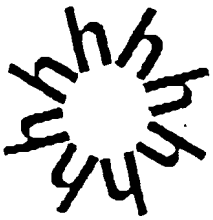


Rural Wisconsin
Health Cooperative

(1) 1 of 3

CMS-R-193

April 18, 2007

OMB Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building
Room 10235
Washington, DC 20503

RE: Notification Procedure for Hospital Discharges - Comments on the Proposed I nformation Collections for the Important Message

To Whom It May Concern:

Rural Wisconsin Health Cooperative is owned and operated by 30 rural Wisconsin hospitals, and as such, are committed to advocacy for rural hospitals as well as to ensure equitable processes for Medicare beneficiaries at PPS and CAH hospitals alike.

My first concern regards the fact that CMS has noted timing of the initial or follow-up notice to be 1 or even 2 days before discharge – and when the hospital cannot anticipate the discharge, it should deliver the IM/follow-up as soon as the discharge can be anticipated. In as much as the initial final rule established that discharge date determination is more difficult to ascertain on acute care patients for a multitude of reasons, I question why the first page of the IM includes the statement "If you don't feel like you have enough time to consider your appeal rights, call 1-800-Medicare (1-800-633-4227), or TTY: 1-877-486-2048". This infers additional rights upon their dissatisfaction, invites beneficiary complaints about the system, and may incite unnecessary confusion about the appeal process. Given that FAQ under section IV Q1 has noted that hospitals may not establish policies that allow the follow up copy of the IM to be delivered routinely to patients on the day of discharge, I encourage CMS remove that bullet off the first page of the IM – and/or to at least revise the verbiage to only inform the beneficiary to call 1-800-Medicare if there are further questions/concerns regarding a hospital discharge process.

My second concern regards page 2 of the notice - Steps to Appeal your Discharge, Step 1. Here it indicates that the patient should notify the "...QIO no later than your planned discharge date and before you leave the hospital. If you do this you will not have to pay for the services you receive during the appeal (except for copays and deductables)." You noted that the beneficiary must appeal before their planned discharge date –

880 Independence Lane • P.O. Box 490 • Sauk City, Wisconsin 53583 • (608) 643-2343 • FAX (608) 643-4936 • www.ruhc.com

2 of 3

however, you also note that they won't be responsible/won't have to pay for services during the appeal. Therefore, the beneficiary could interpret this to mean that IF the hospital gave them the notice on day 2 to be discharged on day 3 – and if they appealed on day 2, they wouldn't have to be responsible for anything after day 2, which is even prior to the planned discharge date. The hospital should not ever be held liable for those services provided prior to the anticipated discharge date; therefore, I encourage this language to be more specific.

I also have comments regarding the timing of the notice noting liability/charging issues. Whereas this language states that the beneficiary will not be financially responsible for services provided after the appeal, it infers that the hospital may not bill for anything after they appeal. I encourage CMS to clarify if this truly infers that the hospital will not be able to bill for services after planned discharge date/appeal date – or if this means that the patient will not be billed for those services. For example, if the patient were delivered the notice on day 2 and decides to appeal on day three (day of discharge), please further inform if ALL meds dispensed after appeal will be able to be reported/billed to the account. I strongly encourage these services/meds to be allowed to be included within the patient account so that hospitals aren't burdened with unnecessary pharmaceutical costs.

Furthermore, if patients are not to be liable for services after the appeal, then this will most certainly affect length of stay statistics and bed occupancies at Critical Access Hospitals. If CAHs are planning on discharging one or two Medicare beneficiaries in a given day/time period, but must keep the patient up to two days after their planned discharge date, this will definitely jeopardize CAH's LOS and bed occupancy participation requirements. In addition, if the Medicare beneficiary at a CAH challenges the discharge date, and CMS does indicate that the beneficiary is not liable for charges after the planned discharge date, then I strongly encourage CMS to further inform if CAHs should count these appeal days as Medicare Days on their Cost Reports. As noted the beneficiary will not be held liable, but please further instruct if the CAH will report those appeal days as patient days and/or if inform CAH CFOs how to account for these occasions on the Cost Report. Many rules have taken DRG payment structures into account; however, this timing issue truly affects the CAH LOS, bed occupancy opportunities, as well as financial reporting structures. Therefore, we strongly encourage CMS to more thoroughly review these scenarios and provide further specifics to CAHs.

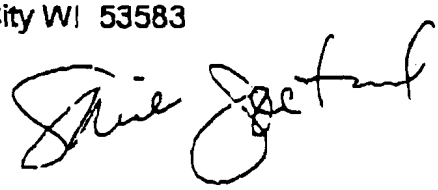
Next, this most recent proposal informs that beneficiaries can appeal on planned discharge date, and stay in the hospital without financial liability until at least noon of the day after the QIO notifies the hospital, the beneficiary, and the physician of it's decision. To apply this, this infers that the beneficiary can actually stay in the hospital for two additional days after the planned discharge date. Again, one additional day to financially absorb for PPS and CAHs will be burdensome; however, two additional days will be a tremendous hardship. Noting the aforementioned participation requirements for CAHs and DRG payment issues for PPS hospitals, I strongly encourage CMS to remove the additional day AFTER the QIO notifies the hospital requirement for this

373

yields no value to the patient and only serves as an additional financial burden to all hospitals.

In summary, we support the patients need to be well informed of their rights under the Medicare system. Nevertheless, we request that you reconsider the aforementioned timing issues, redefine patient liability concerns, as well as consider CAH requirements while providing this written notice to Medicare beneficiaries. Many current aspects will create a burden on hospitals for compliance that will escalate PPS and CAH health care costs.

Respectfully submitted by:
Sheila Goethel, RHIT, CCS
Rural Wisconsin Health Cooperative
Sauk City WI 53583



(2)

TriHealth
CARING FOR PEOPLE FIRST®

CMS-2-193

April 16, 2007

OMB
Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building, Room 10235
Washington, DC 20503
Fax (202) 395-6974

The proposed CMS 2-step process requiring facilities to repeat the Important Message Notice to every Medicare beneficiary prior to discharge of his or her Medicare rights is costly, impractical and most importantly unnecessary.

- The current process of issuing the Important Message to beneficiaries at the time of admission adequately explains their rights to have their discharge decision reviewed by the local Quality Improvement Organization (QIO) if they believe they are being discharged too soon. The IM provides all the information needed by a beneficiary to request such an appeal and explains they will not be financially liable while the QIO reviews their case. If the patient disagrees with the discharge decision a Hospital-Issued Notice of Non-coverage adequately provides the Medicare beneficiary with their appeal rights and allows them to express dissatisfaction with an impending discharge when necessary. The Medicare Advantage plans are required to issue the Notice of Discharge and Medicare Appeal Rights when a beneficiary disagrees with the discharge decision. These processes already provide the beneficiary with all of the necessary details regarding their rights. Repeating the IM notice prior to discharge after already issued upon admission is re-work and inefficient use of staff time.
- The language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.
- The hardcopy signature and record keeping requirements are counter productive to hospitals' movement to electronic medical records.

The process of issuing a notice to all Medicare beneficiaries offers no benefit to the patient. In reality, this may add more confusion to the already complex and difficult to understand health care system for Medicare beneficiaries. If the patient is in disagreement with the discharge then detailing the appeal process and contacting the QIO is reasonable and already in place with the current HINN process.

- There are very few instances in our facilities in which a patient expresses concern over being discharged too soon. Giving all patients a personal letter and requesting a signed acknowledgement of receipt, for the few instances of a perceived problem adds an administrative cost and is unnecessary.
- The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns. *Physicians, not hospitals, make discharge decisions.* The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation and, for most hospitals, by the Joint Commission on Accreditation of Healthcare Organizations standards. In both cases, those standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. We also have a care management program to ensure appropriate care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.
- Adopting the same process for acute care hospitals as are in place for skilled and long term facilities makes no sense. The level of care and LOS vary greatly between these settings.
- The paperwork indicates the QIO is available for these appeals 24/7 and they are not. I spoke to our local QIO and they indicated that they would have a person carrying a pager but the actual appeal process would not take place after hours.
- The form also requires that we enter the name and telephone number of the Medicare Advantage plan. This requirement adds an additional burden for the hospital to provide the patient with this detail when it is not readily available.

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

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

Sincerely,

Linda Hood RN

April 17, 2007

Dear Sir/Madam

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

ALLINA.
Hospitals & Clinics

April 18, 2007

OMB
Human Resources and Housing Branch
Attention: Carolyn Lovett
New executive Office building Room 10235
Washington, DC 20503

RE: Draft Revisions to Form # CMS-R-193 (00/07) Important Message from Medicare

Dear Ms.Lovett;

On behalf of Allina Hospitals and Clinics, I appreciate the opportunity to comment on the proposed changes to the Important Message from Medicare (IM) Form. Allina Hospitals & Clinics is a family of hospitals, clinics and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, to medical transportation, pharmacy, durable medical equipment, home care and hospice services. Allina serves communities around Minnesota and in western Wisconsin. Allina hospitals submitted well over 300,000 claims annually, representing $2.0 billion in total charges. Needless to say, we have a vital interest in providing our patients with the most up to date and accurate information regarding their length of inpatient stay and potential financial liability.

We commented on the proposed rule that the process must be efficient and not require unnecessary redundant work. We appreciate that CMS listened to our concerns and moved forward with the use of existing tools. However, we continue to have concerns about the double notification required for patients with greater than 2 day stays. We know that the final rule has been written and we will allocate resources necessary to duplicate the form and give it a second time to our longer stay patients but feel the need to raise our concern one more time. From a policy standpoint we would like to see Critical Access Hospitals exempted from the second notice since the length of stay is only 3 days. A notice provided at admission that should be sufficient for a 3 day stay.

We have reviewed the latest revisions to the IM form and have a few suggestions:

1. Please drop the word "attending" from the physician identifier line. The physician that admits the patient, when they receive their initial notice, may not be the same physician that writes the discharge order. Please consider dropping the word "attending" and leaving it as physician.
2. Please add a blank under the signature line on the first page. In cases where the patient is unable or refuses to sign the document we need a place to document reasons why no signature.

Thank you for the opportunity to provide input on the proposed revision to the IM form. Please feel free to contact me at 612-262-4912 if you have any further questions.

Sincerely,

Nancy G. Payne

Nancy G. Payne, RN
Director Regulatory Affairs

Dear Sir/Madam

CMS-R-193 (4)

With regard to CMS-R-193, I would like to state that this is not necessary and adds a workload on already overburdened staff working with Medicare patients.
If a patient has a disagreement with his/her discharge then I think then is the time to work with the patient to be sure all of his/her rights are protected. To go through this for every patient regardless of whether or not there is any patient concern with being discharged is bureaucracy at the extreme and serves no one well. It costs money, wastes paper, confuses folks who were not confused and creates public relations issues where none existed before.
If OMB must insist on adding paperwork it may be better served limiting it to when ther is an actual dispute.
Thanks You,

Joseph W. Haney,
Director, Patient Business and Access
Community Hospital of the Monterey Peninsula
Monterey, California
831-625-4924

(5)

Baptist Health
MEDICAL CENTER
Little Rock

9601 Interstate 630, Exit 7
Little Rock, AR 72205-7299
501 202-2000

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

CMS-1193
&
CMS-10064

April 23, 2007

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am the Director of Case Coordination at Baptist Health Medical Center, an 800+ bed community hospital located in Little Rock, Arkansas.

As a Director of Case Coordination I have been directly involved with discharge planning for the acute inpatient 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: patient over age 70, Medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

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

2 of 2

Baptist Health
MEDICAL CENTER
Little Rock

9601 Interstate 630, Exit 7
Little Rock, AR 72205-7299
501 202-2000

In addition, delivery of the follow up copy of the Important Notice from Medicare also poses an unnecessary financial burden on the hospital. In addition, access to post-acute care facilities (LTACH, SNF, Acute-Rehab, & Hospice) is not within the control of the hospital. Beds in these facilities are in great demand and can be difficult to locate. Once a patient is accepted, the post-acute care facility expects the patient to be transferred or the bed may be assigned to another patient. Delays in discharge and/or transfer to post-acute facilities can result in even greater (and inappropriate) lengths of stay in acute-care hospitals. No one wishes for the patient to miss the opportunity to receive the appropriate level of care.

In our hospital the average LOS is 5 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12 noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal. Many patients are discharged from the hospital in 1-2 days, very soon after the patient has received their Medicare rights information during the admission process.

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 significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expected results, and indeed, the increased costs (administrative and LOS) do not justify the means.

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

Sincerely,

Sandy Guthrie, Director Case Coordination
Baptist Health Medical Center
Little Rock, Arkansas

VHA