CMS-R-193 11 of 13

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

February 27, 2006

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attn: Bonnie L. Harkless
CMS-R-193, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Document Identifier: CMS-R-193
Agency Information Collection Activities: Proposed Collection; Comment Request
Published in the *Federal Register* of January 5, 2007 (72 FR 568-569)

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 proposed collection of information through a revised "The Important Message from Medicare" (OMB 0938-0692), which is used by hospitals to notify Medicare beneficiaries of their inpatient discharge appeal rights.

New regulations set forth in the final rule CMS-4105-F require hospitals to secure an appropriate signature on "The Important Message from Medicare" from every Medicare patient receiving inpatient services, including those enrolled in a Medicare Advantage managed care plan, within two days of admission. The hospital is also required to give a follow-up copy of the signed "Important Message" to the beneficiary within two calendar days before discharge. We recommend that CMS consider our suggestions for improving the "Important Message," the full cost of compliance, and a number of other issues in finalizing this form and the discharge notification process.

Ways to enhance the quality, utility, and clarity of the information to be collected

We have several suggestions for improving the revised "Important Message:"

- On page 2, the second bullet point erroneously refers to the QIO being available 24 hours a day. In Illinois, the beneficiary helpline at the QIO is currently staffed 8:00 a.m. to 4:30 p.m., Monday through Friday. CMS will need to articulate any special instructions that apply to evenings, weekends, and holidays so that the beneficiary is

11 of 2

familiar with applicable timeframes and knows what to expect. It would also be helpful to clarify that the beneficiary should contact the QIO whether they are enrolled in the original Medicare program or have elected a Medicare managed care product.

- The instructions for completion of the notice indicate that the hospital is to insert the name and telephone number of the Medicare Advantage plan on page 2 if the patient is an enrollee in such a plan; however, there is no designated place on page 2 to do this. We would suggest, however, that hospitals not be required to provide this information on the form. Beneficiaries enrolled in managed care plans frequently present their Medicare cards upon admission, and the hospital does not discover until later that the patient is in a Medicare Advantage plan. As a result, the hospital may not know at the time of admission that the beneficiary is not enrolled in the original Medicare program. If CMS believes the contact information for the health plans must be provided to beneficiaries, we recommend that CMS be responsible for creating and updating a list of plan names and telephone numbers and making it available to hospitals, rather than requiring individual hospitals to do this.

- The "Important Message" currently includes a single space for the date that the beneficiary or representative initially signed the form. We suggest that additional space be added for hospitals to record the dates that copies of the form are given to the patient.

- We would like to see more direct language that if the patient does not appeal the physician's discharge decision and elects to remain in the hospital, the beneficiary will be responsible for payment.

Accuracy of the estimated burden

CMS estimates that the revised regulations will increase the time for hospitals to deliver the "Important Message" from an estimated one minute per beneficiary to 13.8 minutes on average for the delivery of the two notices, with 13 million beneficiaries receiving the initial notice and 60 percent of beneficiaries with inpatient stays of more than three days (or 7.8 million) also receiving a copy of the signed notice closer to discharge. CMS indicates in the final rule CMS-4105-F that it will take the hospital an average of 12 minutes to deliver the initial revised "Important Message" and obtain a signature, and that the follow-up delivery of a copy of the notice will take an average of three minutes per patient.

We believe that CMS has underestimated the length of time it will take the hospital to deliver the second notice to the beneficiary. We can only assume that CMS arrived at three minutes per patient by envisioning a process that requires staff working near the patient's room to remove a copy of the signed "Important Message" from the patient's chart and hand-deliver it to the patient without any explanation whatsoever.

What has not been taken into consideration is the time to explain the form again to the beneficiary or the beneficiary's representative, to locate the beneficiary's representative if the beneficiary is not able to understand the form, or to secure any necessary translator services. It also does not account for the fact that hospitals may designate staff in departments not physically located by the patients' rooms (e.g., discharge planning, social work, patient representatives) to deliver the notice. Finally, the estimate does not consider

situations where multiple copies of the "Important Message" will need to be delivered to the patient if a discharge occurs later than initially expected for whatever reason. CMS will need to clarify its expectations for delivery of the copy and to better take into account how this delivery occurs.

Additional Issues

As CMS develops a Medicare transmittal to communicate its administrative instructions on implementation of the revised "Important Message," we ask that the following issues be addressed:

- Do the procedures apply to beneficiaries with Medicare Part B only benefits?
- Who meets the definition of the patient's representative? We suggest that a liberal definition be adopted.
- 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?
- How is the QIO staffed for these changes? Will the QIOs be provided enhanced funding for additional staffing so appropriate access and services are available seven days a week?
- What information will CMS develop for hospitals to share with physicians to educate them about this new process?

Further Information

Thank you again for the opportunity to review CMS' proposed changes to the "Important Message" 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

Susan W. Melczer
Director, Patient Financial Services

17

CMS-R-193

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

Heather Freiheit, RN, BSN
Clincal Manager, Emergency Services
Rogue Valley Medical Center
2825 E Barnett Road
Medford OR 97504-8332

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

I am writing this letter to express my concern with the plan to initiate a second distribution of the *Important Message From Medicare* (IM). Currently patients receive the IM at their initial entry into the hospital and confirm acceptance via a signature. If the mandate is enacted to give patients a second copy of the IM two days prior to discharge; I believe not only will this be an operational nightmare for the hospitals to implement there will also be a high incidence of failure and non-compliance.

This failure will not come from lack of trying but the inability of case managers, discharge planners, etc. to accurately know 48 hours prior to a physician's plan to discharge the patient. Frequently, the physician's decision to discharge the patient is a result of a final test or study result. In addition, with the increased use of Hospitalists, a different doctor may be the attending physician for the patient each day. As it is, currently just obtaining an estimated discharge date form the doctors is challenging enough for long-term placement and Home Health follow-up. With the confusion around how to give and who will need to receive the IM, if the patient also has a commercial or secondary payor it doesn't seem realistic to assume re-delivering the 2nd IM will only take 3 minutes. Frequently, patients will be too ill, tired, or medicated to receive the form and there may not be any family present to take the IM.

Although I can appreciate the initial vision of the 2nd IM, since only a small percentage of in-patients exercise their right to appeal. It seems as if hospitals would make better use of their staff's time and valuable resources to work on patient placement or discharge to facilitate hospital room turnover and decrease the length of stay.

I am urging CMS to re-evaluate the feasibility of this plan and asking you to please re-evaluate if a second IM is really necessary or will it be a financial strain and labor intensive for hospitals who are already struggling with finding qualified staff and trying to be fiscally responsible.

Thank you,

Heather Freiheit, RN, BSN

FRANKLIN MEMORIAL HOSPITAL
A Caring Hospital for a Healthy Community

13

CMS-R-193

February 13, 2007

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

To Whom It May Concern:

This is a response to CMS–R–193, your proposal of issuance of an additional Important Message from Medicare at an acute care facility.

We fail to see the purpose or advantage of this practice. Medicare **already** has a denial process in place for inpatient stay. This process **(Hospital Issued Notices of Non-coverage)** covers all possible instances, i.e. admission, continued stay and/or refusal of a skilled bed. They include notification and review by your QIOs to protect the recipients and insure correct Medicare utilization. What you propose is redundant.

Our average length of stay is 3.6 days. Therefore, we would have to issue the notice at admission or the next day. When a patient is acutely ill, the stress and anxiety of the illness or procedure should not be compounded by what is perceived as a threat of (non-payment) financial responsibility for their stay. No matter how eloquent the explanation, experience shows that "hearing" stops with the word **"denial"** or "if you stay in the hospital after your planned date of discharge, it is likely that your charges for additional days in the hospital **will not be covered by Medicare or your Plan."** This type of anxiety can prolong the illness **or** encourage the patient to leave before they are medically stable.

The government has the QIO, C-DAK, PEPPER, JCAHO, the Fiscal Intermediary, and state licensing and regulatory agencies monitoring hospital's acute care management and patient outcomes as well as Medicare's fiscal utilization. In this day and age of sky rocketing health care costs, it is irresponsible to require a redundant program that requires an increase use of resources and personnel to manage. It will inevitably cause delays in discharge, which again will increase health care costs.

Sincerely,

Gerald R. Cayer
Chief Operating Officer

David Dixon, MD
VP, Medical Staff Affairs & Education

Peter Cordner, DO
Hospitalist

111 Franklin Health Commons Farmington, ME 04938
Tel: 207-778-6031 ME 800-398-6031 TTY: 207-779-2662 Fax: 207-779-2548 www.fchn.org
An Affiliate of Franklin Community Health Network

CMS R-193 14 g

Harkless, Bonnie (CMS/OSORA)

From: Malamud, Matthew [mmalamud@aha.org]

Sent: Tuesday, March 06, 2007 10:07 AM

To: Harkless, Bonnie (CMS/OSORA)

Subject: RE: Important Message from MedicareUse: Requirements that hospita ls notify beneficiaries in inpatient hospital settings of their rights as a hospital patient...

Attachments: Important Message Revision Comment Letter 030607.pdf

Dear Ms. Harkless:

The AHA appreciates the opportunity to comment on the information request published in the Federal Register (Vol. 72, No. 3) on Friday, January 5, 2007. Attached as a pdf are our comments. Thank you.

Sincerely,

Matthew M. Malamud
Executive Assistant, Policy
American Hospital Association
325 Seventh Street, NW, STE 700
Washington, DC 20004
202.626.3754
202.626.4626 Fax
mmalamud@aha.org
www.aha.org

3/6/07
spoke to Matthew to inform him that comment should not be sent electronically. He should follow the FR. instructions & send them via the mail. Matthew noted that the original was sent to Tim Miller in DC.

American Hospital Association

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

14 of 6

March 6, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS Proposed Revision of Important Message from Medicare and Related Paperwork Requirements (Vol. 72, No. 3), January 5, 2007

Dear Ms. Norwalk:

The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed revision of the "Important Message from Medicare" (IM) and its related paperwork requirements as submitted to the Office of Management and Budget. This revision seeks to implement the revised regulations on notification of Medicare beneficiaries regarding their hospital discharge appeal rights, which were published on November 27, 2006 in the *Federal Register*.

AHA appreciates the extent to which CMS responded to many of the practical problems identified in our comments on the proposed rule. While the final regulation is much more workable, it still represents a significant increase in burden on hospitals. Our comments on the proposed notice package now focus on how to minimize that burden, where possible, and resolve open questions regarding the notice and appeal process.

MINIMIZING ADMINISTRATIVE BURDEN FOR HOSPITALS

Currently, hospitals provide the IM to beneficiaries when they are admitted to the hospital, generally in the patient's admission package. The IM explains a beneficiary's right to have their discharge decision reviewed by the local Quality Improvement Organization (QIO) if they believe they are being discharged too soon. The notice provides all the information needed by a beneficiary to request such an appeal and explains that they will not be held financially liable for continued hospital care while the QIO reviews their case. A more detailed notice with specific reasons why hospital care is no longer required is provided when beneficiaries indicate that they are not comfortable with the planned discharge date.

14 of 3

Under the new regulations, which take effect on July 1, the IM will be provided to beneficiaries no later than two days following admission, but hospital staff must ensure that the beneficiary understands the notice and signs a copy of it documenting when he or she received it and that they understand it. A copy of the signed notice will be given to him or her at that time. The hospital must then provide another copy of the signed notice no more than two days prior to discharge. Detailed information about a particular discharge will be required only when a beneficiary requests a QIO review. We believe that focusing the process and beneficiary questions on the front-end of the admission will help form more realistic beneficiary expectations about hospital admissions and improve their understanding of how decisions are made and how the discharge planning process works. However, it comes at a heavy price.

Even with the conservative burden estimate included in the paperwork clearance package, CMS projects that the burden will increase from 208,333 hours to 2,990,000 hours – a more than fourteen-fold increase. And, while the former notice was provided by admissions clerks, the new process requires someone with the ability to explain medical necessity and the discharge planning process – generally a nurse case manager or social worker – to present the paperwork. The national average hourly wage for clerks is about $12.50, while the average hourly wage for nurses and social workers is about $24.00 – $28.00. Conservatively, that takes the cost from about $2.6 million to between $71.8 and $83.7 million.

Even though it might require some minor adjustments to the final rule, ***AHA urges CMS to take the following actions to minimize the administrative burden of this new notice and process:***

- ***Eliminate the requirement that the repeat notice at discharge be a copy of the notice signed at admission.*** Since beneficiaries would receive a copy of the signed notice when they sign it, it would be simpler and less burdensome to allow hospitals to provide just the generic notice language at discharge. We have heard from some hospitals that it would be significantly more efficient to simply print the notice as part of their discharge instruction package.

- ***After the first year of implementing this new process, perform an evaluation of whether the new process has yielded sufficient benefit to warrant this significant increase in administrative costs.*** Too often, administrative requirements are adopted to address anticipated or perceived problems. That has already happened once with this requirement. It was adopted by statute when the inpatient prospective payment system was enacted and there were widespread fears of "quicker, sicker" discharges. Those fears were not realized. There also was an earlier requirement for beneficiaries to sign for receipt of the notice; that too was found to be unnecessary and subsequently eliminated.

- ***Provide significant latitude to hospitals in how they provide the notice to beneficiary representatives if the beneficiary is unable to receive or understand the notice.*** This issue was raised during comment on the proposed rule, and the preamble discussion of the final rule indicated that CMS planned to provide guidance regarding how hospitals and health plans may deliver the appropriate notice in cases where a beneficiary's representative may not be immediately available. Such guidance was not included in the instructions for the notice. We urge CMS to allow hospitals to use any means of communication (telephone, fax, email, etc.) necessary to conduct the notice process with beneficiary representatives and allow record notations when these alternatives to in-person notice are used.

14 94

- ***Provide on CMS' Web site the text of the notice translated into the top 15 languages hospitals frequently encounter.*** Almost one-fifth of the U.S. population speaks a language other than English at home. Hospitals are required to provide language services for such individuals, but they do not receive compensation for the cost of those services. The size of this population and the vast number of languages now being encountered make it very difficult for individual hospitals to provide translated documents. Since the text of this notice cannot be altered by the hospital, CMS should obtain and provide translations of the key beneficiary notices. The Social Security Administration has a list of 15 languages that it uses for such purposes. Last year, the AHA's research affiliate, the Health Research and Educational Trust, conducted a survey of hospital language services which found 15 languages that at least 20 percent of hospitals encounter frequently. They are: Spanish; Chinese; Vietnamese; Japanese; Korean; Russian; German; French; Arabic; Italian; Laotian; Hindi; Polish; Tagalog; and Thai.

NEEDED CLARIFICATIONS

There are several clarifications that would be helpful in the notice and instructions.

- ***Clarify on the first page of the notice that beneficiaries have the right to receive "medically necessary" hospital services covered by Medicare.*** Beneficiaries need to understand that the standard is medical necessity, not what they think is needed.

- ***Issue instructions to the QIOs regarding their required availability 24/7 to deal with beneficiary appeals.*** The current QIO manual indicates that QIOs are not required to be available 24 hours a day, only during normal business hours. They are required to have an answering machine to take messages, but they are not required to pick up or return messages until the next business day. Page 2 of the notice is inconsistent with the QIO manual.

- ***Reconcile the notice form and the instructions for completing the notice for Medicare Advantage plan enrollees.*** Hospitals are told to fill in the name and telephone number of the Medicare Advantage plan for enrolled beneficiaries, but there is no place on the form to do so.

If you have questions about our comments, please contact me or Ellen Pryga, AHA director for policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

cc: Bonnie L. Harkless

15 of 1
CMS-R-193

Memorandum

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

From: Jackie Birmingham, RN, MS, CMAC
VP Professional Services
Curaspan, Inc./ the eDischarge Company
70 Bridge Street, Suite 201
Newton, MA 02458
jbirmingham@curaspan.com
CT office: (860)668-7575
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Jackie Birmingham, RN, MS, CMAC
Vice President, Professional Services

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jbirmingham@curaspan.com

[redacted]

Date: March 2, 2007

Re: Comment on a Revised Version of the Important Message from Medicare

"Important Message from Medicare (IM) (CMS-R-193)

Dear Ms. Harkless,

As a health professional working in the acute care setting, and in particular discharge planning services, I support the initiative to inform Medicare Beneficiaries of their rights to participate in their discharge plan and their right to appeal their discharge. Currently I am working for a company that provides discharge planning software that is a web-based work flow tool that connects hospitals with post-acute providers to facilitate the discharge planning process. Because of this I am acutely aware of the challenges facing hospitals and Medicare beneficiaries.

I have reviewed the proposed IM and wish to recommend some changes in the working and sequence of information. As an aside to this letter, I wanted to let you know that I am a member an organization that is also submitting comments (The American Case Management Association). I wanted to also make comments as an individual and as a Medicare Beneficiary. For your convenience, I have enclosed three documents. The first is the proposed IM (yellow) , the second is the proposed IM with recommended changes, and the third (pink) is the way the IM would look if all of the recommended changes are accepted.

I look forward to tracking this very important project.

Jackie Birmingham, RN, MS
March 2, 2007

OMB Approval No. 0938-0692

15 of 2

AN IMPORTANT MESSAGE FROM MEDICARE

(Please Read Carefully)

Patient Name _____ Patient ID Number _____

Attending Physician _____ Date of Notice _____

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare or covered by your Medicare Health Plan (your "Plan") if applicable..
- You have the right to be involved in any decisions that the hospital, your doctor, your Plan or anyone else makes about your hospital stay.
- You have the right to receive services you need after you leave the hospital (that is, after you are "discharged").
- *You have a right to know about these services, and the have freedom to choose where you will get services.*
- *You will be offered a choice between appropriate and available agencies or services ordered by your physician.*
- Medicare or your Plan may cover some of these services if ordered by your doctor

YOUR HOSPITAL DISCHARGE AND MEDICARE APPEAL RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you and your doctor (and your Plan, if applicable) to plan for your discharge and arrange for services you may need after you leave the hospital. When your doctor decides you no longer need hospital care and can safely receive care in another setting, you will be informed of a discharge date

If you think you are being discharged too soon:

- Talk to the hospital staff and your doctor (and your Plan, if applicable) about your concerns.
- If you are not satisfied with the discharge plan, you have the right to request an appeal
- The appeal process involves an independent review from the Quality Improvement Organization (QIO) in your area.
- If you are concerned about your discharge you should contact the QIO as soon as possible after you are informed of your discharge date, but before you leave the hospital
- Staff at the QIO will give you and your doctor a second opinion about whether you are ready to leave the hospital.
- If you appeal your discharge by your discharge date, your hospital services will continue to be paid by Medicare, or your health plan, during the appeal process.

Page 2 outlines the appeal process and how to contact your QIO.

Please sign below to show that you have received this notice and understand it.

_____ _____

Signature of Patient or Representative Date

15 of 3

PAGE 2: HOW TO ASK FOR AN IMMEDIATE APPEAL OF YOUR DISCHARGE

- If you want to request an appeal about your discharge, you should contact the Quality Improvement Organization (QIO) as soon as possible after you are informed of your discharge date, but before you leave the hospital.
- **If you request an appeal by your discharge date, your hospital services will continue to be paid during the QIO review until at least noon of the day after the QIO notifies you of its decision.**
- Here is the contact information for the QIO: _____{insert name and number of the QIO}_____.
- The QIO accepts requests for appeals 24 hours a day. You may also call the QIO if you have questions about the appeal process.
- If you request an appeal, you and the QIO will both receive an explanation from your doctor and the hospital staff, if applicable, that explains the reasons that your doctor determined that you are ready to be discharged.
- The QIO will ask for your concerns related to your discharge, and review the information about your medical condition provided by your doctor and the hospital. . You do not have to prepare anything in writing, but you or your representative have the right to give the QIO a written statement or any information you wish. You or your representative should be available to speak with the QIO.
- The QIO will notify you of its decision within one day after it receives all necessary information.
    - If the QIO agrees that you are not ready to be discharged, Medicare will continue to cover your hospital services that are medically necessary.
    - If the QIO finds you are ready to be discharged you will be responsible for payment of your hospital services beginning at noon of the day after the QIO notifies you of its decision until you are discharged.

YOU ALSO HAVE APPEAL RIGHTS AFTER YOU HAVE BEEN DISCHARGED:

- **If you have Original Medicare:**
    - If you were notified of your date of discharge and disagreed with the date, but did not appeal before you were discharged, you may still ask the QIO to review your hospital stay.
        - The hospital can charge you immediately for services you received after your planned date of discharge.
    - If the QIO decides your Medicare coverage should have continued after you have made payments, you will receive a refund.
    - A bill for your hospital services will be submitted to Medicare by the hospital.
        - You will receive a Medicare Summary Notice (MSN) regarding the decision on your appeal and your right to appeal that decision.

- **If you belong to a Medicare Health Plan:**
    - If you do not request an appeal by your discharge date, you may still ask the QIO for a review of your hospital stay. However, if your health plan decides discharging you was the appropriate decision, you may be responsible to pay for any hospital services you receive after your discharge date from the hospital.

Consult your Medicare Handbook or call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about this notice and the Medicare claims appeal process.

OMB Approval No. 0938-0692

15 dy

AN IMPORTANT MESSAGE FROM MEDICARE

(Please Read Carefully)

Patient Name _____ Patient ID Number _____

Attending Physician _____ Date of Notice _____

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare or covered by your Medicare Health Plan (your "Plan") if applicable.
- You have the right to be involved in any decisions that the hospital, your doctor, your Plan or anyone else makes about your hospital stay.
- You have the right to receive services you need after you leave the hospital (that is, after you are "discharged").
- *You have a right to know about these services, and the have freedom to choose where you will get services.*
- *You will be offered a choice between appropriate and available agencies or services ordered by your physician.*
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YOUR HOSPITAL DISCHARGE AND MEDICARE APPEAL RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you and your doctor (and your Plan, if applicable) to plan for your discharge and arrange for services you may need after you leave the hospital. When your doctor decides you no longer need hospital care and can safely receive care in another setting, you will be informed of a discharge date.

If you think you are being discharged too soon:

- Talk to the hospital staff and your doctor (and your Plan, if applicable) about your concerns.
- If you are not satisfied with the discharge plan, you have the right to request an appeal.
- The appeal process involves an independent review from the Quality Improvement Organization (QIO) in your area.
- If you are concerned about your discharge you should contact the QIO as soon as possible after you are informed of your discharge date, but before you leave the hospital.
- Staff at the QIO will give you and your doctor a second opinion about whether you are ready to leave the hospital.
- If you appeal your discharge by your discharge date, your hospital services will continue to be paid by Medicare, or your health plan, during the appeal process.

Page 2 outlines the appeal process and how to contact your QIO.

Please sign below to show that you have received this notice and understand it.

_____ _____

Signature of Patient or Representative Date

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You should contact your QIO as soon as possible after you are informed of your discharge date, but before you leave the hospital.

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PAGE 2: HOW TO ASK FOR AN IMMEDIATE APPEAL OF YOUR DISCHARGE

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- Here is the contact information for the QIO: _____ {insert name and number of the QIO} _____.
- The QIO accepts requests for appeals 24 hours a day. You may also call the QIO if you have questions about the appeal process.
- If you request an appeal, you and the QIO will both receive an explanation from your doctor and the hospital staff, if applicable, that explains the reasons that your doctor determined that you are ready to be discharged.
- The QIO will ask for your concerns related to your discharge and review the information about your medical condition provided by your doctor and the hospital. You do not have to prepare anything in writing, but you or your representative have the right to give the QIO a written statement or any information you wish. You or your representative should be available to speak with the QIO.
- The QIO will notify you of its decision within one day after it receives all necessary information.
    - If the QIO agrees that you are not ready to be discharged, Medicare will continue to cover your hospital services that are medically necessary.
    - If the QIO finds you are ready to be discharged, you will be responsible for payment of your hospital services beginning at noon of the day after the QIO notifies you of its decision until you are discharged.

YOU ALSO HAVE APPEAL RIGHTS AFTER YOU HAVE BEEN DISCHARGED:

- **If you have Original Medicare:**
    - If you were notified of your date of discharge and disagreed with the date, but did not appeal before you were discharged, you may still ask the QIO to review your hospital stay.
        - The hospital can charge you immediately for services you received after your planned date of discharge.
    - If the QIO decides your Medicare coverage should have continued after you have made payments, you will receive a refund.
    - A bill for your hospital services will be submitted to Medicare by the hospital.
        - You will receive a Medicare Summary Notice (MSN) regarding the decision on your appeal and your right to appeal that decision.
- **If you belong to a Medicare Health Plan:**
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Consult your Medicare Handbook or call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about this notice and the Medicare claims appeal process.

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OMB Approval No. 0938-0692

15 JS

AN IMPORTANT MESSAGE FROM MEDICARE

(Please Read Carefully)

Patient Name _____ Patient ID Number _____

Attending Physician _____ Date of Notice _____

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare or covered by your Medicare Health Plan (your "Plan") if applicable..
- You have the right to be involved in any decisions that the hospital, your doctor, your Plan or anyone else makes about your hospital stay.
- You have the right to receive services you need after you leave the hospital (that is, after you are "discharged").
- *You have a right to know about these services, and the have freedom to choose where you will get services.*
- *You will be offered a choice between appropriate and available agencies or services ordered by your physician.*
- Medicare or your Plan may cover some of these services if ordered by your doctor

YOUR HOSPITAL DISCHARGE AND MEDICARE APPEAL RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you and your doctor (and your Plan, if applicable) to plan for your discharge and arrange for services you may need after you leave the hospital. When your doctor decides you no longer need hospital care and can safely receive care in another setting, you will be informed of a discharge date

If you think you are being discharged too soon:

- Talk to the hospital staff and your doctor (and your Plan, if applicable) about your concerns.
- If you are not satisfied with the discharge plan, you have the right to request an appeal
- The appeal process involves an independent review from the Quality Improvement Organization (QIO) in your area.
- If you are concerned about your discharge you should contact the QIO as soon as possible after you are informed of your discharge date, but before you leave the hospital
- Staff at the QIO will give you and your doctor a second opinion about whether you are ready to leave the hospital.
- If you appeal your discharge by your discharge date, your hospital services will continue to be paid by Medicare, or your health plan, during the appeal process.

Page 2 outlines the appeal process and how to contact your QIO.

Please sign below to show that you have received this notice and understand it.

_____ _____

Signature of Patient or Representative Date

15 of 22

PAGE 2: HOW TO ASK FOR AN IMMEDIATE APPEAL OF YOUR DISCHARGE

- If you want to request an appeal about your discharge, you should contact the Quality Improvement Organization (QIO) as soon as possible after you are informed of your discharge date, but before you leave the hospital.
- **If you request an appeal by your discharge date, your hospital services will continue to be paid during the QIO review until at least noon of the day after the QIO notifies you of its decision.**
- Here is the contact information for the QIO: _____{insert name and number of the QIO}_____.
- The QIO accepts requests for appeals 24 hours a day. You may also call the QIO if you have questions about the appeal process.
- If you request an appeal, you and the QIO will both receive an explanation from your doctor and the hospital staff, if applicable, that explains the reasons that your doctor determined that you are ready to be discharged.
- The QIO will ask for your concerns related to your discharge, and review the information about your medical condition provided by your doctor and the hospital. . You do not have to prepare anything in writing, but you or your representative have the right to give the QIO a written statement or any information you wish. You or your representative should be available to speak with the QIO.
- The QIO will notify you of its decision within one day after it receives all necessary information.
    - If the QIO agrees that you are not ready to be discharged, Medicare will continue to cover your hospital services that are medically necessary.
    - If the QIO finds you are ready to be discharged you will be responsible for payment of your hospital services beginning at noon of the day after the QIO notifies you of its decision until you are discharged.

YOU ALSO HAVE APPEAL RIGHTS AFTER YOU HAVE BEEN DISCHARGED:

- **If you have Original Medicare:**
    - If you were notified of your date of discharge and disagreed with the date, but did not appeal before you were discharged, you may still ask the QIO to review your hospital stay.
        - The hospital can charge you immediately for services you received after your planned date of discharge.
    - If the QIO decides your Medicare coverage should have continued after you have made payments, you will receive a refund.
    - A bill for your hospital services will be submitted to Medicare by the hospital.
        - You will receive a Medicare Summary Notice (MSN) regarding the decision on your appeal and your right to appeal that decision.

- **If you belong to a Medicare Health Plan:**
    - If you do not request an appeal by your discharge date, you may still ask the QIO for a review of your hospital stay. However, if your health plan decides discharging you was the appropriate decision, you may be responsible to pay for any hospital services you receive after your discharge date from the hospital.

Consult your Medicare Handbook or call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about this notice and the Medicare claims appeal process.

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

16 of 1

February
Twenty-Seven
2007

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

RE: Agency Information Collection Activities: Proposed Collection; Comment Request
Document Identifier: CMS – R – 193
Important Message from Medicare
OMB #: 0938 – 0692

To Whom It May Concern:

Greater New York Hospital Association (GNYHA) represents more than 175 not-for-profit and public hospitals in New York State, New Jersey, Connecticut, and Rhode Island. We welcome the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) notice for the proposed paperwork collection for document identifier CMS – R – 193.

CMS is seeking public comment on a revised version of the Important Message from Medicare (IM) whereby beginning July 1, 2007, hospitals must deliver the IM to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. This notice will be required for original Medicare beneficiaries and for those enrolled in Medicare health plans.

We appreciate CMS's attempt to create an enhanced process for informing Medicare beneficiaries of their discharge appeal rights; however, GNYHA does not believe that CMS accurately calculated the burden estimate. In addition, GNYHA is submitting additional remarks with respect to enhancing the quality, utility, and clarity of the information to be collected. Our comments and recommendations are summarized as follows:

- CMS has significantly underestimated the cost burden on providers by failing to consider the additional expenses and work effort that providers will incur to: a) issue the follow up IM to *all* Medicare beneficiaries; b) pursue signatures from the authorized representative at admission and prior to discharge when the patient is not capable of comprehending the

IM; and c) develop and purchase specialized carbonless multi-page forms to demonstrate compliance with this new Medicare regulation.

- The revised IM is materially inaccurate with respect to the stated hours that the QIO is available to accept and process discharge appeals. In addition, because of the time-sensitive nature of requesting a discharge appeal, the IM should be revised to include a brief explanation to make the Medicare beneficiary aware of potential financial liabilities.
- The revised IM does not contain fields for annotating the health plan name and telephone number as outlined in the draft instructions. For reasons that we outline later, GNYHA believes this information requirement should be eliminated in any case since it will not be materially useful to the Medicare beneficiary.
- CMS should consider all reasonable alternative solutions so that hospital staff members do not have to manually annotate the patient name, patient ID number, and physician name on the IM.
- CMS should accept mail, fax, and e-mail as acceptable alternatives for issuing the IM at admission and in advance of discharge when the patient is not competent to understand the IM and the authorized representative is not physically present to receive the notice.

Accuracy of the Estimated Burden

While we appreciate that CMS has attempted to lessen the burden on the provider and will not require that the follow up IM be re-issued if the original delivery and signing of the IM took place within 2 days of discharge, we believe that CMS has understated the cost burden. Suggesting that hospitals implement a process that on an exception basis uses length of stay as a proxy to decide which Medicare patients receive the follow-up IM, as a practical matter is not dependable and could cause some patients to be unintentionally overlooked. It is likely that hospitals will need to establish a uniform notification process for short- and long-stay admissions so that every Medicare patient is included in the re-issuance of the copy of the signed IM, not just patients with longer lengths of stay (i.e., > 3 days). Therefore CMS's estimate of the financial burden is inaccurate in that it only calculates the expense associated with issuing the IM for non-short-stay admissions, that is, 60% of the total Medicare fee-for-service and health plan inpatient hospital discharges. Consequently, the total annual burden associated with delivering a copy of the signed IM to 13 million enrollees will be 650,000 hours—not 339,000 hours—and therefore approximates a cost of $975,000 rather than $508,500.

GNYHA is also concerned that CMS has not addressed the significant work effort that hospital staff will expend to obtain the signature of the authorized representative when the patient is not capable of comprehending and signing the IM at or near the time of admission. This situation occurs often when a nursing home resident is hospitalized and/or a Medicare patient is admitted to a critical care area. We do not believe CMS has considered the additional time to attend the patient on the unit after admission to deliver and explain the IM. Similarly, CMS's estimate does not capture the expense associated with contacting the next of kin by telephone after it is determined that the patient cannot receive visitors or comprehend the notice. In addition, CMS has not accounted for the cost associated with overnight mailing and/or faxing the IM when it is issued via telephone.

Finally, we expect that hospitals will encounter significant additional expense to demonstrate compliance with the new Medicare regulation. Based on preliminary conversations with hospital staff, we are aware that many providers are planning to incorporate a carbonless paper multiple page form or similar manual process to demonstrate compliance and to ensure that: a) the patient signature is recorded on admission; b) a copy of the signed admission IM is retained and then reissued at or near the time of discharge; and c) a chart copy is preserved for the medical record (as evidence of compliance). The CMS cost estimates clearly do not reflect the additional expense to providers to develop and purchase these specialized forms.

Enhancing the Quality, Utility and Clarity of Information Collected

The revised IM published in the Federal Register on January 5, 2007, is materially inaccurate in the following regard. Currently, the Quality Improvement Organization (QIO) is "available" seven days a week to accept requests for appeals; however, this availability is limited to normal business hours. The revised IM suggests that the QIO accepts requests for appeals 24 hours a day. It would be less confusing if the IM stated: "QIO staff is available to accept requests for appeals seven (7) days a week, including holidays, during normal business hours (e.g., 8:30 a.m. to 4:30 p.m.). After hours, you may leave a message and your call will be returned the following day during normal business hours." It is important to provide this distinction because of the time-sensitive nature of requesting a QIO appeal and to prevent the Medicare beneficiary from incurring any unnecessary financial liability. CMS should incorporate language that clearly underscores the importance of requesting the discharge appeal in a timely fashion.

In addition, the revised IM does not contain a field for annotating the health plan name and telephone number even though the draft notice instructions direct that this information be completed. GNYHA believes that CMS should eliminate this requirement unless it mandates that its contracted health plans designate a dedicated telephone number as a centralized contact for enrollees who have discharge appeal questions. Because providers typically encounter an exhaustive and confusing menu of telephone options in their daily dealings with health plans, we believe it is unrealistic that the Medicare beneficiary will be able to negotiate the multiple prompts in a way that is helpful and minimally confusing. Unless CMS enforces that its contracted plans establish a dedicated phone number and posts these numbers on its Web site (www.cms.gov), any generic number that a provider inserts will have limited value for the Medicare beneficiary.

The revised IM should also be amended to permit hospitals that elect to utilize a carbonless paper multiple page form to insert an additional signature line and date line to reflect when and to whom the follow-up IM was issued.

Use of Automated or Alternative Collection Techniques

To minimize the work burden of manually annotating the IM with the patient name, patient ID number, and attending physician, we ask that CMS accept certain automated and otherwise simplified solutions for completing these data fields. Many hospitals utilize addressograph plates or peel off labels to imprint patient information on each document contained in the medical record. This information typically consists of the following data points: patient name, patient

account number, medical record number, sex, age, unit, date of birth, admission/registration date, room/bed location, hospital service and attending physician's name. We ask that CMS endorse all reasonable technology that may be available to providers in order to streamline completion of the IM and to reduce manual work effort.

We believe that it should only be necessary to record the date once on the IM: at the time that the beneficiary or authorized representative signs the notice. If the authorized representative is not available to sign the notice and it is explained via telephone, it should suffice that the hospital worker issuing the notice annotate the applicable date and that it was issued via phone.

As previously explained, patients may not be competent to understand and sign the IM upon admission and, furthermore, may not be accompanied to the hospital by a family member or authorized representative. In these instances, CMS should consider mail, fax, and e-mail as acceptable alternatives for issuing the IM at admission and in advance of discharge.

We appreciate your consideration of these comments. If you have any questions please contact Lillian Forgacs, Associate Vice President Utilization Management and Managed Care, at (212) 506-5534 or forgacs@gnyha.org.

Sincerely,

Kenneth E. Raske
President