ST. JOHN MACOMB HOSPITAL

CMS-4105-F

18 (41)

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

CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations - C
Attention: Bonnie L. Harkless
Room C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

January 23, 2007

To Whom It May Concern:

I am writing in response to the final rule CMS-4105-F, 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 begin 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: All Medicare beneficiaries 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 13.8 extra minutes to deliver the notice and have it signed, provide a copy, and then also provide another copy within 48 hours of discharge. If a signature is required AND the patient is NOT the decision maker, it can take additional time to obtain the signature of the patient's decision maker.

It becomes difficult to predict a discharge 48 hours in advance. Many patients stabilize more quickly than this and our window of opportunity to get them out of the acute care

arena may be hindered by this requirement. 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.

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 also recommend that the QIO's institute some type of weekend coverage for these issues when they arise. There is sure to be a question on a Friday evening that will need to then wait until Monday morning and you have now gone over the 48- hour window and will need to re-issue the notice again. Hospital facilities have always been a 24/7 operation, CMS needs to require this of the QIO as well.

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

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

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January 23, 2007

Centers for Medicare and Medicaid Services
Office of Strategic Operations & Regulatory Affairs
Division of Regulations Development – C
Attn: Bonnie Harkless
Room C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

CMS-R-193

Dear Ms. Harkless,

The additional burden and requirement of acute hospitals to provide each inpatient Medicare beneficiary a duplicate copy of the Important Message from Medicare (IM) within 2 days of discharge is redundant and will place significant additional workload on limited hospital clinical resources.

Acute hospital providers must already provide each Medicare beneficiary with the IM on or near admission. This process is generally supported by clerical staff that typically handles hospital admission paperwork. The discharge IM notice requirement will require that clinical staff intercede and identify potential Medicare patients who will discharge within the required 2-day period. Requiring clinical staff, who are already stretched very thin, to add this clerical duty to their workload may require some providers to add additional clinical staff to coordinate this requirement.

A typical hospital admissions department is generally not made aware of discharge plans until usually the day of discharge. The final rule requires providers to present the discharge IM "as far as possible in advance of discharge", which suggests that notifying the patient on the day of discharge is not adequate. Only Case Management and Discharge Planning staff who work with the attending physician are generally aware in advance of a patient's progress and planned discharge. Therefore, these clinical positions will need to become involved in order to implement the discharge IM notice delivery.

The duplication of IM notice delivery again near discharge is overkill and will also confuse Medicare beneficiaries. The additional costs to providers of requiring clinical staff to present the discharge IM exceeds any potential benefit and is another layer of bureaucracy that contributes to increased medical costs. I urge you to reconsider this requirement, and instead look at ways of insuring providers simply adhere to the present requirement of presenting the IM on or near admission.

Respectfully,

Michael Jex, CPAM
Director, Patient Account Services
Accounts Receivable Management

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January 23, 2007

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations – C
Attention: Bonnie L. Harkless
Room C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Comments: Revised Version – Important Message from Medicare (CMS-R-193)

To Whom It May Concern:

The following comments address the necessity and utility of the proposed information collection and the accuracy of the estimated burden on hospitals, pertaining to Revised Version of the Important Message from Medicare, as requested in a notice published in the January 5, 2007 issue of the Federal Register:

Medicare inpatients currently receive a copy of the Important Message from Medicare on admission. Requiring a signature from patient or family on the revised IM is a throwback to the 1980's, when the IM required a signature. This requirement was dropped in the 1990's, due to the excessive amount of time hospitals spent meeting that requirement for a variety of reasons – patient too ill, too painful, sedated, asleep, no family member present in room, etc. The majority of inpatients are admitted directly to the nursing units from the Emergency Dept., doctor's office, or home. The only scheduled inpatient admissions are generally for surgery or interventional procedures.

Coordinating the hand-off from the delivery of the initial IM from Patient Registration to Case Management for delivery of the IM copy will be an operational nightmare. Estimating discharge date two days in advance is particularly difficult, since most physicians cannot predict in advance that a patient will be stable enough for discharge. Often they do not know a patient will be ready for discharge until test results are available.

There is confusion as to how to handle situations where the primary insurance is a commercial carrier with Medicare as a secondary payor, when Medicaid is the secondary payor, or when the physician/UR Committee changes an inpatient to observation status, per condition code 44, prior to discharge.

Since there was no CMS pilot conducted, we question the accuracy of the time estimates to carry out the provisions of this rule. Three minutes per second IM copy to be delivered seems unreasonably low, considering it will take more than three minutes per case to decide who is to receive the copy.

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Estimating that only 1% of inpatients will exercise their right to appeal pending discharge, based on the number of HINN's (Hospital Issued Notice of Non-Coverage) currently issued, is an exceeding small percentage. Most hospitals have curtailed use of the HINN for continued stay, because it allows the patient 72 hours before assuming financial liability. Rather than serve a notice, Discharge Coordinators try to work with the patients and families to move them expeditiously to the next appropriate lower level of care.

CMS should consider delaying implementation until a hospital pilot is conducted to determine feasibility of projections and financial impact on hospital operations. This regulation will consume more hospital and QIO resources, increase length of stay, and will add one more thing to the rising cost of healthcare.

Sincerely,

Marvin D. Haas
Chief Administrative and Finance Officer

ASANTE® HEALTH SYSTEM

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January 22, 2007

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations – C
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Comments: Revised Version – Important Message from Medicare (CMS-R-193)

The following comments address the necessity and utility of the proposed information collection and the accuracy of the estimated burden on hospitals, pertaining to Revised Version of the Important Message from Medicare, as requested in a notice published in the January 5, 2007 issue of the Federal Register:

- Medicare patients already receive the Important Message on admission. Fifty to sixty percent of all inpatient admissions are from the emergency room or direct admits to the nursing units. In the late 1980's, hospitals were required to obtain a signature on the IM, but that requirement was dropped in the 1990's, because hospitals were spending too much unproductive time trying to get signatures from patients who were critically ill, unresponsive, sedated, asleep, away from the unit for a test or procedure, or in trying to chase down family members to sign for them. The only scheduled inpatients are generally surgical or interventional procedures. This means that the Registration staff will be spending more and more time going to the nursing units, encountering the same situations as listed above. Subsequently, the hand-off from the Registration staff (initial IM) to the Case Management staff for delivery of the IM copy will be a manual process and a coordination nightmare.
- Attempting to determine two days in advance that a patient will be ready for discharge means that the copy of the IM will be kept in a folder, with the Case Manager reviewing every admission everyday to ensure that the IM copy is delivered as mandated. Since the physician decides time of discharge, not nursing, that will necessitate having the physician give an estimated discharge date on a daily basis. Often they do not know a patient will be ready for discharge until test results are available. At that time, they expect to discharge the patient, not continue to make rounds because the IM wasn't presented beforehand. This second step is clearly redundant. Since CMS is requiring an elaborate and detailed explanation of the initial IM, this additional step is unnecessary, will require additional staff to administer, and will take considerably more than the 3 minutes estimated for the entire process - from tracking, to delivering, to explaining, once again, why the patient is receiving another copy.
- With the advent of condition code 44 for inpatients changed to outpatient observation per physician/UR Committee prior to discharge, will hospitals be required to retract the IM?
- What about patients who have Medicare as a secondary payor? Does the patient have the same appeals rights, even though the commercial payor and physician agree that the patient's condition is stable and ready for discharge? Who pays for the days while case is in appeal?
- What about patients who have Medicaid as a secondary payor to Medicare? Even if the QIO agrees with the hospital that the patient is ready for discharge, making the patient financially responsible for continued stay is meaningless (as it is now with the HINN).

- Inasmuch as there was no CMS pilot conducted on which to base the estimated burden, we have serious doubts as to accuracy of these projections. Three minutes per IM copy seems rather meager, considering it will take more than three minutes per person just to figure out who should be getting a second copy, and who received the initial IM within the two-day window and won't need the second copy.
- The estimate that only 1% of Medicare inpatients will probably initiate an appeal, based on current numbers of HINN's (Hospital Issued Notice of Non-Coverage) issued, is grossly underestimated in our opinion. At the two hospitals in this health system, there are less than 6 HINN's per year issued for lack of continued stay necessity for a variety of reasons. If a patient/ and or family are uncooperative in assisting with discharge plans, we try hard to engage them in the process. If it amounts to one-two extra days to get buy-in, we're still ahead, since if we served the HINN, they would have 72 hours before assuming financial responsibility.
- Hospitals follow InterQual criteria to determine with the physician when the patient is stable for discharge to the next appropriate level of care. Medicare patients often feel they are being discharged too soon. They are used to hospitalizations of the past, in which they might have lingered for a week or two following a hernia repair. In this new process, we will continue to remind them via the second IM copy that they really don't need to be discharged, before requesting a determination from the QIO that the physician and the hospital made the right decision. Depending on when the QIO reviews the record and issues a determination, that will result in another 2-3 days in the hospital before they are financially liable for continued stay.
- Our two hospitals track possibly avoidable days. In the last quarter, 95.4% of all possibly avoidable days were attributed to Medicare patients. Of those, 43% were awaiting alternate level placement. Because we review concurrently with commercial payors, those patients rarely stay beyond their certified days.
- **Final comment:** CMS should consider delaying implementation until an actual hospital pilot is conducted to determine reality based numbers and the financial impact on hospitals, taking into account the additional number of FTE's required to implement and sustain this process, as well as the number of delayed discharges that will occur as a result of the enormous focus this process places on alerting Medicare beneficiaries of their appeals option. As it stands now, this regulation will consume more hospital and QIO resources, increase length of stay, and contribute to the rising cost of healthcare, all for a population that already has more benefits and protection than any other of the public sector.

Thank you for allowing public comments.

Cam Christensen

Cam Christensen, RN, BS
Director of Resource Management
Asante Health System
Medford, Oregon

Enc: Summary of Final Rule (CMS-4105-F)

CC: Sen. Gordon Smith
Sen. Ron Wyden
Rep. Greg Walden
Rep. Peter DeFazio

Revised Version of Important Message from Medicare
Notification of Hospital Discharge Appeal Rights

***Background*:** The Centers for Medicare and Medicaid Services released a final rule published in the November 27, 2006 Federal Register on the Medicare discharge notice policy. The final rule mandates that hospitals deliver a revised version of the Important Message from Medicare (IM), which contains patients' rights and includes their discharge appeal rights, to all Medicare and Medicare Advantage inpatients within 2 calendar days of admission. The hospital must provide, explain, and obtain the beneficiary signature or that of his or her representative. A follow-up copy of the signed IM is given again as far as possible in advance of discharge, but no more than 2 calendar days before. Follow-up notice is not required if the provision of the admission IM falls within 2 calendar days of discharge. If a patient decides to appeal a pending discharge, a detailed notice is to be delivered to the beneficiary and the QIO, with necessary supporting documentation. When the beneficiary initiates an appeal, the QIO will issue a determination within 2 calendar days following receipt of the request and pertinent medical record information. The beneficiary is not financially responsible for inpatient hospital services furnished before noon of the calendar day after the date the beneficiary receives notification of the expedited determination by the QIO. The rule becomes effective July 1, 2007.

***Discussion*:** CMS estimates that the final rule will add to the operational burden as follows: An extra 11 minutes for each inpatient to deliver the IM, an additional 3 minutes per patient to give the IM copy before discharge (estimating that only 60% will require the second notice), and an additional 60 minutes for the detailed notice on appeal (estimating that only 1% will appeal). According to the November 27th issue of the Federal Register, in which the final rule is published, CMS did not do a pilot to reach their conclusions. The process supposedly is built on existing hospital notice requirements, and CMS states, "Thus, we do not believe that a pilot in either the proposed process or the proposed notices is appropriate or necessary." Since Patient Registration will assume responsibility for the initial IM notice on admission, and Resource Management will assume responsibility for the second IM notice prior to discharge, both departments will calculate the additional FTE's required to comply with this rule, based on the number of primary and secondary Medicare inpatient admissions per facility. Using FY 2006 information from MIRA for primary Medicare payor admissions and raw figures supplied by Decision Support for secondary Medicare admissions, the number of cases subject to the provisions of this rule are: RVMC = 6,922 and TRCH = 4,405.

A notice was published in the January 5th Federal Register, requesting comments on a revised version of the Important Message from Medicare (CMS-R-193). Comments should include feedback on the "necessity and utility of the proposed information collection and the accuracy of the estimated burden". Comments must be sent to:

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Division of Regulations Development – C
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