
Temple University Health System

3509 N. Broad Street
Philadelphia, PA 19140
Email: granthr@tuhs.temple.edu

Tel: (215) 707-6040
Fax: (215) 707-6108

June 1, 2006

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

Re: CMS-4105-P; Notification Procedures for Hospital Discharges; Provisions of the Proposed Rule

Dear Dr. McClellan:

On behalf of the Temple University Health System, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule covering Notification Procedures for Hospital Discharges, as published in the April 5, 2006 Federal Register.

We agree with CMS that a standardized, generic notice of non-coverage is helpful to Medicare Beneficiaries and Medicare Advantage enrollees (collectively "Beneficiaries"), and that all Beneficiaries who are hospital inpatients should be afforded the same notice, expedited review and appeal rights as other Beneficiaries receiving treatment from non-hospital providers. Nonetheless, we believe the proposed rule underestimates the administrative burden on hospital providers.

CMS estimates that it would take hospitals 5 minutes to deliver each notice of non-coverage to Beneficiaries. While this might be sufficient time to deliver the notice, it is far more time consuming to communicate the determination to the patient, answer questions, ensure that the patient understands his or her rights, and have the patient sign the notice. Given the language barriers, age of the population, dependency on children or significant others to support decision making and other factors representative of the patients we serve, we estimate that the actual time could range from 15 to 30 minutes.

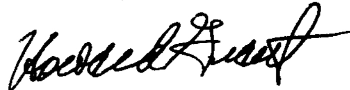
Moreover, the delivery of this notice prior to discharge is placing the discussion at the wrong time in the discharge planning process. Unless the patient has a length of stay of less than 3 days, we recommend that hospitals deliver the notice within 48 hours of admission. This will enable open communication for discharge planning, and assist in the understanding their rights as Beneficiaries. The early notice will enable discussion at both the patient level with their family and at the hospital level in establishing the plan of care for discharge. This timeframe would foster a more open dialogue and help avoid miscommunication and misunderstanding.

Furthermore, we believe that the proposed rule, with its 24-hour notice provision could lead to increased length-of-stay. By providing discharge notice at an earlier stage, providers are better able to manage discharge discussions and avoid unnecessarily extended patient stays.

CMS also projects that 2% of Beneficiaries will request an expedited review of the discharge determination, and that it would take hospital providers and Medicaid plans 60-90 minutes to prepare a case file for the Quality Improvement Organization (QIO). Given that hospitals and physicians bear the burden of showing that services are no longer reasonable or necessary, we believe that it would take 90-120 minutes to organize the medical record and accurately dictate and transcribe physician summaries. In addition to the increased time to prepare the files, providers must also incur the cost of record duplication, courier services and tracking of outcomes from the QIO.

For these reasons, we urge the Centers for Medicare and Medicaid Services to reconsider its proposed Notification Procedures for Hospital Discharges, and to incorporate our concerns into the final rule. Again, thank you for the opportunity to comment.

Sincerely,



Howard Grant, J.D., M.D.
Chief Medical Officer

CC: Melissa Musotto, CMS Regulations Development Group
Carolyn Lovett, CMS Desk Officer

64

Massachusetts Hospital
Association

June 2, 2006

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

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

The Massachusetts Hospital Association, on behalf of our member hospitals and health care systems, submits these comments on the proposed rule concerning the new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. MHA is very concerned that the proposed changes will create large and duplicative administrative burdens on providers, will inappropriately increase the patient's length of stay, and will unnecessarily confuse patients. To that end, we submit the following comments.

Background:
CMS proposes the changes to discharge planning process based on the assumption that the process should be streamlined for acute, non-acute, and post-acute care providers. While the goals are sincere, the proposal fails to acknowledge the large differences in the type of care and services that are received in an acute care hospital versus post-acute providers; such as home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices. Hospitals already provide detailed information on benefits and coverage limitations both on admission and at discharge, that were not available in these other settings prior to CMS developing the termination notices and requirements.

As further stated in the Background section, CMS specifically stated that providing a detailed notice for hospital level patients was not necessary in every case and in many cases was being provided by the Medicare Advantage Organization in cases where the patient disagreed with the discharge plan. However, under the proposed regulations, all patients will now be given a form in an inpatient setting that essentially will be prompting them to object to the plan and result in a longer stays until the process is reviewed. By not taking into account the basic physician discharge order process and the standard discharge planning process by hospital staff, we are doing a disservice to the patient. **To that end, we strongly urge CMS to withdraw the proposal until a workgroup comprised of hospital, physician, beneficiary, CMS, and QIO representatives can meet to fully understanding how the current hospital and other post-acute providers discharge/termination procedures could be coordinated**. While administrative simplification is the goal of all providers, any such efforts must still be coordinated between various provider and payers types.

5 New England Executive Park, Burlington MA 01803-5096 • 781-272-8000 • www.mhalink.org

Provisions of the Proposed Rule:
MHA strongly opposes the proposed rule as it clearly does not take into account how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. As further outlined below, we urge CMS to reconsider their approach on hospitals as the true impact on hospital level of care versus other post-acute care providers has clearly not been scrutinized. At the very least, several current requirements would need to be removed and streamlined prior to implementing a one-size fits all discharge planning process.

Under the proposed rule, the following five steps would occur. First, the patient would still be required to receive the current Important Message from Medicare (IMM) given at admission. Second, the hospital would then deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hardcopy of the signed or annotated notice indefinitely. Third, if the patient objects to the discharge plan, then a more detailed notice is given outlining the care and clinical basis for the discharge. Fourth, since the rule does not remove this requirement, in cases where the patient questions the discharge orders the hospital will need to also issue the detailed Hospital-Issued Notice of Non-Coverage (HINN) as well as provide necessary counseling to assure that beneficiaries are informed of their rights. Fifth, the patient is then also given the actual discharge plan which incorporates several pieces of the detailed notice.

Based on this general review, the proposed rule will **far exceed** the underlying intent of streamlining the discharge planning process for all providers, by creating more duplicative administrative burdens on hospitals versus any other post-acute provider type. Based on more specific impacts on hospitals, we would like to provide the following comments.

Impact on Patients:
MHA believes that the proposed changes will unnecessarily alarm the patient. Patients are under an inordinate amount of stress when admitted to a hospital. This is only exacerbated by requiring hospitals to then provide several notices that the patient may be liable for services, notices that raise questions about the appropriateness of planned discharge, and a notice of non-coverage when Part A coverage runs out during the hospital stay. The outline of the new process above does not take into account the notices of a right to appeal that Massachusetts' hospitals are also required, by the state's Department of Public Health, to issue a patient at the time of discharge, separate and apart from the Medicare notices. The added notices never indicate that discharge decisions would be based on whether the patient requires hospital-level care, could safely go home, or needs to receive post-acute care in another setting. By repeatedly stressing that the patient can stay in the hospital during an appeal without any financial liability – no matter the outcome of the QIO review – the notice

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

The proposed changes will negatively impact timely discharges because the regulation requires notifying the patient one day prior to discharge and therefore allowing an extra medically unnecessary day in the hospital. Many times with short lengths of stay in the hospital, the physician will make a decision to discharge on the same day. Frequently family members or significant others are key decision makers for Medicare patients. If the patient and/or family agree to the discharge plan they verbally agree and then sign a discharge instructions document on the day of discharge. Following the new steps outlined above, additional documents would require three different explanations and two signatures - one the day before discharge and one on the day of discharge. If the patient's family member is not available to sign the document then hospitals would need to wait until they are available, again leading to a delay and possible loss of arranged post-acute bed.

Impact on Current Hospital/Provider Discharge Process:
Hospitals operate a discharge planning process that is governed by Medicare conditions of participation, state licensure standards, and the Joint Commission on Accreditation of Healthcare Organizations standards. In each of these cases, hospitals are required to provide early initiation of the discharge planning process, involvement of the patient and family, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate care in the appropriate setting.

In cases when beneficiaries are transferred to post-acute care, discharges must be made within hours of bed availability or the bed will be lost to another patient. The 24-hour requirement will therefore place Medicare beneficiaries at a disadvantage to other (non-Medicare) patients who would not face these administrative delays, potentially creating access problems and extending their stay in the hospital. Under the preamble of the proposed rule, CMS specifically provides that 2% of all beneficiaries discharged from hospitals disagreed with their discharge decision, therefore assuming that 98% of Medicare beneficiaries agreed with their discharge decision.

By delaying the discharge date by at least 24 hours, patients awaiting admission will be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

Regulatory Impact:
CMS proposes that the impact of the proposed requirements would take an additional 5 to 10 minutes to deliver the detailed notices. This grossly underestimates the true time it takes for a clinical staff to complete the detailed notices. Based on the outline above, the additional steps that are not included in this impact are the following: development and production of the various notices by more than one staff; education and training of physicians and staff on the various forms; internal review, approval and monitoring of notification procedures;

medical record maintenance, copying and mailing; staff time to inform patients multiple times of duplicative requirements, assure their understanding and obtain a signature. The regulation cost information also does not take into account the rising population of Medicare patients and the impact this will have the volume of work that will also occur. Furthermore, there is no recognition of the additional resources needed for those patients who need interpreter services to review each new notice and documentation. All of these additional resources must be accounted before there are substantial new requirements posed on health care providers.

The regulations clearly do not provide any exceptions for those patients whose clinical assessment on admission determines that post acute care is not needed. Further, at a time when many health care providers are facing severe nursing shortages, increasing the administrative requirements on clinicians will only further exacerbate the problem. When the patient or family members have questions and want to receive a detailed notice regardless of the clinical determinations, more resources to coordinate and deliver the notices will take time away from clinical care of the patient and possibly leading to discharge delays. The burden of this regulation would stretch the available staff (nursing, discharge planners, social workers) to have to complete the process for more documentation that is clearly not beneficial to patients.

Conclusion:
Clearly there are too many issues and concerns that have not been addressed or considered by CMS in developing these proposed changes to the discharge process. While hospitals have not heard complaints about the current discharge planning process, we strongly urge CMS to consider developing a workgroup as mentioned above to develop a better process that meets the goals of streamlining the administrative process. Given that the IMM and the HINN are congressionally mandated forms issued by hospitals, then changes need to be made to the content of those notices rather than creating new duplicative notices and procedures. MHA and our members are willing and ready to work with CMS to articulate how such changes could be made under the current discharge planning process. Should you have any questions about our comments or are interested in convening MHA members for a workgroup, please contact Anuj Goel of my staff at (781) 272-8000, ext. 140.

Sincerely

Karen S. Nelson, MPA,R.N.
Senior Vice President of Clinical Affairs

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BMC
BIXBY MEDICAL CENTER

Member of PROMEDICA HEALTH SYSTEM

June 1, 2006

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

Dear Centers for Medicare & Medicaid Staff,

We have reviewed the Federal Register, Volume 71, Number 65/April 5, 2006/Proposed Rules on Notification Procedures for Hospital Discharges. We have several concerns regarding this process.

First of all, the rule concludes that it will only take five minutes to present these to patients. If they only needed to be presented, no understanding needed to be gleaned, and no signature needed to be obtained this might be adequate; however, to produce the letters and distribute them alone would take five minutes. Additional time will be needed to help elderly patients understand the rule and obtain their signature or obtain their request for additional appeal. A format or form for such notification also is not provided.

Since this notification must include the date covered services would end and the date financial liability would begin, it has to be certain that discharge is to occur. In many cases in the hospital actual test results which may include Radiology, interventional tests, or Lab tests need to be obtained prior to discharging the patient. Presently, this can occur on the same day once those results are reviewed. This would require potentially an additional day length of stay so that we could determine the actual date of discharge and beneficiary responsibility as well as giving the one day advance notice. In already crowded facilities and in Critical Access facilities, where we are approaching the four day length of stay, we will be in a situation where to issue this letter the day before discharge may add to our length of stay at the same DRG rate. This costs the Medicare/Medicaid system nothing but imposes an additional burden to the hospital on caring for patients who are prepared for discharge.

For patients with a short length of stay such as patients who may be coming in and have to stay after a procedure and it is anticipated that that length of stay may be two days at

818 Riverside Avenue, Adrian, MI 49221 (517) 265-0900 www.LHAnet.org

most three days, these patients may be receiving their notice of discharge at nearly the same time they have been admitted to the hospital. This process works well in Nursing Homes where patients stay may be weeks or months; however, in a situation where the average length of stay may be three days, this means we have some very short length of stay patients and notice will have to be given in a very short period of time.

The other concern is what if the discharge status changes? The patient is notified that they will be responsible starting tomorrow and they have to stay an extra day and something happens in the meantime to prohibit this discharge from occurring. Perhaps the patient status changes, perhaps they become more short of breath for a COPD patient, perhaps their respiratory status changes? In these cases, how is the notice retracted and does the notice then have to be reissued when the patient again is ready for discharge?

This regulation does not include providing within the hospital the system to manage the process to:

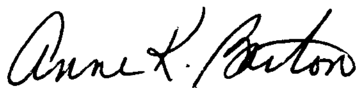
a. know when patients are ready for discharge in manual handwritten records,
b. to assure that there is staff on duty seven days a week to obtain this information,
c. produce those letters, and
d. provide them to the individual patients.

These are a little different than the Medicare general statements that are provided on admission because those are not individualized for the patient. The general Medicare information is just a generalized statement that can be handed to every patient exactly the same. The content of these letters would require individualization for every patient and production of these through some kind of letter merge document.

I am the Director of Quality Resources at two community hospitals, one which is a Critical Access facility. I am very concerned regarding this proposed rule and would ask that the Centers for Medicare and Medicaid Services weigh the actual benefit to patients who are discharged every day from our facilities. It would seem appropriate with short lengths of stay to include a paragraph in the general Medicare information that indicates their rights at discharge. They may be fully aware that they have the right to get additional information and how to submit that request, perhaps with a tear off portion at the bottom of the letter or some easy format so that this can be handed at Registration and everyone would "be informed".

Thank you for the opportunity to provide my comments. I hope to hear a reasonable decision in the Federal Register about these weighty requirements.

Sincerely,



Anne K. Barton, BSN, MEd
Director, Quality Resources

1316 East Seventh Street • Auburn, IN 46706 • (260) 925-4600

May 31, 2006

Center for Medicare and Medicaid Services
Department of Health and Human Resources
Attention: CMS-4105-P
7500 Security Blvd
Baltimore, MD 21244-1850

Re:CMS proposed changes to hospital discharge notice requirements

The proposed legislature, while well intentional, is impractical and will drive up costs to our hospital and create frustration for patients and doctors. If approved, this new ruling could result in thousands of unnecessary hospital days.

DECISION TO DISCHARGE IS MADE THE **DAY OF DISCHARGE** APPROXIMATES 50% OR MORE OF CASES. PATIENT'S LABS, X-RAYS, FEVERS, SYMPTOMS,ETC,ETC, ARE EVALUATED UP UNTIL THE HOUR OF DECISION TO DISCHARGE.

Therefore, any communication such as suggested should NOT BE TIED TO THE DAY BEFORE DISCHARGE. It should be conveyed to the patient at the time of admission. It should communicate only patient's rights and the process for resolution in event of dispute.

Mark Souder M.D.
Utilization Chairman

James Buchanan M.D.
Medical Director

68

June 4, 2006

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

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

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

RE: File Code: **CMS-4105-P**
Medicare Program: Notification Procedures for Hospital Discharges Proposed Notice

Comments

This letter is written on behalf of the Society for Social Work Leadership in Health Care. Our Society is an association, 1300 members strong, dedicated to promoting the universal availability, accessibility, coordination, and effectiveness of health care that addresses the psychosocial components of health and illness. The majority of our members are employed in acute care hospital settings either in management positions or in direct practice. As professional social workers in hospitals, we often assist patients and their families in preparing for discharge and transition to other healthcare settings. Not infrequently patients and families find themselves having to make difficult decisions for which they are often unprepared. They rely on the knowledge and expertise of healthcare professionals including professional social workers.

Society for Social Work Leadership in Health Care • 100 North 20th Street, 4th Floor • Philadelphia, PA 19103 • 866.237.9542 • Fax: 215.545.8107 • info@sswlhc.org

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

Social workers and others in healthcare are taxed with the awesome responsibility of assisting individuals at very difficult and trying periods in their lives. They therefore require the time and attention needed to address their clinical needs. Adding another piece of paper to an already voluminous amount of documents that need to be read, sometimes interpreted and signed by the patient, in our view, diverts needed resources from the effort to provide care, treatment and assistance to patients. We share the view of other professional healthcare organization that the CMS estimate (5 minutes) of the amount of time expended for the provision of the second step notice is grossly understated. Given the time required for delivery of the document, explanation and discussion of the letter's intent and to respond to questions posed by patients in their families the process would take at least 20-30 minutes. Patients who have language barriers or are unable to communicate due to their medical condition would require even greater expenditures of time.

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

One outcome from this new rule will be more unnecessary appeals by patients or their families who wish to extend the hospital staff for the 2 or 3 days necessary to resolve an appeal. Hospital resources such as hospital beds are often at a premium. CMS has prided itself on its efforts to prevent unnecessary acute care hospital days. This new rule would have the opposite effect.

Recommendations

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

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

69

June 5, 2006

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

I realize that CMS is trying to provide more information to patients by proposing this rule but it is not practical.

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

It will be very difficult to provide the proposed notices. From a practical point, just trying to find the patient in the room due to tests and procedures can be almost impossible. A delay in a procedure or communication can cause a delay in discharge. If for some reason we can not talk to the patient because their family might be present, the discharge can again be delayed.

The proposed discharge notice invites or encourages unwarranted appeals and longer lengths of stay.

The true costs associated with this proposed requirement are grossly understated. In addition, it will not add value to the patient.

For the aforementioned reasons, along with others, we encourage you to reject this Discharge Notification Proposal.

Sincerely,

Terry R. Lambert
Chief Executive Officer

CentegraHealthSystem
Memorial Medical Center
3701 Doty Road
Woodstock, IL
60098

June 2, 2006

To: Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Summary of Comments

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

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

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

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

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

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

Sincerely,

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

Linda Gray
Manager, Utilization
Centegra Memorial Medical Center
3701 Doty Road
Woodstock, IL 60098

71

MARGARET MARY
COMMUNITY HOSPITAL
P.O. BOX 226 • 321 MITCHELL AVENUE
BATESVILLE IN 47006-0226

June 5, 2006

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

I am writing in response to the proposed rule CMS-4105-P, Medicare Program: Notification Procedures for Hospital Discharges. I am the manager of social services at Margaret Mary Community Hospital, a critical access hospital, in Batesville, Indiana.

As a social worker I have been directly involved with discharge planning for Margaret Mary Community Hospital for 16 years. Our current discharge planning practices begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, social workers interview all patients meeting the hospital's screening criteria: patients over age 70, Medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. We have an interdisciplinary team, which meets Monday through Friday to discuss each patient for discharge needs. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is very close to 3 days. Since lengths of stay are short and patient' conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance.

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

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

I appreciate the role of CMS in protecting patient rights. But this is something our social workers do on a daily basis when meeting with patients. We believe we must protect patients rights while also stewarding government resources and ensuring patients do not take advantage of an opportunity to unnecessarily extend a length of stay adding significant costs to Medicare.

Sincerely,

Linda L. Tuttle, LSW
Social Services Manager

INGALLS HEALTH SYSTEM

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

June 5, 2006

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

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

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

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

Summary of Comments

We are writing on behalf of Ingalls Memorial Hospital ("Ingalls") and its Medical Staff. Ingalls is a 563-bed general acute care hospital located in Harvey, Illinois, with an organized Medical Staff of approximately 425 physicians. We appreciate the opportunity to provide comments on the above referenced notice of proposed rulemaking, which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process similar to what is currently in place for other Part A providers. Ingalls appreciates and understands the CMS quest for uniformity, as

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

Background

Ingalls Current Process

Ingalls currently delivers the "Important Message from Medicare" to all Medicare beneficiaries at the time of admission, and provides a hospital-issued notice of non-coverage (HINN) to beneficiaries in the original Medicare program who are dissatisfied with a pending discharge. For Medicare Advantage plan enrollees, the responsibility for notification rests with the MA organization, which uses a "Notice of Discharge and Medicare Appeal Rights" (NODMAR) if the patient disagrees with the MA organization's discharge decision or its plans to discontinue coverage of the inpatient stay.

Comments

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

Individual patient discharge decisions are made by the attending physician responsible for the patient's care, but the hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharged timely, collaborates with the physician to expedite the discharge process. At times, the physician is reluctant to discharge a patient, or the patient's family is reluctant to make a decision regarding post-acute care. Sometimes putting a mother or father into a long term care facility can be a traumatic experience. Decisions get delayed due to social and family factors. The HINN has been effective in prompting action by both the physician and the patient's family in certain circumstances. We are extremely concerned that the new rule will provide the opportunity to buy time and delay discharge when no legitimate basis for appeal exists. We see such delays happen all the time now, and we are concerned the proposed process would only increase such delays.

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

CMS Proposal

CMS proposes to establish a "two-step" discharge notice similar to the process in effect for SNFs, HHAs, CORFs, and hospices because this process is "helpful to beneficiaries" and is not "overly burdensome to providers or Medicare Advantage organizations" (17053). CMS reasons that beneficiaries in an inpatient hospital setting should have the "same notice of appeals rights to which other beneficiaries are entitled," and explains that the proposal "would provide a more consistent approach to communicating appeal rights" to all Medicare beneficiaries in all settings. (17053) CMS reiterates that the proposed rule "is intended only to provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings." (17054)

The "two-step" process would require hospitals to deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date where the patient's physician agrees with the discharge. This notice, which includes limited patient-specific information, would be delivered "as soon as the discharge decision is made" (17054), and would require the hospital to obtain the beneficiary's signature to acknowledge receipt. If the patient disputes the discharge, the hospital would be required to deliver a more detailed discharge notice similar to that used in other Part A settings. The current HINN and NODMAR forms for discharge would be eliminated (although HINNs would still be used for preadmission situations and other instances where the physician does not concur with a discharge decision). **Discharge could be delayed at least one full day just to give the notice.**

Comments

The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not well suited for the acute care hospital setting. The current process, however, does work well, and CMS has offered no compelling reason, other than uniformity, for standardizing the process. Hospitals are required to provide the "Important Message from Medicare" at the time of admission, which is a form that is not required in other settings. The "Important Message from Medicare" outlines the beneficiary's discharge and appeal rights.

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

The proposed discharge notice process is not consistent with the timing of physician decision-making and with hospital operations. The generic notice erroneously indicates that the hospital determines that Medicare will not pay for the hospital stay after the discharge date on the form. The detailed notice also indicates that the hospital has determined that Medicare coverage for the

hospitalization "should end." The language is potentially misleading, so that the patient could assume the hospital has made the discharge decision, not the physician. Discharge decisions are made by physicians, not hospitals. The physician may document an anticipated discharge or write a discharge plan, but generally does not make a discharge decision until the day of discharge. The discharge order entered into the patient's record at that time is the discharge decision. The physician may give discharge approval pending certain clinical criteria being met, e.g. test results being negative or within specified limits, or absence of a fever.

The proposed discharge notice process could add at least one additional day to every Medicare stay since CMS requires that the notice be given to the beneficiary at least one day in advance of discharge. The generic notice cannot be delivered until after the discharge decision is made and documented by the physician and the specific date of discharge is entered on the notice. It is not possible to accurately identify the date of discharge one day in advance for every Medicare patient (and remember 45% of our patients are Medicare beneficiaries).

The proposed generic discharge notice invites longer lengths of stay, thus consuming valuable hospital resources. The proposed notice emphasizes that the beneficiary's "hospital services will continue to be paid for during the review." This is the only sentence in the two-page proposed notice that is underlined. By highlighting the lack of a possible financial penalty to the patient, the message to beneficiaries and their families is that there is no reason not to appeal, even if the patients are medically ready for discharge. This is just the opening that some patients' families are looking for when a difficult social, or personal situation exists.

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

Recommendations

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

Ingalls would be happy to participate in a national workgroup comprised of hospital, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures impact the various parties, and to ensure that any proposed revised procedures truly balance hospital, operations and beneficiary rights.

Sincerely,

Kurt E. Johnson
President and Chief Executive Officer

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

cc: American Hospital Association
Illinois Hospital Association

73

JUN -2 2006

VIA Hand Delivery

June 5, 2006

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

Attention: CMS–4105–P

Dear Dr. McClellan:

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

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

A. Background

Under the proposed rule, hospitals must comply with a two-step notice process in connection with the termination of Medicare coverage for services provided during an inpatient hospital stay. Prior to discharging any Medicare beneficiary, hospitals would be required to deliver "on the day before the planned discharge" a standardized notice to each Medicare beneficiary whose physician agrees with the discharge decision. The notice would inform each beneficiary when Medicare coverage ends and financial liability for continued services begins, and would explain the beneficiary's appeal rights. The second step is triggered if the beneficiary disagrees with the decision to terminate services. In such cases, the hospital

would be required to deliver a detailed notice providing specific information about the decision to terminate services. The proposed process would extend to hospitals the process that currently is required of post-acute care providers, such as home health agencies (HHAs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs) and hospices.

B. Delivering A Notice One Day Prior to Discharge Would Require An Unncessary Extension of Patients' Stays

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

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

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

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

C. The Proposed Process is Redundant to Current Requirements and Unduly Burdensome.

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

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

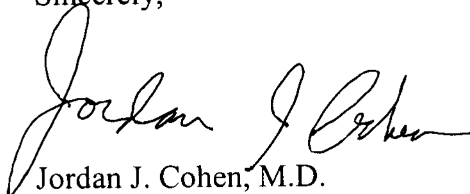
D. Conclusion

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

* * * * * * * * * *

If you have questions concerning these comments, please contact Karen Fisher at kfisher@aamc.org, or 202-862-6140 or Diana Mayes, at dmayes@aamc.org, 202-828-0498.

Sincerely,



Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC
Diana Mayes, AAMC

-74

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

June 5, 2006

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

RE: Medicare Program; Notification Procedures for Hospital Discharges Proposed Notice of Rulemaking, CMS-4105-P

Dear Dr. McClellan:

In response to the proposed rule, concerning notification procedures for hospital discharges, the California Hospital Association (CHA) respectfully submits comments on behalf of its nearly 500 hospital and health system members. Through the proposed rule the Centers for Medicare & Medicaid Services (CMS) proposes to require hospitals to provide a new notice of Medicare discharge appeal rights to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission, which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

In addition to these comments, CHA supports the comments and recommendations of the American Hospital Association. The proposed rule recommends several significant changes that are of concern to CHA.

CHA believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting; how the discharge planning process works; and the real impact, both financially and operationally, that the proposal would have on hospitals. In addition, it is important to note that CMS has not presented a compelling case in support of implementing this proposed change. Without a more thorough and realistic examination of the process, CHA does not believe CMS should proceed with these changes.

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

By providing the IMM at admission and a detailed notice when a beneficiary believes he or she is being asked to leave the hospital too soon, hospitals currently follow a two-step process for

1215 K Street, Suite 800, Sacramento, CA 95814 · *Telephone:* 916.443.7401 · *Facsimile:* 916.552.7596 · www.calhospital.org

Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

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

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

Several problems with the proposed approach are highlighted below:

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

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

To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost 13 million hospital admissions a year, nationally, an extra inpatient day for each admission at an approximate cost of $1,000 per day would impose a significant burden on hospitals. Moreover, for many patients,

they would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

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

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

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

- CHA is concerned that the language of the proposed generic discharge notice (included in the paperwork clearance package) could cause a beneficiary to doubt whether the planned discharge is appropriate. The proposed notice focuses solely on a termination of Medicare payment and financial liability for the beneficiary if they do not appeal by noon the day after the notice is received. Nowhere in the notice is there language notifying the beneficiary that the discharge decision would be based on whether the beneficiary requires hospital-level care, could safely go home, or needs to receive post-acute care in another setting. The notice could lead to requests for more detailed and unnecessary notices and appeals, which hospitals and the QIOs would then have to review. Also, we are concerned that by repeatedly stressing that the beneficiary can stay in the hospital during an appeal without any financial liability — no matter the outcome of the QIO review — the notice would likely encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based on medical necessity.

- The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions. The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide de-

tailed and specific reasons why services are no longer reasonable or no longer covered by Medicare, and specifically cite the relevant Medicare rule or policy that applies to the beneficiary's case. Direct input from the physician, a resident or a hospitalist would be required to complete this notice, but they likely would not be able to cite specific applicable Medicare coverage policies; hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria.

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

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

Thank you for the opportunity to provide comments on this proposed rule. If you have any questions or would like to discuss these comments, please contact me at (202) 488-4688 or mholloway@calhospital.org.

Sincerely,

Margot Holloway
Vice President, Federal Regulatory Affairs

MH:cr

America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

75

Rec'd 6/5/06 L.N.W.

AHIP

June 5, 2006

Centers for Medicaid & Medicaid Services
Department of Health and Human Services
Attention: CMS–4105–P
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS–4105–P

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) in response to the notice of proposed rulemaking, "Medicare Program; Notification Procedures for Hospital Discharges," published in the Federal Register (71 FR 17052) by the Centers for Medicare & Medicaid Services (CMS) on April 5, 2006. AHIP is the national trade association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. These proposed amendments are of significant interest to AHIP's member organizations, many of which participate in the Medicare Advantage (MA) program and the Medicare cost plan program.

AHIP has consistently supported implementation of efforts that promote beneficiary understanding of and access to appeal rights under the MA and Medicare cost plan programs, so that beneficiaries can take advantage of those rights whenever needed and will receive timely determinations. We believe that this goal is best served through workable requirements that add value for beneficiaries. In response to the practical challenges that have been identified in delivering notices to beneficiaries at the time of discharge from an inpatient hospital stay, such factors as the inability to anticipate, in many instances, when the physician will make the discharge decision and the highly varied length of stay (i.e., from one day to many weeks), we have supported direct involvement of the hospital in the delivery of such notices and establishment of uniform requirements for delivery of notices to all beneficiaries.

Important Message from Medicare. To this end, one important step has been inclusion of information regarding appeal rights in the Important Message from Medicare which must be provided by hospitals at the time of admission to all beneficiaries. We believe it is critical for this notice to be provided on a consistent basis at every admission. In addition, to supplement this requirement, MA organizations and Medicare cost plans have the obligation to give the enrollee a notice on the day before discharge explaining the reason that inpatient hospital care is no longer needed, if the beneficiary disagrees with the discharge decision. (See §422.620.) We

believe that these processes are sound, and we would support additional training, compliance, and monitoring efforts to ensure that these notices are provided.

Outreach and education. We also continue to strongly support our longstanding recommendation for intensified outreach and education efforts to improve beneficiary awareness of their appeal rights and the steps for initiating an appeal under both the Medicare fee-for-service program and the MA and Medicare cost plan programs. We believe that collaboration between CMS, beneficiary groups, health plans, hospitals, and other interested parties will be essential to the success of such initiatives.

Proposed rule. With the goal of improving beneficiary access to appeal rights, the proposed rule seeks to establish new notice requirements for hospitals along with related requirements for MA organizations and Medicare cost plans to supplement the requirements already in place. As noted above, while we support the goal of promoting beneficiary knowledge of and access to the appeals process, we are concerned that the practical issues surrounding the proposed notice requirements are likely to mitigate against their effectiveness in contributing to achievement of this goal. These concerns, as discussed in detail below, focus principally on the later delivery of a written description of the discharge decision to beneficiaries who disagree with the decision and resulting disadvantages for beneficiaries and costs to the Medicare program.

Strengthening implementation of current process. We recommend that CMS reconsider the proposed approach and focus on strengthening implementation of the current process and increasing efforts to promote beneficiary awareness of the appeals process, as discussed above. For example, we believe that there are additional steps to supplement existing processes that could make the current notice requirements more effective and valuable for beneficiaries. Building on current functions, hospitals could ensure that physicians, nurses, and others in daily contact with patients are trained to refer beneficiaries who object to a discharge decision to discharge planners or other staff trained to provide information on the appeals process and expedite issuance of a written explanation of the discharge decision. For beneficiaries who are enrolled in an MA or Medicare cost plan, the hospital staff could be responsible for contacting the MA organization or Medicare cost plan to facilitate provision of the required notices. We recommend that CMS consult with MA organizations, Medicare cost plans, and hospitals to develop such requirements.

General Comments

CMS is proposing a two-step process for hospital discharges that is analogous to the fast track appeals process that MA organizations and Medicare cost plans have implemented for beneficiaries receiving services from home health agencies (HHAs), skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs). The requirements apply whenever services are reduced or terminated. These settings are significantly different from the

inpatient hospital setting, and we believe that application of a similar notice process for inpatient hospital discharges could delay provision of a written explanation of the discharge to beneficiaries who express disagreement with the discharge decision. In turn, this delay has the potential to delay the decision by the beneficiary to pursue an appeal and to delay the QIO's determination regarding the appeal. The result could be a longer period of uncertainty for the beneficiary in instances where the QIO finds in the beneficiary's favor and in cases where the discharge decision is upheld, in longer hospital stays that may not be either necessary or desirable and that will increase costs to beneficiaries and the Medicare program inappropriately.

AHIP believes that effective implementation of the existing process has two advantages over the proposed process. Under the existing process, in addition to the Important Message from Medicare, beneficiaries who disagree with a discharge decision must receive the written explanation of the decision the day prior to discharge, which is at the point when the second notice of appeal rights is provided under the new process. AHIP believes this explanation is critical to the beneficiary's ability to make a more informed decision regarding the need to pursue an appeal. In addition, because the reasons for the discharge would have been articulated and conveyed to the beneficiary at an earlier point, the QIO will also make its decision within a shorter period following the initial discharge decision. This shortened decision making period will provide earlier resolution for the beneficiary whose appeal is successful and reduce the expense incurred by the Medicare fee-for-service program and the MA organization or Medicare cost plan in paying for hospital stays that are later determined to be unnecessary.

Specific Comments

In the event that CMS moves forward with the approach reflected in the proposed rule, AHIP is providing the following comments on the proposed amendments §422.620 and §422.622 which directly affect MA organizations and Medicare cost plans.

Note: AHIP notes that the appeals requirements of Subpart M of the MA regulations are incorporated by reference into the Medicare cost program regulations at §417.600(b). Since these regulations apply under both programs, for simplicity, in our comments below our reference to MA organizations is also intended to encompass Medicare cost plans.

- **Delivery of generic notice—Hospital notice to the MA organization (§422.620).** The hospital must make valid delivery of a notice of non-coverage prior to any discharge of an MA enrollee, and the MA organization must be prepared to provide a written explanation of the discharge if the enrollee decides to appeal. However, the proposed regulations do not require the hospital to notify the MA organization that a notice has been delivered, nor do they require the hospital to provide a copy of the notice to the MA organization, so that the MA organization would be able to readily produce the notice

upon audit by CMS. Because of the strong interest of the MA organization in knowing when a hospital has provided an enrollee with a notice of non-coverage, AHIP recommends that CMS revise the proposed regulations to add a paragraph to §422.620 that requires the hospital to notify the MA organization as quickly as possible following delivery of a notice of non-coverage to an enrollee and to send a copy of the generic notice to the MA organization. Under the proposed requirements, compliance with the issuance of this notice will require close cooperation between hospitals, attending physicians, and MA organizations. Therefore, AHIP also recommends that CMS provide education and training for all parties about their responsibilities under the proposed discharge notification process.

- **Obligation to provide detailed beneficiary notice by close of business of the day QIO notifies MA organization of request for QIO review (§422.622(c)(2)).**
  + The proposed rule requires that the QIO must notify the MA organization of the enrollee's request for immediate QIO review on the date the QIO receives the request. The MA organization must deliver a detailed notice to the enrollee by the close of business on the same day. We are concerned that in the event the QIO notifies the MA organization at the end of the business day, the MA organization will be unable to comply with the timeframe for notification of the enrollee. AHIP notes that the timeframe for the MA organization to act is shorter than:
    (1) the timeframe in the HHA/SNF/CORF fast track appeal process which gives the MA organization an additional day to provide the notice and
    (2) the existing requirements for the Notice of Discharge and Medicare Appeal Rights (NODMAR) under the MA program which gives the MA organization until close of business of the first full working day immediately following the day the enrollee submits the request for review to respond to the QIO's request.

    To afford an adequate opportunity for MA organizations to provide a written explanation of the discharge decision to the enrollee, AHIP recommends that CMS revise (§422.622(c)(2)) to require the MA organization to provide the written explanation of the discharge decision to the enrollee by close of business on the day following notification of the MA organization by the QIO. Since the MA organization will be financially responsible for the costs for the additional length of stay that could be associated with this timeframe, the enrollee would not be disadvantaged by this change. Similarly, AHIP recommends that the information that the MA organization is required to provide the QIO under §422.622 (c)(4) of this section be due by the close of business of the day after the MA organization is notified of the request.

- **Financial responsibility for coverage (§422.622(c)(5) and §422.622(e)).** The proposed regulation provides that, except in the case of an admission that was never approved by the MA organization or that does not constitute emergency or urgently needed care, the MA organization

  > continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed until noon of the day after the QIO notifies the enrollee of its review determination.

  AHIP recommends that CMS modify this provision to address the following important issue.

  + The hospital has the responsibility to make valid delivery to the enrollee of a general notice of non-coverage prior to any discharge. If the hospital fails to meet this obligation, the enrollee may be discharged at a later date than that provided for in the discharge decision. Under the proposed regulation, the MA organization will be financially responsible for the additional length of stay attributable directly to the hospital's failure to provide valid notice to the enrollee. We believe that the hospital should bear financial liability for extension of the hospital stay that is due to the hospital's failure to meet its obligations under the regulations to provide to the enrollee timely, valid notice of non-coverage. Therefore, we recommend that the proposed regulations be revised to state that the MA organization will not be financially responsible if the hospital fails to provide valid notice.

- **Solicitation of the views of the enrollee (§422.622(d)(3).** The QIO is responsible for soliciting the views of the enrollee regarding the discharge decision. Although the proposed rule explicitly permits the MA organization to make information necessary to the determination by the QIO available to the QIO by phone as well as in writing, it is silent regarding the method by which the QIO may solicit the views of the enrollee. In light of the responsibility of the QIO to conduct an "immediate review," AHIP recommends that the regulation be modified to clarify that the QIO may fulfill its responsibility by soliciting the views of the enrollee by phone to expedite the QIO's review process.

- **Implications §422.622(e) (Liability for hospital costs) for Medicare cost plans (page 17061).** As noted above, under the Medicare cost plan program regulations at §417.600(b), Medicare cost plans are required to follow the appeals rules applicable to MA organizations. To address the following two issues unique to Medicare cost plans

that are related to the proposed regulations, AHIP recommends that CMS modify proposed §422.622(e) or the Medicare cost plan regulations (Part 417, Subpart Q):

+ **Billing Option 1.** CMS offers Medicare cost plans two billing options. Under Option 1, CMS, through the fiscal intermediaries (FIs), pays hospital claims on behalf of the Medicare cost plans, and the Medicare cost plan has no liability for these claims. Under Option 2, the Medicare cost plan pays hospital claims directly. The requirements in §422.622(e) regarding liability for hospital costs should be applicable to a Medicare cost plan electing billing Option 2 but not to a cost plan electing Option 1. Therefore, to avoid inappropriate imposition of financial liability on Medicare cost plans electing Option 1, AHIP recommends that the MA or Medicare cost plan regulations be revised, as they relate to requirements for the Medicare notice of non-coverage, to state explicitly the circumstance in which a Medicare cost plan would not be financially responsible for the costs of the hospital stay.

+ **Addressing circumstances when Medicare fee-for-service rules apply to Medicare cost plan enrollees.** CMS' current policy is that the Medicare fee-for-service appeals rules apply when a Medicare cost plan enrollee is admitted to a non-network hospital and that admission is neither an emergency admission nor an admission covered under a referral by a network provider. AHIP recommends that CMS revise §422.620(a) (Applicability and scope) to state Medicare fee-for-service appeals rules would apply in these circumstances.

- **Short lengths of stay (Preamble, page 17054).** In the preamble, CMS invites comment on whether a different notice requirement should apply for short lengths of stay (i.e., 1 – 3 days). Since the required time frames for notice to beneficiaries that are included in the proposed rule would be unworkable for short stays, AHIP recommends that a different process be established for these stays. While we recognize that CMS may retain the two step notice approach included in the proposed rule, we believe that, particularly in the case of short stays, provision of the Important Message from Medicare would alert beneficiaries to their appeal rights and allow them to decide whether to contact the QIO to initiate the appeals process and delivery of the written explanation of the discharge.

- **Projected time to prepare detailed notice and case file (Preamble, page 17056).** In the preamble, CMS invites comments on its projection of the time necessary for the MA organization to prepare the detailed notice and the case file for the QIO. CMS estimates that preparation takes 60 to 90 minutes. AHIP believes that this estimate is understated. For example, it takes one MA organization approximately 180 minutes per case to prepare materials for the fast track appeal process. This assumes that the MA

organization is able to obtain the timely cooperation of all parties, and it is possible that additional time may be needed to make multiple contacts or conduct extended discussions in an effort to obtain all necessary records. Similar action would be needed to implement the proposed requirements for the Medicare notice of non-coverage. We recommend that CMS reevaluate the estimate associated with the notice of non-coverage and take such factors into account.

AHIP appreciates the opportunity to comment on these proposed rules. If you would like to discuss any of the issues we have raised or would like additional information, please contact me at (202) 778-3209 or at cschaller@ahip.org.

Sincerely,

Candace Schaller
Senior Vice President, Regulatory Affairs

Rec'd 6/5/06 J.N.W.

76

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4780
Fax 202.626.4833

June 5, 2006

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

Attn: CMS-4105-P

Via Electronic Mail

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

Dear Dr. McClellan:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to comment on the proposed rule on Medicare notification procedures for hospital discharges issued April 5, 2006 (71 Fed. Reg. 17052). BCBSA is made up of 38 independent, locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for more than 94 million people—nearly one in three Americans. As you are aware, many BCBS Plans offer Medicare Advantage plans.

BCBSA has significant concerns with the proposed rule's new requirements for Medicare Advantage Organizations (MAOs) to provide a proposed "detailed" notice (CMS-10066) when a QIO review of a pending hospital discharge is initiated by a beneficiary. We believe the proposed new requirements are unworkable because:

- many Medicare Advantage Plans today do not have contracts with hospitals to assure compliance;

- the second notice must include detailed clinical information that perhaps only the applicable hospital and attending physician, not the MAO, have access to when notice must be developed for timely delivery to the patient; and
- the timeframes for delivery of the notice are unworkable.

Because of concerns with this proposed rule outlined in this letter, BCBSA recommends an alternative workable approach that assures delivery of standardized notices to beneficiaries of their appeal rights prior to and after discharge from a hospital. We believe the hospital community also endorses a more workable process. We recommend this proposed rule be withdrawn and additional consideration be given to either maintaining the status quo or adopting BCBSA's alternative approach to hospital notification processes.

BCBSA Recommendation:

BCBSA recommends CMS revise the current hospital notice process for original Medicare and MA beneficiaries and provide all beneficiaries with a more useful notice of Medicare appeal rights at the time of admission and standardize the notice delivery process for hospitals and MAOs. Specifically, we propose that, in lieu of the proposed notices in the rule under consideration or the current notices in use today (i.e. HINN and NODMAR), that a single "universal" form be developed containing detailed information on appeal rights for both original Medicare and MA beneficiaries. We recommend one single comprehensive standardized notice be delivered by hospitals to every beneficiary at the time of admission.

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

We believe our recommendation is workable and meets CMS' objective to notify beneficiaries of their rights as a hospital patient and also notify beneficiaries of additional processes available if a QIO review results in a denial of their continued hospital stay.

Specifically, BCBSA recommends the alternative two-step process described below:

Step One: For every Medicare beneficiary admitted to a hospital, all hospitals would provide a standardized notice "Important Message to Medicare Beneficiaries Admitted to a Hospital," a newly created document that is a more detailed notice than provided today at the time of admission. The new notice would contain, at a minimum:

- a statement of a beneficiary's right to appeal any discharge by noon of the day of the scheduled discharge;
- detailed information as to how to contact the QIO;

- timelines for a QIO response;
- information on coverage while the review is being conducted; and
- additional appeal/reconsideration processes available after discharge.

Step Two: A second standardized notice would be developed and subsequently provided to a beneficiary by the hospital after a QIO has been formally notified to initiate a review to:

- acknowledge the QIO review of the stay in question,
- provide information on required timelines for a QIO decision,
- provide information on coverage while the review is underway; and
- provide information on additional appeal processes available to a beneficiary if the QIO rules the pending discharge should proceed.

CMS recently published a new document entitled "Your Medicare Rights and Protections." We believe many sections of this publication could serve as the basis for a new publication that would be used in Step One of the hospital notification process. We encourage CMS to consider an abridged version of this publication to serve as a standardized notice given to all beneficiaries at the time of admission to a hospital. We would be happy to work with your offices on development of such a document.

We also believe that our recommendation would be in keeping with CMS' settlement agreement resulting from the Weichardt lawsuit [Weichardt v. Leavitt; No. C 03-05490 VRW (N.D. Cal.), filed December 5, 2003], in which CMS agreed to publish a proposed rule establishing a two-step discharge notice process in the hospital setting—a generic notice prior to discharge and a second notice after a beneficiary requests a QIO review.

BCBSA Concerns with the Proposed Rule:

BCBSA fully supports efforts to ensure beneficiaries understand their rights to appeal a hospital discharge. However, BCBSA believes the two-step process outlined in the proposed rule is unworkable for reasons outlined below. We support a two-step process. However, we believe that providing more information at the time of admission, rather than the day before discharge, allows for better understanding of available processes by the beneficiary. The day before discharge can be a busy time for a beneficiary and a notice on that day imposes unnecessary burdens on the patient for critical decision-making—not only for the patient, but often for family members as well. CMS also fails to acknowledge that many discharge decisions are made on the actual day of discharge. Providing two standardized notices to all Medicare patients would assure consistent approaches and information in every hospital, for every MA plan, and for every beneficiary admitted to a hospital, no matter what the length of stay or actual day of discharge.

Also, by removing the "day before discharge" time frame, this new approach would avoid unnecessary Medicare hospital days due to failure to provide notice on a specific day. Some stays are only one to two days in length. A notice process tied to "the day before discharge" imposes potential new liabilities on hospitals and MA plans. The notice process described in the proposed rule could create increased compliance risks for hospitals and MA plans and require

them to extend hospital stays longer than medically necessary to avoid liability for failing to provide notices within the required time frames. Unnecessary hospital days for Medicare and Medicare Advantage plans should not be tied to hospital notification processes. Also, patients should not be in a hospital setting longer than medically appropriate as this may increase the risk of infection and other poor outcomes.

Previous CMS Proposed Rule Withdrawn

On January 24, 2001, CMS proposed a similar rule (66 Fed. Reg. 7593) requiring hospitals to provide a notice of appeal rights and reasons for discharge to all Medicare patients in a hospital at least one day prior to the patient's discharge. The hospital community opposed this rule. After review of public comments, CMS determined a detailed notice was not necessary in every case and eliminated this proposed requirement for all beneficiaries to receive a detailed notice from a final rule published April 4, 2003 (68 Fed. Reg. 16651). In the preamble to that final rule, CMS acknowledged that new notice requirements in the proposed rule imposed an unreasonable administrative burden on hospitals.

CMS offers no new information to change this conclusion. Although we are aware of the Weichardt lawsuit, we believe BCBSA's recommendations are in keeping with the terms of settlement of that case.

We are also aware of the *Grijalva v. Shalala* class action suit [946 F. Supp. 747 (D. Ariz. 1996)] and the subsequent final CMS rule related to this case that implemented certain notices required only for Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs). That rule requires a two-step notice process for MA enrollees with an advance notice of a pending termination of coverage (68 Fed. Reg. 16652; April 4, 2003). It is our understanding that this notice process was set up because these specific levels of care frequently involved limited benefits. Medicare beneficiaries were often "surprised" or had no previous knowledge that their SNF stays or treatment plans involved limited coverage. Limited coverage issues rarely involve beneficiaries who have a hospital stay. With hospital care, the subject of an appeal or QIO review generally concerns the length of the beneficiary's stay in relation to its medical necessity, not a question of availability of benefits.

BCBSA believes that it is unnecessary to resurrect and expand CMS' previous attempt to require hospitals to provide all Medicare beneficiaries, at least one day before the scheduled date of discharge, a notice of appeal rights and the reasons for the discharge decision (66 Fed. Reg. 7593; January 24, 2001). At that time, and as noted in the "Background" section of this proposed rule, hospitals successfully advocated dropping this provision because imposing such a notice requirement on the day before discharge would have posed a significant administrative burden.

In this proposed rule, CMS states that previous concerns are mitigated since the proposed notice is a standardized generic form that would require minimal processing by the hospital. In regard to the second, "detailed" form to be delivered by hospitals or MAOs in the event a beneficiary appeals the discharge decision, CMS offers that use of the second form would not be frequent

enough to constitute a significant burden in implementation. We disagree with that conclusion. The proposed rule speaks to an annual volume of 12.5 million Medicare hospital stays, yet asserts this second detailed process might apply to only 2 percent of admissions. Whether or not these estimates are accurate, multiple hospitals and MAOs would have to be involved in an administratively cumbersome process for thousands of hospital cases.

We believe adoption of BCBSA's recommendation of a more detailed notice at the time of admission, coupled with a second notice of a QIO review, provides a beneficiary with the information they need as to their rights and assure adequate protection against an inappropriate hospital discharge.

It also should be noted that the proposed rule would require detailed notices even when the hospital discharge is followed by an admission to another level of care (e.g. hospice, SNFs, HHAs, etc). Discharge from a hospital does not always mean loss of Medicare coverage, but may mean a discharge from an acute setting to a more appropriate level of care to meet the patient's needs—including HHA, hospice, etc. Providing a notice about extending a hospital stay to a patient when a patient is to be transferred to a more appropriate level of care seems to be of questionable value, and could delay transfers where certain medical services might be in the best interest of the patient, e.g. intensive rehab services, hospice care, etc.

MAOs and Hospital Relationships in Medicare Advantage Today

The proposed rule mandates a MAO to deliver a detailed second notice to their member by the end of the day the QIO notified the MAO of a request for a review of a beneficiary's discharge. We understand that this detailed notice may also be delegated to a hospital by the MAO.

This provision is unworkable given the varied options in Medicare Advantage today. Some years back, most Medicare Advantage Plans were local HMOs with established provider networks and hospital arrangements. This is not the Medicare Advantage program today. Many Medicare beneficiaries are enrolled in Regional or local PPOs, as well as Private Fee-For-Service (PFFS) options, where patients select the physician or hospital of their choice and where the provider—such as a hospital—may have no relationship or contract with the beneficiary's MAO. PFFS plans are non-network options, and Regional PPOs and local PPOs provide out-of-network services. Many MAOs might not even know of a covered hospital stay until after discharge and a claim is presented to the MAO for payment. The MAO may have no contract with the hospital and may not have advance involvement in, or information regarding, the medical condition or care of the patient. MAOs may also not be in a position where they can even delegate the delivery of the notices to such hospitals through contract provisions as there is no contract between many MAOs and hospitals today in Medicare Advantage. The same will hold true with the introduction of MSAs in Medicare Advantage in 2007.

Therefore, if this rule were to be adopted, the challenge for MAOs to comply would be considerable, if not at times impossible, especially where the MAO had no active involvement in the beneficiary's hospital stay or has a contract with the hospital in question. This problem is magnified in cases where the hospital is located in an isolated community, and the MAO has no

working relationship with that hospital. At that time, only the applicable hospital and the attending physician would have readily available information on the patient's condition. Hospitals and QIOs would have to work with hundreds of MA organizations, and the interchanges and administrative systems would be challenging at best.

BCBS Plans also have concerns with HIPAA privacy considerations/compliance with faxes or other information-sharing methods required if the MAO must deliver a notice containing information that only an attending physician and hospital might have at the time the detailed notice has to be developed. This is of particular concern when the two entities involved in the information sharing have no pre-established relationship and the transactions involve the patient's personal health information. This HIPAA-protected information would have to "travel" over fax, phone, or by e-mail, perhaps over different time zones among many offices and then be transmitted back from the MAO to the hospital to the patient—all in a matter of hours. This is unworkable.

Unworkable Timeframes

The proposed rule requires an extremely short timeframe for MAOs to compile comprehensive information on the patient's medical condition and deliver the detailed notice ". . . by close of business the day of the QIO's notification of enrollee's request." [Proposed §422.622(c)(2)] Since the patient has to notify the QIO by noon of the day of the suggested discharge, this means the MAO could have less than five hours to collect and deliver to the patient detailed information on their discharge, assuming the QIO notified the MAO of the request immediately upon receipt. As discussed above, at that time perhaps only the hospital and the attending physician would have the detailed information needed to fulfill the requirements of the proposed rule. There would be substantial administrative interchanges needed to implement such a process in a limited number of hours. This proposed timeframe also does not take into consideration that the MAO might be hundreds of miles from the patient and the hospital in question, and the events might occur in different time zones which would then narrow (or expand) the hours needed to fulfill all transmissions, development of detailed notices, and delivery back to the specific patient or their representatives (who also might not be known to the MAO and is not on site as the hospital.).

Cost Contracts

A number of BCBS Plans have Medicare cost contracts. We raise concerns that the proposed rule does not address how provisions of this rule would apply to these Plans. Specifically, the proposed rule identifies the circumstances in which the MAO will be financially responsible for hospital care. For cost plans that have a CMS intermediary pay hospital claims, financial responsibility for hospital claims rests with the CMS intermediary, not the MAO. This issue and application of this rule to cost plans is not addressed.

Summary:

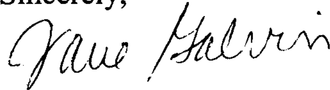
We respectfully request CMS withdraw this proposed rule at this time. We suggest CMS maintain the status quo as to hospital notification processes or adopt BCBSA's recommended alternative approach in a new proposed rule. We hope CMS will review our concerns and recommendations and allow BCBSA and other industry stakeholders to work together to develop a streamlined, as well as workable, hospital notice process related to discharges.

We believe BCBSA's recommended two-step notification process, coupled with revised notice documents, will achieve our commonly shared objective of educating beneficiaries on their rights and available appeal processes when admitted to a hospital.

Questions concerning these comments may be directed to my office at 202.626.8651 or by e-mail at Jane.Galvin@bcbsa.com.

Thank you.

Sincerely,



Jane Galvin
Director
Regulatory Affairs

JERSEY SHORE
HOSPITAL

May 26, 2006

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

To Whom It May Concern:

In response to the proposed rule published April 5, 2006 in the Federal Register Sections 405.1205, 405.1206, 422.620 and 422.622, I offer the comments below from the perspective of utilization/case management/discharge planning in a Critical Access Hospital (CAH).

As a CAH, we work under the average length of stay restriction of 96 hours for inpatients, so discharge planning is a very dynamic proactive process commencing, whenever possible, prior to or at admission. We are familiar with discharge notices as these are required 48 hours prior to discharges from our swing bed unit. Fulfilling this requirement has been found to be a challenge, and providing 24-hour notices for inpatient discharges appears to be totally unworkable in our situation with our mandated length of stay restriction.

For most of our patients in the acute status, it is difficult to predict when discharge will occur. In most cases, physicians are awaiting diagnostic study results in order to determine if the patient can be safely discharged. Also, the patients must be observed for an appropriate length of time to determine if diet is tolerated or if expected response to treatment is attained. Attempts could be made to anticipate these late day discharges, but providing notification based on anticipation alone would cause an unnecessary and burdensome workload on discharge planning staff, which is very limited in tiny hospitals such as our own. In a great many cases, notification of discharge would actually need to be delivered on the day of, or the day after, admission in order to be in compliance that, again, would be extremely difficult. The patient could receive the required Important Message from Medicare at the same time as the discharge notification, which provides essentially the same information.

Moving a patient along the continuum of care in an efficient manner is vital in a critical access facility. When a patient no longer meets acute care criteria, transition to the appropriate level of care is expedited. As we do have swing beds in our facility, many patients in need of skilled rehab services choose this option. An example of this would be a patient admitted for elective total knee surgery, usually a three-day stay in an acute bed followed by a short swing bed stay for rehab. This patient would receive the Important Message from Medicare on the day of admission. On the second post-op day, he would receive the notification of discharge letter. On the day of discharge from acute (post-op day #3), he would receive the SNF Hospital

Notification of Noncoverage letter. Forty-eight hours prior to discharge from the swing bed, we would need to give the patient the notification of discharge from skilled care letter. Each letter would require the patient's signature. So, for one episode of care, the patient would receive a minimum of four letters. Additional letters would be needed if the patient could not be discharged from each level of care as planned, or if the patient chose to appeal at any time to the QIO.

The ultimate result of attempting to stay in compliance with this requirement will be delays in hospital discharges and an increase in overall length of stay.

I hope that the above example will be cause for consideration of the effect of the proposed rule on small hospitals. New legislation combined with existing restrictions will make it impossible to remain in compliance while providing necessary health services to rural Medicare recipients.

Sincerely,

Sandra J. Bender, R.N.
Director, Utilization Case Management

Cc: Alberta Smith, Director, Corporate Risk
Betsy Crossley, Vice President, Nursing

EMORY HEALTHCARE
EMORY HOSPITALS

June 2, 2006

Emory University Hospital
1364 Clifton Road, NE
Atlanta, Georgia 30322
Phone 404-712-7021

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

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

To Whom It May Concern:

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

This proposal adds unnecessary procedures 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 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,

Mary Alice Merrill, LCSW/CCM
Director Social Services/Utilization Review
Emory Hospitals

DCH Regional Medical Center

809 University Boulevard East
Tuscaloosa, Alabama 35401
205.759.7111

75

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

June 1, 2006

To Whom It May Concern:

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

As a Director of Case Management I have been directly involved with discharge planning for inpatients for the past year. Our current discharge planning practices begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the Case Manager assesses the patient's current living situation and needed resources. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

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

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is approximately 5 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance.

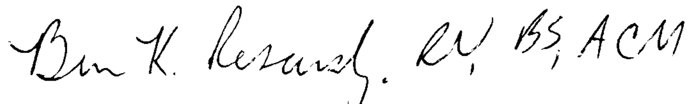
Many patients are discharged from the hospital in 1 – 2 days, very soon after the patient has received their medicare rights information during the admission process.

I have read that CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross

underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1 – 2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expect results, and indeed, the increased costs (administrative and LOS) do not justify the means.

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

Sincerely,



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

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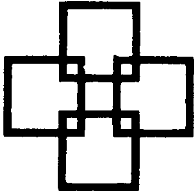


Kentucky Hospital Association

Representing Kentucky Health Care Organizations

May 30, 2006

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

Re: Proposed Revision; Medicare Program; Notification Procedures for Hospital Discharges – CMS-4105-P, *Federal Register*, Vol. 71, No. 65, April 5, 2006

Dear Dr. McClellan:

The Kentucky Hospital Association (KHA), on behalf of all hospitals in the Commonwealth of Kentucky, appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed revision to hospital discharge notice requirements. Similar changes were proposed for hospitals in January 2001 and rejected by CMS in 2003 due to considerable administrative burden. Kentucky's hospitals again have significant concerns with this proposal which are outlined in detail below. In short, we believe that this proposal would be extremely burdensome and costly for hospitals, and is unnecessary in light of standard discharge planning and physician discharge order patterns as well as existing notices hospitals already provide to beneficiaries. **If CMS has concerns with the hospital discharge planning process, then a task force of hospital discharge planners should be convened to discuss how those concerns can be addressed without imposing unreasonable additional workload and cost on hospitals. Therefore, KHA recommends that CMS postpone making these proposed regulatory changes until they consult with hospital discharge planners. Representatives of Kentucky hospitals would be happy to participate in such a task force.**

Hospitals already follow a two step process by providing all beneficiaries the Important Message from Medicare (IMM) at admission, and a detailed notice when there is any question raised about the appropriateness of a planned discharge. The proposed rule would add a third step by requiring hospitals to give <u>all</u> Medicare beneficiaries a standardized notice of non-covered services the day before discharge. This additional notice will create numerous problems and is not necessary.

2501 Nelson Miller Parkway
Post Office Box 436629
Louisville, Kentucky 40253-6629
502-426-6220
FAX 502-426-6226

- Physicians make the decision of when to discharge a patient. The discharge "decision" is the physician's discharge order. Physicians do not generally issue this order until the morning of the date of discharge after confirming that the patient's physical condition no longer requires acute care. Discharge orders are not made the day before because a discharge could be postponed due to the patient developing a fever or complication the night before the expected discharge. Physicians have a general idea how long a patient is expected to be hospitalized based on their diagnosis, but this is always subject to change based on each individual patient's condition and how fast they recover. CMS's proposal is unworkable because it would require physicians to be able to accurately assess each patient's date of discharge before they have reviewed any changes in the condition of the patient. If this rule is not deferred, then it should be changed to tie provision of the notice to the "projected or expected" date of discharge.

- If the hospital is forced to provide a notice the day before discharge but the physician's order is not written until the morning of the date that they determine the patient no longer needs hospitalization, CMS will in essence be mandating that hospitals provide an extra day of inpatient care to patients that no longer need it. This will result in significant additional costs.

- For the reasons outlined above, the proposal is also impractical and unworkable with regard to short stay patients – those admitted one day and discharged the next as well as weekend stays (patient admitted Friday and discharged Sunday). If the rule is not deferred, these patients should be exempted from receipt of the notice.

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

  The appeal process is labor intensive, time consuming, and confusing to beneficiaries. Without proper lengthy education, this additional notice will appear to most patients as a denial by the hospital. The proposed language of the notice itself (which was included in the paperwork clearance package) seems designed to create doubt in the mind of

beneficiaries that their planned discharge is appropriate. This could result in patient distrust of their physician and hospital and lead to more requests for detailed notices and appeals than are warranted.

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

In summary, Kentucky hospitals believe the requirement for an additional notice prior to discharge is unnecessary for patients and will be tremendously burdensome on providers. If the purpose of the notice is to notify the beneficiary of their appeal rights, it is not needed as appeal rights have already been communicated at admission. If the purpose is to ensure that beneficiaries have advance notice of their expected discharge for they and their families to be ready, that is already accomplished by the discharge planning process that is required by Medicare. Hospitals are very different than the other post acute care settings upon which this proposed notice requirements is based. During a patient's inpatient stay, they and their families are in constant face-to-face communication with their caregivers and discharge planning staff so that they know what to expect concerning their estimated discharge date and post acute care needs. Finally, if the purpose of the proposed notice is to notify beneficiaries about when they become financially liable if they stay beyond the point that they need acute inpatient care, then the notice should be reserved only for those limited occasions and when the hospital needs to establish that liability.

For the reasons we have outlined, Kentucky's hospitals recommend that **CMS postpone making these proposed regulatory changes and that a task force of hospital discharge planners be convened to address issues or concerns with the discharge planning process.**

Sincerely,

Nancy C. Galvagni
Senior Vice President

81

MN950-1000
P O Box 9472
Minneapolis MN 55440-9472

To: Submitted electronically to: www.cms.hhs.gov/eRulemaking.

From: Teena Ballard Keiser, Director of Regulatory Affairs

Date: June 5, 2006

Re: Proposed Rule Medicare Program; Notification Procedures for Hospital Discharge [CMS-4105-P]

We have reviewed the proposed rule on the Medicare Program; Notification Procedures for Hospital Discharges published in the Federal Register/Vol. 71, No. 65/Wednesday, April 5, 2006. These comments are provided on behalf of Ovations and other UnitedHealth Group affiliates that manage Medicare Advantage business (collectively "United"). Please note that, for the purposes of this letter, "United" includes the Ovations business units that manage the combined PacifiCare and Ovations legacy Medicare Advantage business.

We greatly appreciate the opportunity to comment, and we look forward to continuing to work with CMS to develop successful products and services for Medicare beneficiaries. If you have any questions or concerns on our comments, please contact me at 507/663-1844 or via email teena_keiser@uhc.com.

Proposed Rule Medicare Program; Notification Procedures for Hospital Discharge

Comments Submitted by
UnitedHealth Group/Ovations
June 5, 2006

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In addition, based on our experience, enrollees generally do not want to go to a SNF and prefer to stay in the acute setting. Enrollees who appeal will remain in the acute setting longer thereby taking up acute beds when it is not medically necessary for them to be in an acute bed. Should

enrollees who are scheduled to go to a SNF following their acute inpatient stay, decide to appeal to the QIO, there is the potential to lose their SNF bed while waiting on the QIO decision.

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

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

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

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

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

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

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

Rationale: Based on our experience in implementing the two-step notification process in SNFs, there have been different interpretations of regulatory requirements between MAOs, some SNFs and some QIOs. We are concerned that this will also occur under the proposed rules and will

result in additional administrative burden to MAOs, hospitals, physicians and QIOs in revisiting the requirements. The areas of CMS clarification and enforcement include in SNFs include:

1) Responsibility of SNFs to delivery the notice;

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

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

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

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

June 5, 2006

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

RE: CMS-4105-P

Dear Sir/Madame:

On behalf of Pennsylvania's 225 member hospitals and health care systems, The Hospital & Healthsystem Association of Pennsylvania (HAP) and the Delaware Valley Healthcare Council of HAP (DVHC) welcome this opportunity to comment on the proposed rule in **"Medicare Program; Notification Procedures for Hospital Discharges,"** as published in the April 5, 2006, *Federal Register.*

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

BACKGROUND

In response to a final rule promulgated under the Benefits, Improvements, and Protection Act (BIPA) for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospices, HAP submitted a comment letter that outlined the burden and operational requirements associated with home health agencies providing advance written notice to Medicare Advantage enrollees and Medicare beneficiaries and detailed notices to Medicare beneficiaries when an expedited review is filed with the state's QIO. It is evident in both this rule and those already promulgated for other service settings that there is a fundamental lack of understanding on how care is delivered in these settings.

HAP's recommendation to CMS in our previous comment letter was that CMS consider implementing the same provisions currently used in hospitals in these other settings—namely to provide a notice at the time of admission for services similar to the "Important Message from Medicare" and to provide information regarding the right for an expedited review/determination to those Medicare beneficiaries who disagree with discharge from or termination of health care services.

PROVISIONS OF THE PROPOSED RULE

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

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

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

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

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

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

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

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

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

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

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

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

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

HAP and DVHC appreciate the interest that CMS has in receiving comments on this proposed rule and believe that CMS has a legitimate interest in ensuring that Medicare beneficiaries have access to an expedited determination review process when they disagree with hospital discharge, termination of hospital services, or when a Medicare Advantage plan determines that the plan will not cover the hospital stay. However, the rule as proposed would create operational problems for hospitals and result in increased lengths of stay that will negatively impact others' access to patient care. Additionally, CMS has not carefully

considered the financial implications of what it is proposing on hospitals or the potentially confusing aspects of mingling decisions made by Medicare Advantage plans about hospital non-coverage versus hospital decisions to discharge the patient in this rule.

HAP and DVHC recommend that the current process should be retained with consideration given to modifying the current "Important Message from Medicare" to make it much more explicit about procedures available to patients who disagree with planned discharge from the hospital or a decision made by a Medicare Advantage plan for hospital non-coverage. HAP and DVHC strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Should you have any questions regarding the comments submitted by HAP or DVHC, please feel free to contact Lynn Leighton, Vice President, Professional and Clinical Services, HAP at (717) 561-5308 or by email at lgleighton@haponline.org or Pam Clarke, Vice President of Managed Care, DVHC at (215) 575-3755 or pclarke@dvhc.org.

Sincerely,

PAULA A. BUSSARD
Senior Vice President, Policy and Regulatory Services

Dr. Aiyenowo
73

P.O. Box 308 • Newton, Kansas 67114-0308 • 316-283-2700

May 3, 2006

To Newton Medical Center Physicians-

Recently staff at NMC were made aware of a proposed rule from CMS (Medicare) that would require a one day notice to each Medicare inpatient that they were being discharged the next day and that their Medicare benefits as an inpatient were being stopped. The notice allows for expedited appeals for the patient to call KFMC (Kansas Foundation for Medical Care) and voice concerns that the discharge was occurring and that the patient felt they should continue to be hospitalized. The hospital then must respond in less than 24 hr with a copy of the chart and also then give the patient a detailed notice of why the services are being discontinued and they are being discharged. If KFMC agrees the discharge occurs but if not then we will be required to keep the patient longer. This is to occur 7 days a week.

CMS states this should only take the hospital 5 minutes per patient to issue the original notice but it must be signed and if the patient can't sign then we must obtain the signature of the DPOA and if the DPOA can't be reached we must send the notice by certified mail to the DPOA. As you well know the majority of our patients are Medicare and not only does it involve hospital staff but you as physicians as well. In order for the hospital to give these notices in a timely fashion, we will need your help in knowing when the patient is to be discharged. This will also apply to surgical patients that you only anticipate staying one night, we must then give the notice on admission.

Currently this is a proposed rule and it is in the comment period, so I am asking each of you to sign the attached letter, place it in the attached addressed envelope, which will need postage and mail it. Maybe if they get flooded with comments CMS will rethink things again.

Thank you for your help in this matter, and if you have questions please let me know. The comment letter is written in the format required for submission and just have all of the sections identified that are commented on.

Sincerely,

Ellen Patry RN

Ellen Patry RN
Director of Case Management
Newton Medical Center
Extension 1701

84

AMERICAN CASE MANAGEMENT ASSOCIATION

May 31, 2006

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Musotto:

Enclosed is the response to CMS-4105-P from the American Case Management Association. I have included a copy of the cover letter sent to the Centers for Medicare & Medicaid Services and the Collection of Information portion of the response.

If any further information is needed, please do not hesitate to contact me.

Cordially,

Jennifer L. Knight
Administrative Assistant
ACMA
Phone: (501) 907-2262
Fax: (501) 227-4247

Creating Collaborative Solutions

10310 West Markham, Ste 209 ◆ Little Rock, AR 72205 ◆ Phone (501) 907-2262 ◆ Fax (501) 227-4247
www.acmaweb.org ◆ theacma@acmaweb.org

To: The Centers for Medicare and Medicaid

From: Donna Ukanowicz, RN, MS, ACM, President

L. Greg Cunningham, MHA, CEO

Jackie Birmingham, RN, BSN, MS, CMAC, Chair of Legislative Advocacy Committee

American Case Management Association

10310 West Markham, Suite 209

Little Rock, Arkansas 72205

501-907-ACMA (2262) • Fax: 501-227-4247

Date: May 30 , 2006

Regarding: Medicare Program; Notification Procedures for Hospital Discharges

Via electronic comment: http://www.cms.hhs.gov/eRulemaking. Re: File code CMS-4105-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services 42 CFR Parts 405, 412, 422, and 489

[CMS-4105-P] RIN 0938-AN85 [Federal Register: April 5, 2006 (Volume 71, Number 65)]

[Proposed Rules] [Pages 17052-17062]

The American Case Management Association (ACMA) is a professional organization representing nurses, social workers, physicians and other health care professionals uniquely involved with the patient's continuum of care, assessing patient's needs, facilitating a smooth transition from one level of care to another, and coordinating the patient's discharge.

Our members represent health professionals who work in hospitals and health care systems providing services including case management, utilization review and discharge planning. As the premier organization for hospital and health care system case management we are in a unique position to address issues related to patient discharge.

ACMA <u>supports</u> this very important effort to assure that a Medicare Beneficiary is informed of his/her 'discharge status', that he or she is no longer requiring a hospital level of care, and of the right to appeal discharge decisions. A Beneficiary's rights to timely notice of discharge and potential financial liability is important to them, to physicians, health professionals who work across the continuum, and to hospitals whose mission is to provide acute level of care.

The Board of Directors of ACMA have reviewed this proposed rule referred to above and are prepared to make the following recommendations.

<u>Recommendations</u>:

1. The Board strongly recommends that this proposed <u>rule not be adopted</u> in it's current format, i.e., requiring the delivery of a 'generic discharge notice' 24 hours before discharge of any and all Medicare Beneficiaries. <u>Examples of reasons from the accompanying table:</u>
    a. This requirement will increase Length of Stay in hospitals already experiencing capacity crises.
    b. Discharge is a natural event following admission and should be treated as such, and not as a potentially unexpected or risky event.
    c. The time required is under-estimated and will take away from other more important duties.
    d. It has the potential to induce more appeals.
    e. It has the potential to have a negative influence on patient/family satisfaction should the notice be given and discharge delayed for medical reasons.
    f. Physicians' responsibility about the determination of the appropriate time for discharge will be compromised.
    g. Post-acute providers such as SNFs, Home Health Agencies, transportation companies, DEMPOS, Hospices will be affected in that there may be an 'administrative delay' in discharge.
    h. Quality Improvement Organizations will be required to increase staff levels hours of operation (7 days a week) to address increased appeals.
    i. Utilization Review Committees will be spending more time on this administrative task, taking away from their functions of assuring quality and appropriate care.

j. Case Management nurses and social workers will be taken from the function of assuring that an appropriate and timely plan of care is completed at the time the patient is cleared for discharge.

2. The ACMA Board of Directors and members strongly recommend that the following actions be taken: [Examples taken from the accompanying table.]
    a. The monitoring of compliance to existing regulations regarding Discharge Planning, Patients' Rights, Utilization Review, and others as listed in the accompanying table, should be undertaken by CMS.
        i. JCAHO standards include continuity of care and patient's rights. The Interpretive Guidelines are used to review hospital compliance and these more than adequately address notice of discharge.
    b. The 'Important Message for Medicare Patients' given at the time of admission should be modified to include the following statement: "Your physician and hospital staff will work with you throughout your hospital stay to set up an appropriate discharge plan. Since the discharge plan will be based on what your needs will be after the hospital stay, and the timing of your discharge will be determined by your physician, please be aware that you may be discharged at any point in time when you are medically stable."
    c. Develop educational tools for all staff involved on the myriad rules governing discharge and the impact on quality patient care. The Medlearn Matters program should be involved in teaching and informing health professionals about the 'discharge process' for Medicare Beneficiaries.
3. The ACMA Board of Directors wishes to extend an offer to CMS to be part of a task force in discussing how to best resolve the issue of notifying Medicare Beneficiaries of their discharge status and the health systems commitment to make this a safe and high quality phase in the health care delivery.

We look forward to being involved in this very important endeavor.

Please note: On the next pages you will find a Word document (in landscape set-up) that addresses the content of the proposed rule in Table format so that the above comments and recommendations can be easily referenced. In column one is the heading based on the Federal Register document,

column two contains excerpts from the notice and related 'ACMA comments." Column three contains discussion solicited from the Board of Directors and Membership of ACMA with explanations, questions and specific areas of concern expressed by the members.

We will be submitting the section of the Table on pages 11-12 to Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, and the Office of Information and Regulatory Affairs, Office of Management and Budget as directed in the Notice. These pages are included here for your review.

References used in preparation of the comments and recommendations:

1. Social Security Act § 1861 (ee), Discharge Planning
   http://www.ssa.gov/OP_Home/ssact/title18/1861.htm

2. State Operations Manual- Interpretive Guidelines [Discharge Planning- pages 238-250], [Utilization Review- pages 212-220]
   http://new.cms.hhs.gov/manuals/downloads/som107ap_a_hospitals.pdf

3. Conditions of Participation for Discharge Planning [Title 42, Volume 3]
   http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/42cfr482.43.htm

4. Medicare Claims Processing Manual: Chapter 30 - Financial Liability Protections: (Rev. 594, 06-24-05) [HINN}
   http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf

5. Conditions of Participation for Patients' Rights [Sec. 482.13
   http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/42cfr482.13.htm

6. InterQual® Clinical Decision Support Criteria
   http://www.interqual.com/IQSite/about/history.aspx

7. AMA Report 4 of the Council on Scientific Affairs (A-96) Evidence-based Principles of Discharge and Discharge Criteria
   http://www.ama-assn.org/ama/pub/category/13663.html

8. Joint Commission on Accreditation of Healthcare Organization: Patient Safety Standards: G
   http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/06_npsg_cah.htm

Collection of Information <u>mail</u> copies to:

Centers for Medicare & Medicaid Services,
Office of Strategic Operations and Regulatory Affairs, Regulations Development Group,
Attn: Melissa Musotto, CMS-4105-P, Room C4-26-05, 7500 Security Boulevard,
Baltimore, MD 21244-1850;
<u>and</u>
Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503,
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

III. Collection of Information Requirements	<u>Excerpt from Notice</u> • The accuracy of our estimate of the information collection burden. • The quality, utility, and clarity of the information to be collected. • Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.	A recommendation to minimize the information collection is to not add an additional burden of a 'standardized, generic' notice to all beneficiaries who are being discharged from acute level of care. The beneficiaries are already getting so many papers at time of admission and discharge that they are overwhelmed. These papers will more than likely not even be looked at unless they are questioning their discharge. This will create a burden of someone having to print and follow up with the patient, when they already have so many people giving them information.
Section 405.1205 Notifying Beneficiaries of Discharge From Inpatient Hospital Level of Care	<u>Excerpt from Notice</u> For <u>any</u> discharge from the inpatient hospital level of care, the hospital must notify the beneficiary in writing of the impending non-coverage <u>and</u> discharge.	Mixing impending non-coverage AND discharge is confusing. The HINN process deals with 'impending non-coverage'. The proposed requirement and hospital manpower involved places a tremendous burden on hospitals, not only in terms of time and manpower, but also in potentially adding a minimum of one additional day to the length of stay. This potential back logs of patients in emergency rooms and recovery areas in hospitals operating at or near capacity can only have a detrimental effect on patient care.
Section 405.1206 Expedited Determination Procedures for Inpatient Hospital Level of Care	<u>Excerpt from Notice</u> Section 405.1206(b) requires any beneficiary wishing to exercise the right to an expedited determination to submit a request, in writing or by telephone, to the QIO that has an agreement with the hospital	The current availability of an appeal process fills this specific requirement/right of patients and is covered in the "Important Message from Medicare" that is given to Medicare beneficiaries at the time of admission.
Section 422.620 Notifying Enrollees of	<u>Excerpt from Notice</u> For any discharge from an	A notice to all patients of 'impending non-coverage' AND 'discharge' will cause confusion for Medicare beneficiaries. The term 'impending non-coverage' is

Discharge From Inpatient Hospital Level of Care	inpatient hospital, the hospital must notify the enrollee in writing of the impending non-coverage and discharge. ACMA Comment: We believe that it would be more beneficial to the patient/family to give the patient/family a notice **upon admission** directing them to prepare for discharge at any time as decisions for discharge are based on stabilization of medical condition(s) and are constantly being re-evaluated and could occur at any time."	intended to be used by the hospital for patients when a patient's MD/DO determines that he/she no longer requires hospital level of care. The existing requirements in the COP for Discharge Planning more than adequately address the issue of notification of 'discharge'. The Utilization Review and HINN requirements adequately address the issue of 'impending non-coverage. The Patient's Rights regulations adequately address the issue of involvement in planning for care after discharge. This notice is not necessary. Compliance with existing rules adequately address this issue.
Section 422.622 Requesting Immediate QIO Review of Decision To Discharge From Inpatient Hospital Level of Care	Excerpt from Notice This section states that an enrollee who wishes to appeal a determination by an MA organization or hospital that inpatient care is no longer necessary, may request QIO review of the determination.	This function is already being carried out.

85

June 5, 2006

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

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

Dear Dr. McClellan:

Duke Health Raleigh Hospital appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.
Duke Health Raleigh Hospital believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. Also, there has been no compelling case for the need to implement this change. Therefore, Duke Health Raleigh Hospital does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process.

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

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

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

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

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

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

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

There are several problems with the proposed approach.

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

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

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

- By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences. The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost 13 million hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would impose a significant burden on hospitals. And for many patients, they would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

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

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

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

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

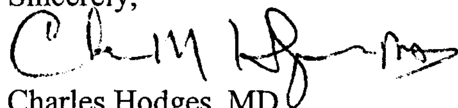
- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons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

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

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

Duke Health Raleigh Hospital appreciates the opportunity to comment on this proposed rule. To discuss any questions or reactions to our comments, please contact our Director of Case Management, Pat Kramer, at 919-954-3274 or via e-mail at patricia.kramer@duke.edu.

Sincerely,



Charles Hodges, MD
Medical Director
Inpatient Medical Service
Duke Health Raleigh Hospital

cc: Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

86

St.Mary'sGoodSamaritan
Incorporated

Cosponsored by Felician Services, Inc. and SSM Health Care

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

June 2, 2006

To Whom It May Concern:

I am writing to oppose the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am a Vice President at St. Mary's Good Samaritan, Inc., a two hospital network located in Southern Illinois that is a part of SSM Health Care and Felician Services Inc.

As the administrator responsible for Case Management and Social Services, I have been directly involved with and provided oversight for discharge planning for the past nearly 10 years in my current position. Our current discharge planning practices begin at the time of admission when patients are provided the Important Notice from Medicare during patient registration. Next, the admission nurse screens the patient's current living situation and needed resources. In addition, a RN Case Manager or Social Worker interviews all patients. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services – in fact we even make available a printed list of all resources offered in the patient's home county. Our process already includes opportunity for patients to change their minds or disagree with the discharge process. It is our policy to NEVER discharge a patient to a location, service or provider for which they are not in agreement. We also provide information to patients about how to contact the Illinois Department of Public Health, JCAHO and the QIO should they have any concerns about their care, which includes discharge.

The CMS proposed change places an administrative burden on the hospital and an emotional burden on patients that greatly outweighs the benefit!

CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. It seems to me to be of greater value to require each facility to develop a process for communicating, and documenting in the medical record if necessary, an anticipated discharge date so that families can prepare themselves adequately. However, as proposed, if a signature is required AND the patient is NOT the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. If this concept remains in the rule, my recommendation is to allow telephonic notification of the decision maker when the decision maker is not the patient.

605 North 12th Street
Mt. Vernon, IL 62864
618.242.4600

www.smgsi.com

In addition, a "days notice" also poses an unnecessary financial burden on the hospital. In our hospitals, the average LOS is 4 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance and patients/families are most often, eager to go home. Again, my recommendation is to have facilities develop a process for communicating anticipated discharge dates to the patient and family and that this not be a written notice.

I have read that CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. However, I have a few concerns with this. First, I believe that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay and not be any more responsible for the cost. Second, Hospital Issued Notices of Non-Coverage are always an emotionally upsetting event for patients and their families.

I appreciate the role of CMS in safeguarding patient rights. We believe we must protect patients rights while also stewarding government resources and ensuring patients do not take advantage of an opportunity to unnecessarily extend a length of stay adding significant costs to Medicare and the hospital. It is in neither Medicare's nor our best interest as hospitals to allow inappropriate utilization of scare healthcare resources.

Sincerely,

Michelle Darnell
Vice President – Systems Improvement

cc: Joby Glenn, Director of Case Management
Keith Suedmeyer, Director of Social Services

87

Northeast Hospital Corporation

June 5, 2006

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

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

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,800 member hospitals and health care systems, and 35,000 individual members, appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

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

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

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

- The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.
- The hardcopy signature and recordkeeping requirements are counter to hospitals' movement to electronic medical records and federal efforts that encourage an even faster conversion.

Background

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

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

Provisions of the Proposed Rule

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

There are several problems with the proposed approach.

- *Physicians, not hospitals, make discharge decisions.* The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a

physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation and, for most hospitals, by the Joint Commission on Accreditation of Healthcare Organizations standards. In both cases, those standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate care in the appropriate setting. **But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.**

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

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

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

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

Collection of Information and Recordkeeping Requirements

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

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

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

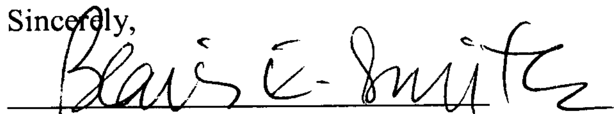
- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons why services are no longer

reasonable or no longer covered by Medicare, and specifically cite the relevant Medicare rule or policy that applies to the beneficiary's case. **Direct input from the physician, a resident, or a hospitalist would be required to complete this notice, but they likely would not be able to cite specific applicable Medicare coverage policies; hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria.**

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

We believe this price is too high just to ensure consistency with requirements designed for very different operating environments. If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice. If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. Even patients and families that are fully competent are often nervous, apprehensive and overwhelmed at the time of discharge. **The time, coordination and emotional burden to patients to stop at this critical transition in their care, and begin to comprehend and learn the scope and complexities of the Medicare system is more detrimental than helpful.** More paperwork does nothing to improve care – it simply consumes resources that would be better devoted to direct patient care. **The AHA recommends that the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.**

Sincerely,



Blair E. Smith, LICSW
Director of Social Work Services
Beverly Hospital
85 Herrick Street, Beverly, Massachusetts 01915 *ph:*978-322-3000

88

80 Jesse Hill Jr. Drive S.E., Atlanta, Georgia 30303-3050

May 25, 2006

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

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

To Whom It May Concern:

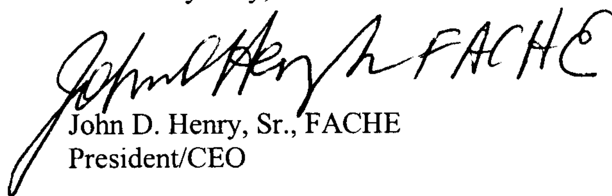
Pursuant to Federal guidelines pertaining to open public comment periods, I am writing this letter in opposition to the proposed ruling – *Notification Procedures for Hospital Discharges (CMS-4105-P).*

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.

Yours very truly,



John D. Henry, Sr., FACHE
President/CEO

85

Beaumont®
William Beaumont Hospital
Royal Oak

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

May 31, 2006

To Whom It May Concern:

We are writing in response to the proposed rule CMS-4105-P, Medicare Program Notification Procedures for Hospital Discharges at William Beaumont Hospital in Royal Oak, Michigan. Our hospital is a 1067 bed teaching-community hospital.

Our current discharge planning practice begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, case managers interview all patients meeting the hospital's screening criteria: patients over age 70, medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO. We would also encourage Medicare to consider that the HINN process provides an avenue for appeal and limits their liability for 72 hours as the patient, family, and physician consider alternatives to the established staff discharge plan.

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

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 5.2 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. Many of our physicians are private attendings, and they round at varied times throughout the day.

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

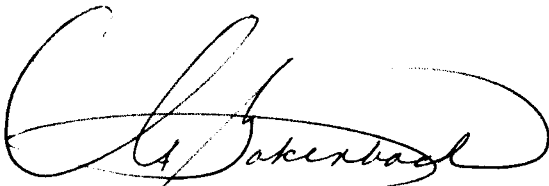
3601 West Thirteen Mile Road Royal Oak, Michigan 48073-6769
248-898-5000

patients in the hospital longer than necessary if the 24 hour rule prior to discharge needs thoughtful consideration, as prolonged hospitalization has been found detrimental to patient safety.

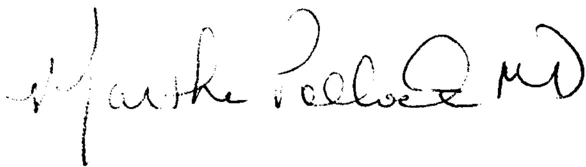
We appreciate the role of CMS in safeguarding patient rights. We believe we must protect patient's rights while also stewarding government resources. We believe this proposed rule will not benefit our patient in any way and will unnecessarily extend length of stay adding significant costs to Medicare.

Sincerely,

Patricia Thomas
Director, Care Management
William Beaumont Hospital-Royal Oak



Valentina Gokenbach
Vice President, Chief Nurse Executive
William Beaumont Hospital-Royal Oak



Martha Pollock, MD
Medical Director, Chairman of UM Committee
William Beaumont Hospital-Royal Oak

90

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

June 1, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am a Director of Case Management at Oconee Memorial Hospital, a 160, community Hospital located in Seneca, SC.

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

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

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4.8 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM

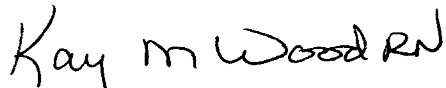
that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

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

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

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

Sincerely,



Kay M. Wood, RN
Director of Case Management

91

June 5, 2006

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

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

Dear Dr. McClellan:

Please accept these comments from the Connecticut Hospital Association (CHA) on behalf of its thirty not-for-profit acute care hospital members regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule: Medicare Program; Notification Procedures for Hospital Discharges (CMS – 4105 – P). The proposed rule concerns a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission that already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

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

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

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

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

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

Background

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

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

Provisions of the Proposed Rule

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

There are several problems with the proposed approach.

- *Physicians, not hospitals, make discharge decisions.* The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation, the Joint Commission on Accreditation of Healthcare Organizations standards and Connecticut state law.

These standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.

- *It is virtually impossible to know with certainty the discharge date a day in advance.* Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. That determination is based on test results and clinical indicators, such as whether a patient is free of fever. Patients generally know their expected day of discharge (often from before admission in the case of elective admissions), which is then adjusted as necessary to reflect their condition during the discharge planning process. There may be an expected discharge date of Thursday for example, but if the patient develops a fever the evening before, the discharge date will be postponed until that fever is gone. There are fundamental differences between the discharge process in hospitals as compared with the process used by home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices that make the proposed rule inappropriate for hospital settings.

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

  To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. This would impose a significant financial burden on hospitals, and many patients would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could exacerbate patient backlog in the Emergency Department (ED) and contribute to increased ED diversions because of the number of patients who would be kept in the ED waiting for an open inpatient bed.

Based on these facts, CHA recommends that CMS withdraw the proposal and retain the current requirements. If there are specific issues with the discharge planning process that

need to be addressed, we recommend that CMS convene a national workgroup comprised of hospital, physician, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures affect the various parties, and ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights.

Collection of Information and Record Keeping Requirements

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

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

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

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

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

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

Sincerely,

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

PJM:mb
By E-mail

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

92

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

2006 JUN -5 PM 4: 38

June 5, 2006

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

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

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,800 member hospitals and health care systems, and 35,000 individual members, appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

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

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

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

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

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

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

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

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

There are several problems with the proposed approach.

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

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

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

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

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

Collection of Information and Recordkeeping Requirements

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

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

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

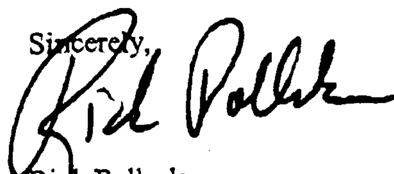
- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons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

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

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

The AHA appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me or Ellen Pryga, director of policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,



Rick Pollack
Executive Vice President

cc: Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

93

John M. Sernulka
President and CEO

June 5, 2006

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

Dear Doctor McClellan:

Thank you for the opportunity to comment on the proposed rule entitled CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am extremely concerned about the impact such a notification procedure will have on patients awaiting admission to our hospital center from our very busy Emergency Department.

By far, the majority of all inpatient admissions to our hospital occur via the ED. The proposed notification procedure has the very real potential of extending inpatient lengths of stay (LOS), thereby increasing the ED backup dilemma we are already struggling to reverse. As you know, this is a situation affecting hospital Emergency Departments nationwide.

Also perplexing is the resultant increases to the cost of healthcare overall from this extended LOS. Here in our semi-rural Maryland community, the cost of healthcare is a very real concern for our patients, physicians, and staff. We believe that proactive information and coordination, at the front end of the service continuum, is most effective and beneficial in assuring patient rights and insuring efficient care delivery. We support the suggestions outlined in the draft letter prepared by the American Hospital Association (enclosed) and respectfully request your reconsideration of the proposed notification procedure.

Sincerely,

John M. Sernulka
President and CEO

Enclosure

cc Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

200 Memorial Avenue
Westminster, MD 21157

410.871.6902
Fax: 410.871.7474

www.CarrollHospitalCenter.org

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

Pegeen A. Townsend
Sr. Vice President, Legislative Policy
Maryland Hospital Association
6820 Deerpath Road
Elkridge, Maryland 21075

ST. JOHN MACOMB HOSPITAL

St. John Macomb Hospital
11800 E. 12 Mile Rd
Warren, MI 48093

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

June 1, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am the Director of Care Management at St. John Macomb Hospital, a 376- bed Community Hospital, part of the St. John Health Care System located in Southeast Michigan.

As the Director of Care Management I have been directly involved with discharge planning for our patient population for the past 15 years. Our current discharge planning practices begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, case managers interview all patients meeting the hospital's screening criteria: patients over age 70, Medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

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

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 5 days. Since lengths of stay are short and patient's

conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

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

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

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

Sincerely,

Mary Beth Pace, RN BSN MBA
Director, Care Management
(586) 573-5982

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

June 1, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4104-P, Medicare Program; Notification Procedures for Hospital Discharges. I am manager of the Case Management Department at a small non-profit community hospital located in Connellsville, Pennsylvania.

As a Case Manager I have been directly involved with discharge planning for the past twenty years. Our current discharge planning practices begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the social workers assess the patient's current living situation and needed resources. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patient to change their minds, or disagree with the discharge process and request appeals to the QIO.

The CMS proposed change places an administrative burden on the hospital that greatly outweighs the benefit. CMS estimates it will take 5 minutes to deliver the generic notice and have it signed. If a signature is required and the patient is not the decision maker, it can take an additional day to obtain the signature of the patient's decision maker. CMS also did not take into consideration that many hospital Case Management departments are not staffed seven days a week and on off shifts. The provision of the advance notice will then fall to nurses. Adding more paperwork to nurses will create job dissatisfaction among nurses at a time when hospitals are working to decrease paperwork by nurses so that they can spend more time in direct patient care. Given the national workforce shortage for nurses, we should be looking at ways to decrease the administrative burden on nurses and not increase it. Even the most diligent nurse may end up failing to give an advance notice to the patient because of the multitude of other tasks and patients for whom they provide care.

401 East Murphy Avenue • Connellsville, PA 15425-2700 • Phone: 724.628.1500 Fax: 724.626.2334

As previously stated above, the length of stay for many Medicare patients could be extended by at least one day in order to comply with the requirement to provide advance written notice 24-hours before discharge. This will create further financial strain on hospitals. For a majority of patients receiving hospital care, it is difficult to predict with certainty whether patients will be cleared for discharge until the actual day of discharge. This is particularly true for complex medical and surgical patients. There are many parameters that have to be met to warrant hospital discharge, including acceptable lab values, the ability to tolerate meals without nausea and vomiting, mobility, acceptable radiology studies, normal temperature, etc. Physicians and hospital staff often cannot know precisely when those parameters will be met to warrant discharge. When the physician determines that a patient is clinically stable and safe for discharge, the right thing to do is to discharge the patient in a timely manner, and not wait for a "defined" 24-hour notice before discharge. In our hospital the average length of stay is 4 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance.

This rule will also impact other areas of the health care delivery system as a whole and will complicate other critical issues including patient flow, hospital capacity, emergency department crowding and emergency department diversions.

CMS should also consider the costs to hospitals for additional staffing, training nursing staff, physicians and other health care professionals. The detailed explanation must describe any applicable Medicare coverage rule, instruction or Medicare policy, including citations to the applicable Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy. Further, the detailed notice must contain facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case. This would be extremely time consuming and require additional staff. For evening and weekend discharges, nursing staff would be responsible to provide this information to beneficiaries, which would not be feasible. Their responsibility is to provide patient care.

I have read that CMS estimates only 1-2% of beneficiaries will request an expedited appeal. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay by at least another day until a review can be completed. I believe the number of patients requesting an expedited review will be well beyond the 1-2 %. Many of our patients are elderly and live alone who prefer to stay in the hospital rather than be at home. Patients continue to receive health care services while their case is under review and are at no personal financial risk while the review is taking place regardless of the decision. This again imposes more financial burden on the hospital providing staff to assist with the expedited appeal and also extending length of stay.

I understand that the Hospital Association of Pennsylvania has recommended that the current process should be retained with consideration given to modifying the current "Important Message from Medicare" to make it much more explicit about procedures

available to patients who disagree with planned discharge from the hospital or a decision made by a Medicare Advantage plan for hospital non-coverage. I agree with their recommendation.

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

Sincerely,

Marcia Whittaker, R.N.

96-0 (17)

NORTHSIDE HOSPITAL-CHEROKEE

on the R.T. Jones Medical Campus

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

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

To Whom It May Concern:

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

This proposal adds unnecessary procedures 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,

[signature]

201 HOSPITAL ROAD, CANTON, GEORGIA 30114
P.O. BOX 906, CANTON, GEORGIA 30169
770-720-5100
Accreditation by the Joint Commission on Accreditation of Healthcare Organizations

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(2)

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Saint Joseph Medical Center

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333 North Madison Street • Joliet, Illinois 60435
(815) 725-7133 • www.provenasaintjoe.com

June 5, 2006

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

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

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

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

Summary of Comments

I am writing on behalf of Provena Saint Joseph Medical Center, Joliet, Illinois. We appreciate the opportunity to provide comments on the above referenced notice of proposed rulemaking, which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process similar to what is currently in place for other Part A providers.

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

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

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

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

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

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

Background

Current Process

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

Comments

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

Individual patient discharge decisions are made by the attending physician responsible for the patient's care. The hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharged timely, collaborates with the physician to expedite the discharge process. Occasionally, the physician is reluctant to discharge a patient, or the beneficiary or the beneficiary's family is reluctant to make a decision regarding post-acute care. Beneficiaries and their families have an inherent financial interest in delaying post-discharge decisions since their out-of-pocket costs are generally greater in a nonacute setting. The HINN is an effective vehicle for prompting action by both the physician and the patient's family.

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

CMS Proposal

CMS proposes to establish a "two-step" discharge notice similar to the process in effect for SNFs, HHAs, CORFs, and hospices because this process is "helpful to beneficiaries" and is not "overly burdensome to providers or Medicare Advantage organizations" (17053). CMS argues that beneficiaries in an inpatient hospital setting should have the "same notice of appeals rights to which other beneficiaries are entitled," and explains that the proposal "would provide a more consistent approach to communicating appeal rights" to all Medicare beneficiaries in all settings. (17053) CMS reiterates that the proposed rule "is intended only to provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings." (17054)

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

Comments

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

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

The proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations. The generic notice erroneously indicates that the hospital determines that Medicare will not pay for the hospital stay after the discharge date on the form. The detailed notice also indicates that the hospital has determined that Medicare coverage for the hospitalization "should end." This type of language does not accurately recognize the role of the physician, and it creates an unwarranted barrier in the hospital/patient relationship. Discharge decisions are made by

physicians, not hospitals. The physician may document an anticipated discharge or write a discharge plan, but generally does not make a discharge decision until the day of discharge. The discharge order entered into the patient's record at that time is the discharge decision. The physician may give discharge approval pending certain clinical criteria being met, e.g. test results being negative or within specified limits, or absence of a fever.

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

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

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

The proposed generic discharge notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources and jeopardizing the ability of hospitals to meet the acute care needs of other patients. The language of the generic discharge notice, particularly the repeated references to "an immediate review," will raise doubt in the beneficiary's mind with respect to whether the discharge is appropriate. It basically invites beneficiaries to appeal. Hospitals find that families of some Medicare beneficiaries will take advantage of every opportunity to appeal a discharge decision, especially when there is no financial penalty to do so. Most if not all of the one to six annual HINNs issued by MCHC member hospitals were appealed. It is our belief that the vast majority of the proposed generic notices will be appealed. The reality is that many Medicare patients do not want to leave the hospital, not because they are not medically ready to be discharged, but because the acute hospital setting offers a more emotionally secure and comfortable environment than they will find at home or in a post-acute healthcare setting. Other beneficiaries resist discharge because a bed has not become available in a non-acute setting of their choice (although beds are available elsewhere).

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

While patients may have nothing to lose financially by appealing a discharge decision, hospitals stand to incur significant additional administrative and patient care expenses should the proposed discharge notice procedures be finalized. It is Provena Saint Joseph Medical Center's belief that providing a patient-specific discharge notice to every Medicare

beneficiary will lead to unnecessary and longer hospital stays while discharge decisions are being appealed. This will create significant throughput issues for the hospital, which do not have unlimited capacity, longer Medicare stays, combined with current high occupancy rates, will threaten the hospitals' ability to treat other patients who need acute care who are waiting for available beds. We envision back-ups in hospital emergency departments, and the possibility of some hospital EDs being on by-pass, and thus being unable to readily meet the healthcare needs of their communities, including non-Medicare patients.

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

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

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

Collection of Information and Recordkeeping Requirements

CMS Estimates

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

Comments

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

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

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

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

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

  Unlike the current HINN, which makes a generic statement that the inpatient services are not medically necessary or the patient's condition could be safely treated in a

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

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

- **Additional length of stay** – MCHC member hospitals estimate that the proposed requirement to provide a patient-specific generic discharge notice would add at least one day to each Medicare beneficiary's stay, and the requirement to issue a detailed notice would add a minimum of two days to the stay. We also believe that the generic notice will prompt most Medicare beneficiaries to seek an immediate review. Using an average cost per day of $1,525, and assuming a very conservative one-third of beneficiaries request an immediate review, we estimate that CMS' proposed discharge notice procedures will cost the average Chicago-area hospital $9.9 million just from the additional length of stay. Based on 80 percent of Medicare beneficiaries requiring a detailed notice, this figure climbs to $13.3 million per year for the average Chicago-area hospital.

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

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

Recommendations

Provena Saint Joseph Medical Center recommends that CMS not implement the proposed discharge notice procedures. We suggest that prior to making any changes to current hospital procedures for notifying Medicare beneficiaries of their appeal rights and issuing HINNs, CMS needs to better understand hospital operations and to develop more realistic

estimates of the administrative and financial burden of the proposed requirements on hospitals.

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

Further Information

Thank you again for the opportunity to review CMS' proposal and to offer comments. If you have any questions about the issues raised above or you need any additional information, please feel free to contact me at (815) 773-7005, email nancyasulzberger@provenahealth.com

Sincerely,

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

cc: Jeff Brickman
Linda Charley
Lon McPherson

MCHC
Metropolitan Chicago Healthcare Council

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

May 30, 2006

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

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

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

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

Summary of Comments

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

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

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

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

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

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

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

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

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

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

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

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

Background

Current Process

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

Comments

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

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

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

CMS Proposal

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

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

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

Comments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Collection of Information and Recordkeeping Requirements

CMS Estimates

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

Comments

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

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

Further Information

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

Sincerely,

Susan W. Melczer
Director, Patient Financial Services

cc: American Hospital Association
Illinois Hospital Association

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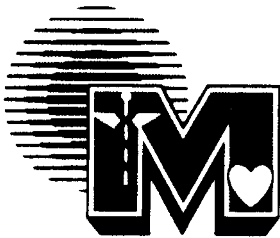


MAURY REGIONAL HOSPITAL

1224 TROTWOOD AVENUE • COLUMBIA, TENNESSEE 38401
931-381-1111

May 25, 2006

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

Re: CMS-4105-P, notification procedures for hospital discharges

To Whom It May Concern:

The proposed Medicare rule requiring healthcare providers to give patients written notice of their upcoming discharge will be a hardship on hospitals and distressing to patients. I do not support this proposal and foresee multiple negative implications if passed. Requiring hospitals to issue an advanced written notice to patients of the upcoming discharge will result in increased lengths of stay, over-utilization of hospital resources, unhappy physicians, and an increased number of hospital issued notices of non-coverage.

Physicians become upset when they perceive a healthcare facility is interfering in the care and discharge of their patients. Additionally, physicians do not always know or communicate with hospital staff when they anticipate the patient's discharge pending improvement of the patient's condition or pending test results. By not having this information readily available, issuing the discharge notice will not be feasible resulting in a discharge delay and unnecessary hospital days. Also, discussion with patients regarding date of discharge is the physician's responsibility since the physician is in control of the patient's hospital admission and determines when a patient is stable for discharge.

I also believe the time involved in issuing a discharge notice is grossly underestimated. It will take more than your estimated five minutes per patient to print the notice and explain it to a patient and/or family member. Considering the number of discharges per day, the hospital staff could better use this time to provide care and arrange an appropriate discharge plan for Medicare patients.

Sincerely,

Charles A. Ball, M.D.
Medical Director

CAB/sbg

99-0
(24)

May 3, 2006

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

To Whom It May Concern:

I am writing regarding the proposed rule: CMS-4105-P.

There are several points in this proposed rule that I would like to comment on:

- The first is "PROVISIONS OF THE PROPOSED RULE". In this section of the proposed rule it states that the "Important Message from Medicare", which now provides much of the same information about appeal rights, although earlier in the hospital stay... Why is it that any extra information could not be included in the "Important Message from Medicare", rather than another whole process, increasing costs for everyone. Granted the discharge date could not be included but if the message stated clearly the benefits and appeal rights of the beneficiary it would seem to save a lot of time, and still provide the needed information.

- **Section 405.1205** Notifying Beneficiaries of Discharge From Inpatient Hospital Level of Care. This section states that it would only take hospitals 5 minutes to deliver each notice. In response I need to say that the Medicare population at Newton Medical Center has a high percentage of nursing home patients that the DPOA must be notified and followed up with a written notice if these are going to be patterned after the Generic notices for SWSN bed introduced in July, 2005. This is NOT a 5 minute process, Case Management often ends up needing to call the DPOA several times prior to reaching them, and then if the DPOA is unable to come to the hospital to sign the paper and it needs to mailed to them it is an even longer process. In addition Case Management has found that the beneficiary, even though legally able to sign for themselves will not sign papers until a trusted member of the family is present, because they do not totally understand the notice. As the patient physician, I believe that the patient should understand what they are signing and feel comfortable with it, again Case Management cannot complete the task within the 5 minutes that CMS says is standard and still meet the standards expected of them to provide the patient with adequate knowledge. As a physician I also anticipate difficulty notifying the Case Management department of anticipated discharges so the notice can be given. This is time consuming from our side as well, either to write the order anticipate discharge tomorrow or developing a system to notify Case Management of the impending discharge. In addition, when a patient improves more rapidly than expected and can be discharged that day instead of the next it

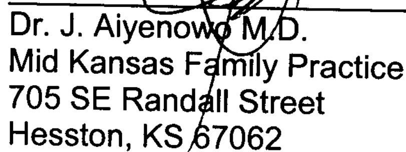
again provides the patient one additional day stay until the letter is issued and the patient has the right to appeal.

- **Section 422.620** Notifying Enrollees of Discharge From Inpatient Hospital Level of Care presents the same issues as Section 405.1205 above.

- **Section 422.622** Requesting Immediate QIO Review of Decision To Discharge From Inpatient Hospital Level of Care does address a 60-90 minute time frame to complete the detailed notice and prepare documents for the QIO, but it fails to address the time frames the hospital must meet as required by the QIO. Because Newton Medical Center is a rather small hospital with a total of 108 licensed beds as of July 2006, the staff who will be responsible for this duty is only here Monday through Friday from 6 am to 4:30 pm and Saturdays from 8 am to 12 noon. Our beneficiary is requiring a detailed notice be sent by close of the business day on the day the QIO was notified of the appeal, 7 days a week. Since, as you stated these are expected in only 2% of the cases, we must figure out how to have knowledgeable staff available who can complete the detailed notice and who has access to Medical Records, which is locked after business hours and on weekends. If Newton Medical Center pays on call wages the cost again exceeds the amount CMS has allocated, and to pay someone to be here all the time when there is only a 2% chance that this will occur seems to be wasteful in terms of Medicare dollars spent.

Thank you for allowing the physicians who admit patients to Newton Medical Center to enter our comments and concerns about Newton Medical Center's ability to carry out Proposed Rule CMS-4105-P.

Sincerely,



5/12/06

Dr. J. Aiyenowo M.D.
Mid Kansas Family Practice
705 SE Randall Street
Hesston, KS 67062

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Carolinas HealthCare System

James E.S. Hynes
Chairman

Michael C. Tarwater, FACHE
President & CEO

May 31, 2006

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

Re: CMS-4105-P

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am a case management director at Carolinas Medical Center-Pineville, a 97 bed hospital located in Pineville, NC that is part of Carolinas Healthcare System.

As a director I have been directly involved with discharge planning for a diverse population for the past 5 1/2 years. Our current discharge planning process begins at the time of admission when patients are provided with the Important Message from Medicare during registration. Next, the admission nurse screens the patient's current living situation and available resources. In addition, case managers assess all patients who may need post-acute services or who may be at risk for discharge delays. Patients and their families are involved in discharge planning activities and given a choice of providers for post acute services. Our process also includes ample opportunity for patients and families to consider all options, and if in disagreement with the discharge decision, to appeal the decision to the Carolinas Center for Medical Excellence, the Quality Improvement Organization (QIO) for North Carolina.

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

The CMS proposed change places administrative burdens on the hospital that greatly outweigh the benefit. CMS estimates it will take only five minutes to deliver the generic notice and have it signed. This is a grossly underestimated time allotment given the fact that most patients and family members will not sign a document without carefully reading it and asking questions.

Experience has shown that the delivery of any official governmental notice defining a discharge date and the details of patient financial responsibility consumes a tremendous amount of case management's time. It is more realistic to assume an average of thirty minutes for the delivery of each generic notice. In cases where the patient is not the decision-maker, it will take much more time to locate and wait for the responsible party to arrive to sign the Notice. This will often be late at night when nurse staffing ratios are at their highest and after hours for case management.

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

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

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

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

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

Sincerely,

Mary M. Rich, RN
Director, Clinical Case Management

101-0
(2)

Douglas B. Vinsel
Chief Executive Officer

June 5, 2006

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

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

Dear Dr. McClellan:

Duke Health Raleigh Hospital appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.
Duke Health Raleigh Hospital believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. Also, there has been no compelling case for the need to implement this change. Therefore, Duke Health Raleigh Hospital does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process.

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

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

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

3400 Wake Forest Road • Raleigh, NC 27609 • tel (919) 954-3055 • fax (919) 954-3900

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

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

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

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

There are several problems with the proposed approach.

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

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

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

- By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences. The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost 13 million hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would impose a significant burden on hospitals. And for many patients, they would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

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

Collection of Information and Recordkeeping Requirements

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

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

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

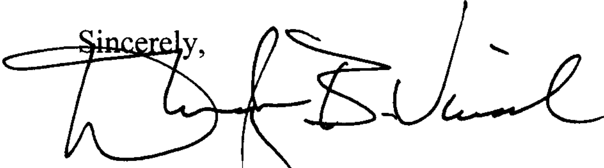
- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons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

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

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

Duke Health Raleigh Hospital appreciates the opportunity to comment on this proposed rule. To discuss any questions or reactions to our comments, please contact our Director of Case Management, Pat Kramer, at 919-954-3274 or via e-mail at patricia.kramer@duke.edu.

Sincerely,



Douglas B. Vinsel
Chief Executive Officer

cc: Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P