8

CARILION
Franklin Memorial
Hospital

Date: 5/2/06

To: CMS

From: Carilion Franklin Memorial Hospital
Gale Scott, Director, Clinical Effectiveness/Case Management

Re: CMS-4105-P Comments – Proposed Rule

This letter is in response to the proposed rule: CMS-4105: Notification Procedures for Hospital Discharges.

"PROVISIONS OF THE PROPOSED RULE"
This proposed rule sets forth new requirements for hospital discharge notices under both original Medicare and the Medicare Advantage program. The rule would require hospitals to comply with a two-step notice process when discharging patients from the hospital level of care similar to the process used in HHA, SNF and CORF. It would require a generic notice of discharge (physician concurring) and Medicare appeal rights to be delivered one day before discharge. If the patient disagrees with the physician's decision to discharge, they may request an expedited appeal. This results in the hospital being required to provide a second notice to the beneficiary with detailed explanation why services are either not longer reasonable and necessary or are otherwise no longer covered; a description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy; 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; and any other information required by CMS. All of this information is to be inserted on the detailed notice and should be individualized and written in plain language to facilitate beneficiary understanding.

To be more concise, CMS is requiring the hospital to in effect, document what the Physician's rationale is for discharging the patient which in itself will take significant amounts of time and effort just to obtain the Physician's opinion, and then be well enough versed or perhaps develop Medicare templates to be able to insert into the "individualized" letters to explain medicare's rules and how we use them to determine medical necessity for continued stay.

Perhaps each beneficiary upon enrollment in Medicare should be provided with a copy of the Interqual criteria on medical necessity for admission to acute care for their review and

reference. We will need to be available to explain all of this in "terms" the beneficiary can understand. After the "detailed notice", is presented do we follow with a HINN since the patient likely does not meet criteria for acute inpatient stay or he/she would not be discharged? This generates another notice to deliver and explain appeal rights. Then copy the chart again and send it off to the QIO for review. ...another few days of no liability to the patient and increased resource consumption for the hospital. At this point the patient will be so confused and frustrated with the attempts at ensuring their benefit rights are known to them it will take a Medicare expert to try to explain things.

I have several concerns with this proposed ruling. HHA do not provide the Important Message about Medicare booklet at admission that describes the rights of the beneficiary as the Acute Care Hospitals do. So, we are already providing this information at an appropriate level at admission.

In the acute care setting, unlike HHA, Hospice and CORF/SNF settings the patient's conditions change rapidly. The estimated discharge date is not reliable and therefore it would be next to impossible to ensure delivery of a discharge notice the day before discharge. The notice would have to be delivered with the "Important Message from Medicare" brochure on admissions anticipated to be 1-2 day stays.

In order to do this, massive Physician education and compliance would be required. Physician participation in documenting in advance the plan to discharge and ensuring the appropriate staff were alerted to this in order to facilitate delivery of the notice to discharge would be needed. Currently, Physicians round at various times of the day, evening and night and occasionally write progress notes to indicate a potential discharge the "next day" or "in a few days" and routinely write this daily. Many physicians have remarked to me that they do not write specific plans to discharge "the next day" because they are concerned with insurance denials if they do.

Hospitals would have to increase their UM staff to work much later in the day in order to catch the late rounding physicians in case they document plans to discharge the next day, and hopefully notify the UM department in order to deliver the notice. This process, contrary to the statistical data provided by CMS, will result in a significant burden to the hospitals, both in administrative resource use as well as UM and skilled RN Case Manager staff time. Hospitals would have to increase their staff to meet this regulation. In order to identify potential discharges for the next day, hospitals would have to be reviewing the patient medical records at least daily (or more frequently to catch late rounding physicians) for physician progress notes that indicate a potential discharge and then facilitate the discharge notice or alert other staff to prepare and deliver the notice. The staff delivering such notice would have to be well versed in the Medicare policies, rules and denial and appeal processes. This process would also require a second staff member be present for the delivery and witness of the patient's signature (or refusal to sign) for documentation purposes.

Until the Physicians are directly impacted to comply with this, hospitals will continue to struggle to meet CMS demands. Until CMS requires physicians to comply with their

regulations, compliance efforts will fall short. Even in cases where we "thought" we had a probable discharge for the next day, the likelihood of the plan changing the next day is significant and results in waste of resources of staff to print and complete the letter, deliver the letter, explain the letter and appeal rights, document that the letter was given and explanations provided. Then the patient does not discharge for various reasons and the letter is removed (?), or voided and the cycle starts again when the physician "thinks" he/she may discharge "tomorrow". To try to deliver these discharge notices the day before discharge is next to impossible in the acute care setting. Unlike rehabilitative settings where the plan of care and progress of the patient are more consistent and predictable, acute care setting is fast paced, unpredictable and expected discharge dates, for the majority of patients is unreliable. The only realistic way to accurately provide a beneficiary with a notice to discharge would be for the physician to be responsible for the delivery of the notice to discharge during his/her discussion with the patient about the discharge plan.

Another issue regarding physician interaction is this...if a physician had discharged a patient one would assume that in 99% of the cases the patient no longer meets criteria for acute care stay and is ready to discharge. If the patient disagrees with the discharge and we send in an expedited appeal what happens? Does the QIO call the attending physician to tell them that they think that the patient should not be discharged? Does the QIO then tell the physician how the patient should be treated? Does the hospital now get additional reimbursement as well? If the physician feels the patient is ready to discharge and the patient requests an expedited review is he/she now obligated to cancel the discharge and write some sort of orders to appease the patient and/or the QIO? If the patient truly feels that they should not be discharged for medially necessary reasons related to the diagnosis they are being treated for and not medical convenience or family convenience wouldn't they have discussed this with their physician and the discharge would not have been written? It seems redundant to have a patient be aware that they are to be discharged and then give them a notice that their coverage will end at the time of discharge. This information should have been provided to the patient before they are ever admitted to the hospital; perhaps at the time of enrollment in their insurance plan.

Another concern is that of patient capacity. If the patient lacks capacity to receive the discharge notice and there is no available responsible party what is the course of action. If it is the same process that is used for HINN's then we are keeping a patient in acute care, increasing our LOS, likely at a loss financially, while we try to reach family. Will we be required to go so far as to try to send certified letters to documented responsible parties and await receipt, signed or unsigned, before being able to discharge the patient? This will increase our length of stay and resource consumption in a case that may have already exceeded resource allocation by CMS.

This process will require additional administrative work by licensed staff, diverting highly skilled staff from assessing and developing plans to progress the patient through to discharge. The hospitals would likely have to re-design their staffing in order to increase FTE's to print out discharge notices for delivery whenever notified of a "potential" discharge. This staff would not be administrative staff, they would have to be trained and

well versed in UM and Medicare rules and regulations in order to provide detailed explanations to the patients and families. Explanations that may be best directed to CMS themselves.

Hospitals would also have to increase their staffing in order to cover all weekend and holiday discharges that may not be currently covered by staff with the UM expertise required.

The physician should have more responsibility in informing patients as he is the one making the decisions regarding treatment and should be advising the family about the discharge date. Patients receive so much information during their hospitalization it just adds to their confusion. No other payor provides a notice at discharge.

In summary, our issues with the proposed rule are administrative burden will be both resource/time and cost prohibitive; staff resource use causes undue burden and increased cost to hospitals and concern for the patient's ability to understand the notice. If additional information needs to be given it would be less confusing to the patient if all information was presented on admission with the "Important Message from Medicare". Perhaps that letter needs to be redesigned to include all the required information to be distributed.

We, therefore, request this proposed rule be reevaluated giving more consideration to the patient as well as the hospital.

Director, Clinical Effectiveness/Case Management

'Provisions of the Proposed Rule" CMS 4105

I have worked as a Medical Social Worker for 19 years. Patients can change from day to day, we may letter them and they end up staying, would we have to keep lettering them until they go home? Patients and families are overwhelmed when they come to the hospital and the notices that they are given on admission are hard to understand and long, the majority of patients don't even read them. I think it would be less confusing and much more understandable for patients and their families if every Medicare beneficiary was given a simple bold printed page that is easy to understand, and easy to explain on admission. This way they know their rights it is short and to the point and in bold type and easy to understand. And yet it gives them the right to stay in acute care if they do not agree with the decision to be discharge until a decision has been made by the QIO. An example is as follows.

As a Medicare Beneficiary if feel you are being asked to leave the hospital prematurely you have the right to appeal the decision to discharge you. Simply tell the nurse caring for you that you do not feel you are ready for discharge. You will than be assisted in contacting the Quality Improvement Organization (QIO) who will review the case and make a decision within 24 hours of your request. You will be able to remain in the hospital during the review process. Should the QIA agree with the facility that you are ready for discharge you would be required to leave the facility by midnight on the date of receiving the decision from QIO. If you choose not to leave the facility by midnight you will be responsible for your bill for that full day and the days to follow.

If a person requests a review at this time a detailed notice of why the facility feels the person does not need to remain in acute care would be given and there would be two options for signature, 1. they agree with the detailed notice and are ok with being d/c or 2. They do not agree and the review process would be started.

216 14th Avenue S.W., Sidney, Montana 59270-3586 406-488-2100 1-800-331-7575 FAX: 406-488-2115

I am a strong advocate for patient rights, and want to ensure patients have avenues to ensure they receive the care that is needed. I also see that with each new regulation more staff time is spent on paperwork and documentation and direct patient care is affected. It is also concerning to me that regulations are putting the responsibility on the facility rather than the patient, if a person feels they are not ready to go home they should initiate the review process.

Sincerely,

Kelly Wilkinson, BSW

FAULKNER
HOSPITAL

1153 Centre Street
Boston, Massachusetts 02130
Tel: 617 983-7000

April 28, 2006
Department of Health and Human Services
Centers for Medicare and Medicaid Services
CMS-401-P

To whom it concerns:

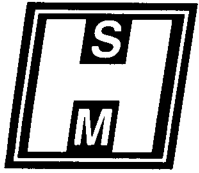
This letter is in comment to the rule CMS-4105-P, proposing that a notice of discharge be given to all Medicare in-patients. Faulkner Hospital opposes implementation of 'PROVISIONS OF THE PROPOSED RULE". CMS states that this 2- step notice would be helpful to the beneficiary, but didn't state the reason it would be good for them. Faulkner opposes this rule as we feel this notice of discharge would unnecessarily alarm the beneficiary. Patient's are under an inordinate amount of stress when admitted to the hospital. Faulkner prefers not to place more stress upon the patient than can be helped. Issuing a notice that says the patient could have a liability would place undue stress on the patient.

CMS is also suggesting the notice of discharge be given the day prior to discharge. In the world of healthcare, patients are often discharged the same day that they have been medically cleared. Delaying discharge an additional day will cause patient flow problems as well as cause many hospitals to go on diversion due to lack of hospital beds. A proposal to give the notice on the day before discharge could possibly worsen the above issues and jeopardize the lives of sick patients who are trying to be seen at hospitals, but are unable to do so because hospital beds are being filled by already treated Medicare patients.

This proposed change would place undue burden upon the hospital. The Department responsible for carrying out this duty would have to be budgeted for at least another .50 FTE, as on any given day Faulkner discharges up to 35 or more Medicare patients. Issuing discharge notices to this number of patients on a daily basis would be very difficult and very time consuming.

In closing, Faulkner Hospital has the utmost respect for CMS, but we ask that you consider our position and the undue stress that would be placed on the beneficiary.

Sincerely,
Katie Mae Miller, R.N.,MM Case Management Director



Schoolcraft Memorial Hospital

(906) 341-3200 • fax (906) 341-3297
500 Main Street • Manistique, MI 49854
www.scmh.org

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May 9, 2006

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

To Whom It May Concern;

I have reviewed the proposal for the new Notice of Non-Coverage and feel very strongly that this is not necessary and will be a substantial burden on hospital personnel responsible for issuing notices.

In the case of a one day length of stay there will not be a 24 hour lead time to issue a letter. Example: a patient gets admitted after hours and discharged the next day while meeting InterQual Criteria for inpatient admission.

It is difficult if not impossible to determine 24 hours in advance of a discharge. Example: A patient "almost meets Criteria for discharge" but needs labs and x-rays to verify. After completion the physician would have to make rounds again late to review and then write the discharge order. Another example: weekend admits and discharges within the weekend. Are you proposing 7 days/24 hour coverage for issuing these letters? This will overburden an already overburdened nursing staff.

We are a Critical Access designated facility. Our patients are discharged or transferred within three to four days. If they do not meet InterQual Criteria they are issued a Letter of Non-Coverage. I feel strongly this is all our Medicare beneficiaries need. If they feel that they are being asked to leave the hospital too early they are immediately given the appropriate phone numbers and information to pursue an expedited review. More routine paperwork will only serve to confuse them.

I appreciate your time and concern protecting beneficiary's rights but these issues are adequately covered under the present system.

Sincerely,

Alicen B. Phillips RN UR

Alicen B. Phillips, RN, UR

FYI Reg Staff 12

DHPPC (Medicare review.)

#590795

Paul K. Whelton, MD, MSc
Senior Vice President for Health Sciences

May 3, 2006

MAY 19 2006
11:00 A.m.

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

Re: File Code: CMS-1531-IFC

Dear Dr. McClellan:

The Louisiana State University School of Medicine (LSUSOM) and Tulane University School of Medicine (TUSOM) welcome the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Medicare Graduate Medical Education Affiliation Provisions for Teaching Hospitals in certain emergency situations. (April, 2006)* We appreciate your staff's work on funding needs for graduate medical education in the hurricane-ravaged gulf south region, fully realizing the competing demands on the agency in the Medicare Drug program and the quality initiatives.

We have numerous comments, many based on the ongoing instability in medical education since the storm and the need to preserve a long term educational strategy for the State of Louisiana. Please note that our two schools combine to graduate over 75% of the physicians receiving their undergraduate and graduate medical education our state.

First, please accept our comments regarding the ***Background*** section of the proposed rule. We realize the CMS interim final rule recognizes the funding obligations of the home and host facilities. In addition to the funding of graduate medical education (GME) through these facilities, it is vitally important to recognize the GME **sponsoring institutions** who provide the educational programs. Due to the storm, both the funding programs and the sponsoring institutions were scrambled in the event. The sponsoring institutions serve as the mainstay for GME despite the loss of the facilities and their funding.

During the emergency period, we request CMS temporarily promote the sponsoring institutions to serve as the coordinating authority by assigning the cap transfers between the host and home facilities. The sponsoring institutions are

accountable to the ACGME and Residency Review Committees (RRC) for assuring a balanced and complete education for the trainees. The temporary placement of the residents requires coordination across the host and home facilities. The sponsoring institution serves as the unbiased agent with a clear focus on providing the best possible educational experience. One way to achieve this is for CMS to recognize an agreement entered into by the home facility with the sponsoring institution authorizing the sponsoring institution to act as its agent for the assignment of resident slots. To assure that there is linkage between CMS payments, and the payment of resident salaries and expenses, CMS could retain flexibility to make direct payments to whichever institution is responsible for resident salary and benefit costs, or could require payment of the salary and benefit expenses to the responsible party by the host hospital as one element of an Emergency Medicare GME Affiliation Agreement.

We would ask for additional clarification of certain provisions. First, despite preamble language, it is not clear from proposed modifications whether a host hospital must be ACGME-accredited in order to receive GME and IME payments.

Second, while we applaud CMS' intentions with GME to recognize the partial closure, partial re-opening and the need for incremental changes across the region, we ask CMS to reconsider the role of the host hospital to only hold caps temporarily while the displaced residents are away from the home facility. It is important to appreciate that the home facilities may return to a new and different functional status. For example, a five hundred bed facility may find it difficult to staff more than 250 beds during the emergency period. Finally, CMS should include a process for handling the long term redistribution of unused resident slots once the ultimate capacity of the home facility has been determined. With shortages in human resources, the training programs rely on a delicate re-balancing of GME as guided by the sponsoring institution. With this in mind in all cases where more than one sponsoring institution trains residents and/or fellows at an impacted hospital, any redistribution should maintain the proportionality of distribution, to protect all sponsoring institutions equitably. **Comments in "TEACHING HOSPITALS AFFECTED BY A DISASTER": OVERVIEW OF THE EMERGENCY MEDICARE GME AFFILIATED GROUP PROVISION.**

We ask CMS to reconsider the timeframe for the effective period for the emergency. The LSUSOM and the TUSOM feel the allowable effective period for the emergency Medicare GME affiliated group will exist at least until replacement facilities are re-established. Re-establishment of healthcare will require restoring or replacing the physical plant, the human resources and the infrastructure for care and education. The loss of the Medical Center of Louisiana New Orleans could take three to five years before restoration of GME to its pre-storm level.

It is entirely possible that the restored or replaced facility may not reach the same size as the pre-storm facility. Still, the State of Louisiana relies heavily on the local physician GME to provide a physician workforce for the beneficiaries in the state. In order to maintain the residency slots with adequate case mix and patient volumes, at the conclusion of the effective period for the emergency, we ask CMS to re-evaluate

the temporary nature of the cap transfer. At the conclusion of the effective period we ask CMS to evaluate the need for a permanent transfer of caps if the pre-storm facilities are only partially restored. **Comments in "APPLICATIONS OF EXISTING RULES".**

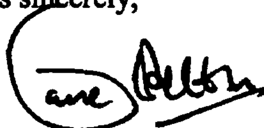
LSUSOM and TUSOM appreciate the attempts by CMS to provide direction for counting resident FTEs and the 3 year rolling average during the effective period. Unfortunately the provisions for host facilities, whether new or established teaching hospitals, create unfunded or partially funded resident positions in a severely damaged healthcare system. The CMS proposal undermines the efforts to host training by underfunding training in financially distressed healthcare markets. Host facilities may attempt to transfer these costs to the sponsoring institutions, who themselves are financially distressed.

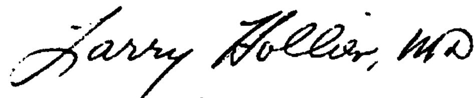
For example, the host facilities have absorbed the uncompensated or poorly compensated care. The financial strains on the remaining facilities is significant. The host facility willingness to engage in GME becomes hampered by the 3 year rolling average methodology. Thus, the host facilities would incur additional costs with only partial funding from CMS for the GME costs. It is far less likely that the host institutions could afford the GME transfers under the current proposal.

We ask CMS to extend the effective period for the emergency until July 2009. We also ask CMS to consider using a fully weighted FTE without using the 3 year rolling average until the end of the effective period of the emergency. At the conclusion of the effective period, we seek to revert to the traditional 3 year rolling average along with our previously noted request to assess the need for permanent resident cap transfers.

Finally, we again express our sincere appreciation for Agency's efforts to expedite restoring GME to the State of Louisiana. Implementation of these few features CMS will assure graduate medical education continues to serve the beneficiaries in our state.

Yours sincerely,





Paul K. Whelton, MD, MSc
Senior Vice President for Health Sciences
Tulane University Health Sciences Center
Dean, Tulane University School of Medicine

Larry H. Hollier, MD
Chancellor
LSU Health Sciences Center
Dean, LSU School of Medicine

Office of the Senior Vice President
for Health Sciences
Health Sciences Center
1440 Canal St., Ste. 2400, TW-5
New Orleans, LA 70112-2709

NEW ORLEANS LA 701
RESPOND
RECONNECT
RE-ESTABLISH
05 MAY 2006 PM 3 T

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

13

Johnson, Sharon B. (CMS/OSORA)

From: Jones, Martique S. (CMS/OSORA)
Sent: Tuesday, May 16, 2006 3:26 PM
To: Johnson, Sharon B. (CMS/OSORA)
Subject: FW: Public Submission

Martique S. Jones
Director,
Division of Regulation Development-B
OSORA/RDG
Centers for Medicare & Medicaid Services
410-786-4674
Martique.Jones@cms.hhs.gov

>-----Original Message-----
>From: Whitcraft, Rosie [mailto:rosie.whitcraft@fda.hhs.gov]
>Sent: Tuesday, May 16, 2006 2:36 PM
>To: Jones, Martique S. (CMS/OSORA)
>Subject: FW: Public Submission
>
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>
>-----Original Message-----
>From: no-reply@erulemaking.net [mailto:no-reply@erulemaking.net]
>Sent: Tuesday, May 16, 2006 2:23 PM
>To: OC AIMS Support
>Subject: Public Submission
>
>Please Do Not Reply This Email.
>
>Public Comments on Medicare Program; Notification Procedures
>for Hospital
>Discharges:========
>
>Title: Medicare Program; Notification Procedures for Hospital
>Discharges
>FR Document Number: 06-03264
>Legacy Document ID:
>RIN: 0938-AN85
>Publish Date: 04/05/2006 00:00:00
>Submitter Info:
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>
>First Name: DONNA
>Last Name: ODOM
>Category: Health Care Industry - PI015
>Mailing Address:
>City:
>Country: United States
>State or Province: AL
>Postal Code:
>Organization Name: ST. VINCENT'S HOSPITAL
>
>Comment Info: ================
>
>General Comment:THIS IS A RIDICULOUS RULE. CASE
>MANAGERS/DISCHARGE PLANNERS
>
>WILL NOT HAVE TIME TO DO ANY ACTUAL WORK IF THEY HAVE TO SPEND
>ALL THEIR TIME GIVING THESE NOTICES. AT OUR HOSPITAL, WE HAVE A

>HUGE MEDICARE POPULATION. THIS IS NOT A REASONABLE
>EXPECTATION. I THINK THIS WILL CAUSE A DELAY IN DISCHARGES AND
>INCREASE THE STRESS LEVEL OF THE PATIENTS AND CASE MANAGERS.
>IT IS SOMETIMES DIFFICULT TO ACCURATELY PREDICT WHEN A PATIENT
>WILL BE READY FOR DISCHARGE.
>
>
>

Johnson, Sharon B. (CMS/OSORA)

From: Jones, Martique S. (CMS/OSORA)
Sent: Wednesday, May 17, 2006 11:52 AM
To: Johnson, Sharon B. (CMS/OSORA)
Subject: FW: Public Submission

Martique S. Jones
Director,
Division of Regulation Development-B
OSORA/RDG
Centers for Medicare & Medicaid Services
410-786-4674
Martique.Jones@cms.hhs.gov

>-----Original Message-----
>From: Whitcraft, Rosie [mailto:rosie.whitcraft@fda.hhs.gov]
>Sent: Wednesday, May 17, 2006 11:24 AM
>To: Jones, Martique S. (CMS/OSORA)
>Subject: FW: Public Submission
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>
>-----Original Message-----
>From: no-reply@erulemaking.net [mailto:no-reply@erulemaking.net]
>Sent: Wednesday, May 17, 2006 11:04 AM
>To: OC AIMS Support
>Subject: Public Submission
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>
>Please Do Not Reply This Email.
>
>Public Comments on Medicare Program; Notification Procedures
>for Hospital
>Discharges:========
>
>Title: Medicare Program; Notification Procedures for Hospital
>Discharges
>FR Document Number: 06-03264
>Legacy Document ID:
>RIN: 0938-AN85
>Publish Date: 04/05/2006 00:00:00
>Submitter Info:
>
>
>First Name: Jodi
>Last Name: Wallis
>Category: Health Care Industry - PI015
>Mailing Address:
>City:
>Country: United States
>State or Province:
>Postal Code:
>Organization Name:
>
>Comment Info: ================
>
>General Comment:This is operationally not feasible for acute care
>facilities. Acute care facilities treat
>patients on a day to day basis. They are truly "acutely" ill.
>There is no

>way to
>predict 24 hours in advance if they will go home. This gives
>the patient and
>the
>family false hope; not to mention puts the hospital in legal
>limbo. I truly
>hope the
>government will reconsider this proposal. It is not a sound
>propasal. There
>are so
>many of our Medicare patients who cannot even accept written
>documentation.
>This would truly lengthen the Medicare length of stay.
>
>
>

15

Johnson, Sharon B. (CMS/OSORA)

From: Jones, Martique S. (CMS/OSORA)
Sent: Tuesday, May 16, 2006 3:20 PM
To: Johnson, Sharon B. (CMS/OSORA)
Subject: FW: Public Submission

Martique S. Jones
Director,
Division of Regulation Development-B
OSORA/RDG
Centers for Medicare & Medicaid Services
410-786-4674
Martique.Jones@cms.hhs.gov

>-----Original Message-----
>From: Whitcraft, Rosie [mailto:rosie.whitcraft@fda.hhs.gov]
>Sent: Tuesday, May 16, 2006 2:39 PM
>To: Jones, Martique S. (CMS/OSORA)
>Subject: FW: Public Submission
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>-----Original Message-----
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>To: OC AIMS Support
>Subject: Public Submission
>
>Please Do Not Reply This Email.
>
>Public Comments on Medicare Program; Notification Procedures
>for Hospital Discharges:========
>
>Title: Medicare Program; Notification Procedures for Hospital
>Discharges
>FR Document Number: 06-03264
>Legacy Document ID:
>RIN: 0938-AN85
>Publish Date: 04/05/2006 00:00:00
>Submitter Info:
>
>
>First Name: cynthia
>Last Name: garrett
>Category: Health Care Industry - PI015
>Mailing Address:
>City:
>Country: United States
>State or Province: AL
>Postal Code:
>Organization Name:
>
>Comment Info: ================
>
>General Comment:This notification is a very time comsuming
>process. Our case managers are
>already functioning in a number of roles and this notification
>process will only add
>to the list or responsibilities that they have to complete on
>a daily basis. Has the

>increase in workload been considered?
>
>

/6

Center for Medicare Advocacy, Inc.
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TUCSON, ARIZONA 85701
(520) 327-9547 FAX (520) 884-0992

ATTORNEYS*
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Brad S. Plebani
Pamela A. Meliso
Gill Deford
Alfred J. Chiplin, Jr.
Toby Edelman
Vicki Gottlich
Patricia Nemore
Lara K. Stauning
Mary T. Berthelot
Mary A. Ashkar

OF COUNSEL
Sally Hart
Wey-Wey Elaine Kwok*

***Admitted in other jurisdictions**

ADMINISTRATOR
Carolyn S. Boyle

MEDICAL ADVOCACY COORDINATOR
Ellen L. Lang, R.N., M.P.H.

DATA PROJECT DIRECTOR
Larry S. Glatz

Sent Via Federal Express

May 22, 2006

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

Re: Medicare Program; Notification Procedures for Hospital Discharges
File Code CMS - 4105 - P
71 Fed. Reg. 17052 (April 5, 2006)

To Whom It May Concern:

This comment letter is submitted by the Center For Medicare Advocacy, Inc., which was counsel for the plaintiffs in Weichardt v.Thompson, C.A. No. 03 5490 VRW (N.D.Cal. Settlement Agreement, October 28, 2005). The proposed regulations concerning notification procedures for hospital discharges of Medicare patients are the result of a settlement agreement reached in that lawsuit with the defendant Department of Health and Human Services.

I. BACKGROUND

It was plaintiffs' position in the Weichardt lawsuit that the regulations concerning discharges of Medicare hospital patients adopted by CMS in the April 4, 2003 final rule on hospital discharges (68

CENTRAL OFFICE: P.O. BOX 350, WILLIMANTIC, CT 06226 (860) 456-7790 FAX (860) 456-2614

Fed. Reg. 16652) did not comply with notice requirements of the Medicare statute or due process. The settlement agreement in Weichardt provides that plaintiffs can renew their challenge if the final regulations resulting from this process do not provide beneficiaries with adequate notice of discharge and expedited appeal rights. If it is necessary, plaintiffs are prepared to exercise this right.

II. PROVISIONS OF THE PROPOSED RULE

The notice process described in the proposed regulations is a significant improvement over the process adopted by CMS in the April 4, 2003 final rule. Obviously, since we participated in the development of the proposed system, we support it. We also support the language and content of the notice forms submitted to OMB in implementation of the proposed regulations, set out at 71 Fed. Reg. 17104 (April 5, 2006). We urge that the proposed regulations and the notice forms be adopted as they are currently presented.

There is a suggestion in the commentary to the proposed regulations that it might be sufficient to give the standardized notice to beneficiaries on the day of discharge rather than 1 day before the planned discharge. In our view it would be preferable that patients be given the notice 2 days before the planned discharge, as is the case for SNF, HHA and CORF patients, rather than 1 day before as currently proposed. The 1 day advance notice, agreed upon as a compromise, gives frail hospital patients, as well as families attempting to assist them, very little time. They must take many steps in response to the generic notice: review the notice, contact physicians, gather and assess facts, and make and communicate decisions about how to proceed. Because of the difficulty for a hospitalized patient in completing these steps in the short amount of time allowed, the proposed regulations should be clarified to specify that the generic notice must be given by at least noon of the day before a planned discharge.

The commentary to the proposed regulation also asks whether there is a maximum allowed amount of time before the end of Medicare-covered services when the generic discharge notice should be delivered. From the standpoint of the patient's decision-making needs, there would appear to be no maximum time before discharge in which the standardized notice should be given. However, it seems very unlikely that accurate decisions about medical necessity of continued inpatient care could be made more than 2 days in advance of discharge, given the unstable condition of hospitalized individuals. We are concerned that allowing hospitals and MA plans to give notices of discharge well in advance, even perhaps at admission, will result in "cookbook medicine" that does not meet the very specific acute care needs of hospital patients.

The precise language of the initial standardized notice, as well as the content of the detailed follow-up notice, is intrinsic to the success of the proposed regulations. The proposals for these notices were carefully designed to provide information needed by patients to understand the consequences of their choices concerning both expedited and standard appeals. Accordingly, we strongly urge that no changes be made in the proposed notices.

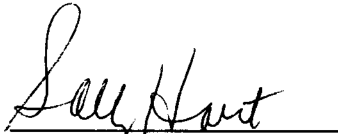
III. COLLECTION OF INFORMATION REQUIREMENTS

It is to be anticipated that both hospitals and Medicare Advantage plans will protest that preparation and delivery of the proposed generic and detailed discharge notices is unduly burdensome for them. It is also predictable that they will find disagreeable the prospect of meaningful appeals of their discharge decisions by patients. However, these self-interested concerns should be evaluated for what they are, and outweighed by the potential harm to patients of premature termination of hospitalization. Indeed, because of the critical nature of hospital care, patients are more vulnerable in the hospital setting than they are in the SNF, HHA, CORF and hospice settings, where discharge procedures like those proposed in the regulations are already in place.

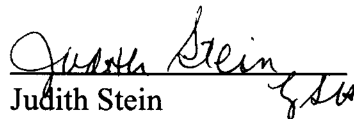
We appreciate your review of these comments on the proposed regulations and hospital discharge notice forms, and we urge you to adopt them without dilution of their protections for beneficiaries.

Yours very truly,

Center For Medicare Advocacy, Inc.



Sally Hart
Litigation Group



Judith Stein
Executive Director

COMMUNITY HOSPITALS AND WELLNESS CENTERS
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909 E. Snyder Ave. Montpelier, OH 43543-1271 Ph (419)485-3154 Fax (419)485-3833
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Medicare Program; Notification Procedures for Hospital Discharges
File Code CMS 4105P

Comments: Proposed rule for hospitals to comply with two step notice process when discharging patients from inpatient level of care.

Burdens for health care facility to proposed rule

Administrative Issues:

- Financial impact
- Policies and Procedure development
- Allocating responsibility to designated staff
- Education of designated staff
- Education of physicians
- Human Resources (staff availability)
- Prolong length of stay

Task Oriented Issues:

- Explanation to beneficiary/representative
- Obtaining signatures beneficiary/representative
- Faxing necessary paperwork to QIO
- Adequacy of facsimile transmission capacity
- Excessive staff time for weekend, holiday, and evening discharges

Beneficiary Issues:

- Comprehension of proposed rule
- Understanding medical necessity criteria
- Financial impact/burden when QIO concurs with healthcare provider

Summary:

Important Message from Medicare is given to beneficiary on admission. This contains a simple explanation of patient rights and appeal mechanism if patient believes they are asked to leave too soon.

The proposed rule to give written notice of non-coverage or as soon as discharge determination is made, but no later than one day before will create conflict for healthcare provider and confusion for the beneficiary.

Perhaps a review of initial Important Message from Medicare could be reinforced/reviewed.

Respectfully Submitted,

Sharon Mesnard, R.N.,
Director of Risk Management/Quality Improvement

18

TEXAS HEALTH RESOURCES

May 9, 2006

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-4105-P
P.O. Box 8012
Baltimore, Maryland 21244-1812

Re: File Code CMS-4105-P. April 5, 2006 Proposed rule- Notification Procedures for Hospital Discharges

To Whom it May Concern:

We have several significant concerns about the proposed rule.

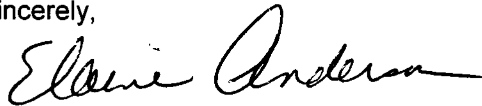
- Under the proposed rule all Medicare beneficiaries must receive an advance written notice of discharge even when the physician and the beneficiary AGREE as to the discharge decision. Further, the notice must be provided on the day before the planned discharge from any inpatient hospital stay. Requiring delivery of the notice at all is questionable when all parties agree. However; requiring delivery **the day before discharge** is not operationally feasible in many cases. It is common for the attending physician to visit a patient in the morning and determine that the patient is ready for discharge that afternoon. In this scenario, the hospital CANNOT comply with the "day before discharge" requirement.
- The proposed rule seems to rely heavily on comparison to home health agencies, skilled nursing facilities and comprehensive outpatient rehabilitation facilities that must provide a standardized notice to Medicare beneficiaries at least 2 days in advance of service termination. We believe acute care hospitals are distinguishable from these provider types. Inpatients often respond to treatment more rapidly than anticipated, thus the physician's medical judgment as the anticipated discharge date may change from one day to the next. Post acute settings are quite different. The proposed rule puts hospitals in a "position to fail" the requirement that the notice be delivered the day before discharge. This is one more example of a CMS rule that cannot be effectively implemented in the real world.
- The imposition of this proposed rule is unnecessary and places an administrative burden on hospitals. We completely support the need to communicate with Medicare beneficiaries and families in advance of the patient's discharge. These discussions occur in depth and include a variety of topics including the patient's readiness for discharge, home care instructions, post acute care needs, etc. Hospitals consistently accomplish the discharge process in a caring and compassionate way assisting patients and families with all discharge considerations. To our knowledge, there is no published data substantiating a "problem" that will be solved by the proposed discharge notice. The proposed rule assumes the beneficiary is unaware of his or her appeal rights. Our experience does not support this assumption.
- CMS determined that the 2003 proposed rule for a discharge notice was unnecessary. We believe the same determination is still valid today. CMS has provided nothing to support the "need" for an "across the board" notice or justifying the increased administrative burden. Furthermore, in many cases, hospitals will find it difficult to comply with the rule merely due to the day-to-day operations of a hospital, physician medical judgments and the lack of predictability needed to carry out the process.

We strongly object to this proposed rule. The proposed rule is not a budget neutral proposition. Implementation will cost the hospital in terms of resource consumption to deliver a notice that is not needed and to unravel the confusion that will be created in beneficiaries' minds when they receive a document telling them about appeal rights that are already clearly established. This will lead to confusion and additional complaints.

We urge CMS to discontinue the implementation of rules that place paperwork and administrative burden on hospitals and beneficiaries with no measurable benefit. Hospitals are struggling to comply with all rules and regulations and cannot continue to absorb needless administrative bureaucracy that does not improve patient care.

In summary, please reconsider the proposed rule. The rule is unnecessary, will be impossible to comply with in all cases and will add cost/administrative burden to hospitals.

Sincerely,



Elaine Anderson
Senior Vice President, Chief Compliance Officer
Texas Health Resources

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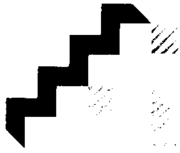

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May 2, 2006

Department of Human Services
Center for Medicare & Medicaid Services
ATTN: Response for Notification Procedures for Hospital Discharges
http://www.cms.hhs.gov/eRULEMAKING

RE: Comments on *'Proposed Medicare Program; Notification Procedures for Hospital Discharges"*

To Whom It May Concern:

On behalf of Catholic Healthcare Partners (CHP), we respectfully take this opportunity to comment on the Center for Medicare & Medicaid Services "Notification Procedure for Hospital Discharges."

Catholic Healthcare Partners is one of the largest not-for-profit health systems in the United States and the largest in Ohio. Our home office is in Cincinnati, Ohio. Our system consists of more than 100 organizations, including acute care hospitals, long-term care facilities, housing sites for the elderly, home health agencies, hospice programs, wellness centers and more. They are divided into nine regions, each of which provides a comprehensive range of services that meet the healthcare needs of people in Indiana, Kentucky, Ohio, Pennsylvania, Tennessee and nearby states. A core value that is central to CHP is providing excellent quality of our services while also being good stewards of our resources. As a system, we have therefore embraced the national movement toward transparency in healthcare system and information delivery and availability to all we serve.

As a system, we are familiar with the proposed notification procedure for hospital discharges. Similar rules are in effect and being followed by both our home care and long term care facilities. We collectively believe that changing the current hospital discharge process would disrupt the hospital flow process and negatively impact the delivery of quality and safe care in the following ways:

- high potential to increase length of stay
- hinder our ability to accept new admissions from the ED or physician offices.
- hinder our ability to move in-house patients from the post-anesthesia care units
- create delays in ICU transfers, leading to inappropriate utilization of ICU resources.

CHP facilities strive to initiate multi-disciplinary discharge/transition planning (which includes patients and caregivers) at time of admission. The goal of the multi-disciplinary discharge/transition planning model is to ensure clinical progression and appropriate levels of care.

We are collectively concerned that the proposed additional data collection steps will add yet another burden to an already stressed system and an intimidating deterrent for patients and families.

Department of Human Services
Center for Medicare & Medicaid Services
May 2, 2006
Page Two

We would like to propose the addition of a statement to "Important Message from Medicare" which is issued at time of admission stating that the "ultimate goal is to return the patient to their optimal state of wellness and to discharge the patient when medically stable to the appropriate agreed-on level of care. At any time during their stay if they have concerns of their discharge level of care that is being planned they have the right to appeal." On discharge, a line can be added to the discharge instructions indicating that the patient was involved in the planning, and agrees with discharge timing and disposition.

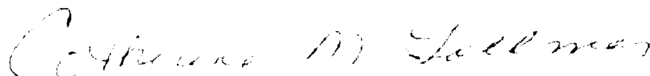
We believe the proposed 5 minute time frame to complete the administrative tasks is grossly underestimated. It is not only our job to deliver the paper, but it is also our responsibility to make sure the patient or family has a clear understanding of what they are reading. Notices such as these are often intimidating and we fear may have a negative impact on the patient/family ability to fully comprehend their discharge plans.

In summary, we collectively believe that the additional burden of the proposed process will deter from our ability to deliver quality, safe care to our patients.

We appreciate having had this opportunity to comment on the *Proposed Medicare Program; Notification Procedures for Hospital Discharges.* If you have any questions, or would like to discuss our comments further, please contact Marcia Messer, RN, MBA, MHA, Vice President of Performance Improvement and Nursing Excellence, at 513.639.2764.

Sincerely,

Marcia Messer, RN, MBA, MHA
Vice President of Performance Improvement
& Nursing Excellence



Catherine Follmer, BSN, CRNI, CHCE
Corporate Director, Home Care Operations
& Chronic Care Initiatives

VHA

Memorial Medical Center

May 12, 2006

To Whom It May Concern:

We are writing in response to the request for comments on the proposed discharge notification process for Medicare and Medicare Advantage patients proposed by Centers for Medicare & Medicaid Services. As we understood the proposed process; it would require hospitals to provide a discharge notification letter to the Medicare and Medicare Advantage patients no later than one day before their planned discharge.

We believe the rules need to be further clarified to address the following:

~ If a patient is admitted for a one day stay, do they need a discharge letter? Clearly it cannot be provided in the timeframe prescribed in the proposed rules.

~ If a patient is issued the discharge letter and it is subsequently determined that the patient can go home that same day, do they have to stay until the next day in order for the letter to be provided in advance? This would drive up the cost of care.

~ What if the patient is ready to go home but no letter was given? Again delay in order to meet this notification will drive up the cost of care.

~ There are concerns that the patient/family will now be able to "negotiate" their length of stay in the hospital. Is this not taking the ability away from the physician's in making the discharge decision?

~ We foresee longer length of stays for the patients that do question and take issuance with the discharge letter. There are the costs of copying and mailing the charts, as well as, the cost of days in the hospital until the QIO makes a decision. What additional reimbursement will be provided and aligned incentives with physician community?

~ Once a discharge letter is given and the patient develops additional medical concerns that increases their length of stay is another discharge letter required to be given?

~ It is concerning that CMS is underestimating the time it will take to provide, review and answer questions about the discharge notification letter with the patient/family.

~ There are concerns that should the hospital have waiting patients in the Emergency Department and Post-Acute Care Units, that discharges will be held up because the Medicare patient is required to receive the discharge notification letter the day before discharge. This will impede patient throughput and availability of appropriate beds for medical care.

Thank you for the opportunity to submit our comments for review.

Sincerely,

Kisha Hortman
Administrator, Patient Management Services
Memorial Medical Center
701 N. First Street
Springfield, IL 62781