(6) 1 of 3

Harkless, Bonnie (CMS/OSORA)

From: Lovett, Carolyn L. [Carolyn_L._Lovett@omb.eop.gov]
Sent: Monday, May 07, 2007 11:03 AM
To: Harkless, Bonnie (CMS/OSORA); PARHAM, WILLIAM N. (CMS/OSORA)
Subject: FW: Comments to Important Message and Detailed Notice

Attachments: IM comment letter-due May 5- 2007-final.doc

IM comment
etter-due May 5- 2..

-----Original Message-----
From: Sheri Krueger-Dix [mailto:sdix@fmlh.edu]
Sent: Saturday, May 05, 2007 5:15 PM
To: Lovett, Carolyn L.
Cc: Nancy Schallert; Roberta Navarro; Catherine Nelson; Deb Gordon
Subject: Comments to Important Message and Detailed Notice

Hello,

Frodtert and Community Health appreciates the opportunity to comment on the April 6th Federal Register notice.
Please see the attached comments.
We will also fax a copy.

<<IM comment letter-due May 5- 2007-final.doc>> Thank you,

Sheryl Krueger Dix RN, BSN, CPHQ, CPM
Patient Care Compliance Consultant
Froedtert and Community Health
at Community Memorial Hospital

office phone: 262-257-3495
pager: 414-590-5580
email address: sdix@fmlh.edu

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May 2, 2007

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

RE: Comments for Medicare discharge notice changes

Dear Ms. Lovett:

Froedtert & Community Health, Inc, Milwaukee, Wisconsin, ("F&CH") appreciates the opportunity to provide comments on the Notification Procedures for Hospital Discharges- Important Message from Medicare notice published in the April 6, 2007 Federal Register/ Vol. 72, No. 66 and the Detailed Notice of Discharge. The following comments and questions regarding the proposed procedures which were compiled by key clinical and financial representatives of Froedtert and Community Health. Your consideration of these comments would be greatly appreciated.

IMPORTANT MESSAGE FROM MEDICARE - FORM REVISIONS

F&CH supports the AHA recommendations for 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 agree that it would be significantly more efficient to simply print the notice as part of their discharge instruction package.

To add to the AHA comments, we would advocate that the copy or second letter not be required. The administrative costs of this second notice are extraordinary and unnecessary.
The second notice, in whatever form, is duplication of what would be provided to the patient within two days of admission. Is the purpose of the notification process to provide information to the patient on their discharge rights (which the first notice adequately does), or is it to encourage the patient in considering an appeal of their discharge (which delivering for a second time the same information already provided to the patient seems to suggest).

- 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.
(AHA, Leslie Norwalk, March 6, 2007)

F&CH would add to the AHA comment to request further clarification for hospitals to address the situation whereby a beneficiary is "unable" to receive the notice or "understand the notice", & has no beneficiary representative (POA or Health Care Agent) currently in place.

NOTIFICATION PROCEDURES FOR HOSPITAL DISCHARGES – DETAILED NOTICE OF DISCHARGE

F&CH continues to share concern that if the detailed notice of discharge is issued, there should be minimal or no grace days offered. The financial responsibility of the patient should begin the day after issuance, dependent on the speed of the QIO decision.

FORM REVISIONS:

1. There is not a signature line for authentication of patient/ representative receipt. Similar to the statement on the IM form:

   Recommend inclusion at the end of the detailed notice:
   Signature of Patient or Representative Date
   If this is completed, could remove notice date from the top section.

Once again, Froedtert & Community Health, Inc. would like to extend its appreciation to you for the opportunity to comment on the above matters. If you have any questions or concerns about the comments within, please feel free to contact Nancy Schallert at (414) 805-2859 or via email at nschalle@fmlh.edu.

Sincerely,

Nancy Schallert
Director of Compliance and Internal Audit
Froedtert and Community Health
9200 West Wisconsin Avenue,
Milwaukee, WI 53226

Medicare Advocacy Project
Protecting your medicare rights.
Greater Boston Legal Services
197 Friend Street, Boston, MA 02114
(617) 371-1234, or toll-free (800) 323-3205
FAX (617) 371-1222
www.gbls.org

(9) 1/3

May 3, 2007

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

Re: Important Message from Medicare, CMS-R-193 (OMB#: 093-0692);
Detailed Notice of Discharge, CMS-10066 (OMB#: 0938-New)
72 Fed. Reg. 17169 (April 6, 2007)

Dear Madam or Sir:

The Medicare Advocacy Project, Greater Boston Legal Services, works to insure that Massachusetts Medicare beneficiaries receive the Medicare and Medicare-related coverage and services to which they are entitled. Our clients include individual and groups of elders and persons with disabilities, especially those with low incomes. On behalf of our clients, we would like to submit the following comments regarding the Centers for Medicare & Medicaid Services' (CMS) draft notices for Medicare and Medicare Advantage hospital inpatients: *Important Message from Medicare* (IM) and *Detailed Notice of Discharge*.

Overall, the draft notices are clearer and more understandable than previous versions. In particular, the description of discharge rights in the (IM) is more prominent, concise and useful to patients. Additionally, the information about patient liability pending appeals is clearer and easier to understand.

We suggest the following revisions to the notices and additions to instructions in order to help patients benefit when they receive a copy of their signed IM prior to discharge, to make the notices even more readable and user-friendly, and to insure timely delivery of this notice.

Help Patients Benefit From the IM Upon Discharge.

We are concerned that upon receiving a copy of their signed IM prior to discharge ("follow up notice"), many patients will fail to read or use it because they will not realize that it relates to

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their impending discharge. To help patients benefit from the follow up notice, we suggest the following:

- Change the title of the IM to include the word, "discharge" (i.e., *"An Important Message From Medicare about Your Inpatient and Discharge Rights"*);
- In the first section listing hospital inpatient rights, add a bullet alerting persons that they will receive a copy of their signed notice prior to discharge; and
- Require hospitals and Medicare Advantage plans to deliver the follow up notice and explain its relevance when patients are told of their discharge.

In the March 23, 2007, *Revisions to the Important Message from Medicare*, CMS indicates it added the bullet telling persons to call 1-800 Medicare if they have insufficient time to consider their rights, to address concerns "that beneficiaries may be given the notice on their way out of the hospital." We query, however, whether this information will actually help patients. First, CMS has not indicated that 1-800 personnel have the authority to extend the deadline for patients to file a QIO appeal. Second, even if 1-800 personnel have the authority to intervene, it is not always possible to reach a live person on a timely basis. We therefore suggest that this bullet be deleted.

Make the Notices More User-friendly and Readable

As we mentioned above, the notices are generally clear and understandable. To make them more concise and user-friendly, we recommend the following:

- In the IM, bold the deadline for requesting QIO review to call the reader's attention to this critical information;
- In the IM, delete the bullet advising patients to contact 1-800 Medicare if they do not think they have sufficient time to appeal, for the reasons mentioned above;
- Require that information written into the *Detailed Notice of Discharge* be legible.

Ensure Timely Delivery of the "Follow up Notice" so Patients who want to will have the Opportunity to Exercise their Appeal Rights

According to the regulations, hospitals and plans must deliver the follow up notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge." 42 C.F.R. §§ 405.1205 (c)(1); 422.620 (c)(1). Because there is no deadline for delivering this notice, Our concern is that many patients could receive it too late, after they have lost any meaningful opportunity to exercise their appeal rights. Notices will be useless to patients if they are delivered as they are packing to leave or being wheeled out the door.

To promote the timely delivery of the follow-up notice, we suggest the following:

- Require that the patient's signature, with date and time of delivery, be obtained on the follow-up notice and that a copy be kept in the patient's record. The information could

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be recorded in the "Additional Information" section. This will allow CMS to monitor when the notices are actually delivered, will discourage hospitals from delivering notices too late, and help assure that notice is actually delivered to the patient.) Requiring the record is warranted given its importance in ensuring the patients actually receive the notice in time to consider their appeal rights. This assurance far outweighs any argument a hospital might raise suggesting that this is too burdensome a requirement.

- CMS should devise a standard to measure whether notices are delivered "as far in advance of discharge as possible." 42 C.F.R. §§ 405.1205 (c)(1); 422.620 (c)(1). Such a standard should require that the discharge notice ideally be delivered to patients no later than the day prior to discharge or, if specific, identified information is not available until the day of discharge, at least five hours prior to discharge. The standard should also specifically prohibit hospitals from adopting a blanket policy of delivering the notices on the day of discharge.

Thank you for the opportunity to submit these comments on behalf of our clients.

Very truly yours,

Diane F Paulson

Diane F Paulson
Senior Attorney

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FAX: (202) 662-1762

May 5, 2007

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

Re: Important Message from Medicare, CMS-R-193 (OMB#: 093-0692);
Detailed Notice of Discharge, CMS-10066 (OMB#: 0938-New)
72 Fed. Reg. 17169 (April 6, 2007)

Dear Sir or Madam:

The American Bar Association appreciates the opportunity to comment on the *Important Message from Medicare and Detailed Notice of Discharge*, published in the Federal Register on Friday, April 6, 2007, 72 Fed. Reg. 17169.

The ABA is the world's largest voluntary professional organization with more than 400,000 members. The ABA has worked for many years to strengthen procedural due process in Social Security and Medicare. Our comments are based on numerous policies of the ABA that support efforts to improve the administrative and judicial process utilized by the Department of Health and Human Services (HHS) and the Social Security Administration (SSA). For almost twenty years, the ABA has advocated that Medicare beneficiaries are entitled to due process throughout the Medicare determination and appeals process. We have consistently advocated for a simplified and orderly determination process, including improvement of the various notices given to beneficiaries about hospital discharges to hospital patients.

Overall, the draft notices are clearer and more understandable than previous versions. In particular, the description of discharge rights in *the Important Message* is more prominent, concise and useful to patients. The information about patient liability pending appeals is more comprehensible. However, we believe additional improvements should be adopted.

To make both notices more readable and user friendly, and to help patients benefit from the second notice and ensure timely delivery of it, we suggest the following revisions.

Make the Notices More User-friendly and Readable

As we mentioned above, the notices are generally clear and understandable. To further improve them, we recommend the following:

- In the *Important Message*, bold the deadline for requesting QIO review to call the reader's attention to this critical information;
- In the *Important Message*, delete the bullet advising patients to contact 1-800 MEDICARE if they do not think they have sufficient time to appeal, for the reasons mentioned above;
- Require that information written into the *Detailed Notice of Discharge* be legible.

Help Patients Benefit From the *Important Message* Upon Discharge.

We are concerned that upon receiving the copy of *the Important Message* prior to discharge ("follow up notice"), many patients will fail to read or use it because they will not realize that it relates to their impending discharge. To help patients benefit from the follow up notice, we suggest the following:

- Change the title to include the word, "discharge" (i.e., *"An Important Message From Medicare about Your Inpatient and Discharge Rights"*);
- In the first section listing hospital inpatient rights, add a bullet alerting persons that they will receive a copy of the notice prior to discharge; and
- Require hospitals and Medicare Advantage plans to deliver the follow up notice and explain its relevance when patients are told of their discharge.

Ensure Timely Delivery of the Second *Important Message* to Afford Patients the Opportunity to Exercise their Appeal Rights

Hospitals and plans must deliver the second *Important Message* "as far in advance of discharge as possible, but not more than 2 calendar days before discharge." 42 CFR §§ 405.1205 (c)(1); 422.620 (c)(1). Because there is no deadline for delivering the follow up notice, many patients could receive it too late, after they have lost any meaningful opportunity to exercise their appeal rights. Notices will be useless to patients if they are delivered as they are packing to leave or being wheeled out the hospital door.

In the "Revisions to the Important Message from Medicare," CMS indicates it added the bullet telling persons to call 1-800-MEDICARE if they have insufficient time to consider their rights, to address concerns "that beneficiaries may be given the notice on their way out of the hospital." However, we do not understand how this information helps patients. First, CMS has not indicated that 1-800-MEDICARE operators have the authority to extend the deadline for patients to file a QIO appeal. Second, even if 1-800-MEDICARE

operators have the authority to intervene, 1-800-MEDICARE docs not have the capacity to respond quickly enough.

To promote the timely delivery of the follow-up notice, we suggest the following:

- Require that the patient's signature, with date and time of delivery, be obtained on the follow-up notice and that a copy is kept in the patient's record. The information could be recorded in the "Additional Information" section. This record will allow CMS to monitor when the notices are actually delivered and will discourage hospitals from delivering them too late. It will also help to assure that notice is actually delivered to the patient. Requiring the maintenance of this record is warranted given its importance in ensuring the patients actually receive the notice in time to consider their appeal rights.

- CMS should devise a standard to measure whether notices are delivered "as far in advance of discharge as possible." 42 CFR §§ 405.1205 (c)(1); 422.620 (c)(1). Such a standard should require that the discharge notice be delivered to patients on the day prior to discharge or, if specific, identified information is not available until the day of discharge, at least five hours prior to discharge. The standard should also specifically prohibit hospitals from adopting a blanket policy of delivering the notices on the day of discharge.

We thank you for the opportunity to submit these comments.

Sincerely,

Denise A. Cardman

Denise A. Cardman
Acting Director

MHA
MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

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May 4, 2007

Ms. Carolyn Lovett
OMB Desk Officer
OMB Human Resources and Housing Branch
New Executive Office Building, Room 10235
Washington, DC 20503

Re: CMS-R-193 (OMB#: 0938-0692) Proposed Revision of Important Message from Medicare and Related Paperwork Requirements (Vol. 72, No. 66), April 6, 2007

Dear Ms. Lovett:

On behalf of its 145 members, the Michigan Health & Hospital Association appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS) regarding its proposed revision of the "Important Message from Medicare" (IM) and related paperwork requirements, which were submitted to the Office of Management and Budget (OMB). The proposed IM would implement the revised regulations requiring hospitals to notify Medicare beneficiaries about their hospital discharge appeal rights, which were published in the November 27, 2006 *Federal Register*.

The MHA appreciates the extent to which the CMS responded to many of the practical problems identified in comments submitted. While the final regulation is more manageable, it continues to pose a significant burden on hospitals that will offset any additional benefit that beneficiaries might accrue. **The MHA is concerned that the CMS will be unable to provide hospitals with the final notice language and instructions to allow hospitals sufficient time to effectively implement the new requirements prior to the July 1 implementation date.**

ADMINISTRATIVE BURDEN FOR HOSPITALS

Currently, hospitals generally provide the IM to beneficiaries in their admissions packet. The IM explains beneficiaries' rights to have their discharge decisions reviewed by the local Quality Improvement Organization (QIO) if they believe they are being discharged too soon. The notice provides all of the information beneficiaries need for requesting an appeal and explains that they will not be held financially liable for continued hospital care while the QIO reviews their case. Hospitals provide a detailed notice with specific reasons explaining why hospital care is no longer required when beneficiaries indicate that they are uncomfortable with their planned discharge date.

SPENCER JOHNSON, PRESIDENT
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Under the new regulations, hospitals must provide the IM to beneficiaries no later than two days following admission. Hospital staff must ensure that beneficiaries understand the notice and sign a copy of it documenting when they received it and that they understand it. Hospital staff are also required to give beneficiaries a copy of the signed notice, as well as another copy of the signed notice no more than two days prior to discharge. Hospital staff will be required to provide a detailed notice with information about a particular discharge only when a beneficiary requests a QIO review. We believe that focusing the process and beneficiary questions at the beginning 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.

Even with the conservative burden estimate included in the paperwork clearance package, the CMS projects that the annual burden will increase from 208,333 hours to 3,250,000 hours – a more than fifteen-fold increase. While admissions clerks provided the former notice to beneficiaries, the revised process requires someone with greater expertise to explain medical necessity and the discharge planning process – generally a nurse case manager or social worker. The national average hourly wage for clerks is about $12.50, while the average hourly wage for nurses and social workers are significantly higher, ranging from $24.00-$28.00. Conservatively, that increases hospital labor cost from approximately $2.6 million to between $78 and $91 million. It is unclear whether this new requirement is going to yield sufficient benefit to Medicare beneficiaries to warrant the significant cost and administrative burden increase to hospitals. **As a result, the MHA recommends that OMB conditionally approve the new form and process and require that the CMS perform an evaluation *after* the first year to determine whether the new process has yielded sufficient benefit to warrant this significant increase in administrative costs.**

Timing of Implementation

It is our understanding that under the best-case scenario, the OMB-approved notice and instructions will not be available to hospitals until late May or early June. With the July 1 effective date quickly approaching, we are very concerned that hospitals will have insufficient time to print the new notices, prepare written internal policies and instructions and train staff prior to the July 1 effective date. If less time is available, we believe they will be unable to meet the July 1 date. **The MHA urges the OMB to give hospitals a minimum of 60 days before they are required to implement the new requirements. As a result, it will be necessary for the CMS to delay the July 1 date.**

Issues Requiring Clarification Prior to Implementation

We believe that the list of issues needing clarification has grown from those previously identified by the AHA and others. **As a result, the MHA recommends that OMB require the CMS to address the following issues and clarifications in its instructions prior to releasing and implementing the new notice:**

- **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.** The AHA and others raised this issue during the comment period on the proposed rule, and the preamble discussion of the final rule indicated that the CMS planned to provide guidance regarding how hospitals and health plans may deliver the notice in cases where a

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beneficiary's representative may not be immediately available. However, the CMS failed to include such guidance in the instructions for the first draft revised notice offered for comment on January 5 or in the second revised instructions submitted to the OMB. In March, the AHA urged the CMS to allow hospitals any means of communication necessary to conduct the notice process with beneficiary representatives (telephone, fax, email, etc.) and allow record notations when using these alternatives to in-person notice. Conversations with the CMS staff suggest that hospitals that follow their usual protocols in dealing with patient representatives on official documents and forms that must be signed will be in compliance as long as they document their methods. **We urge the OMB to ensure that the CMS clarifies this issue in the final instructions.**

- **Provide flexibility on the timing of the first notice to accommodate late Friday and Saturday admissions.** Hospitals participating in a recent teleconference on implementation issues expressed concern that they would be unable to provide notices to patients admitted on weekends when hospital case managers and discharge planners are not working. Although they are on call for immediate problems, it would be impractical to call them in to explain the initial notice. In discussing ways to address the problem, two options emerged. One is to allow scripted registration staff to provide the initial notice and answer typical questions. In cases where the questions require discussion with a case manager or discharge planner, the CMS could allow follow up in the early part of the next work week. Another option is to simply provide an extra day to provide the initial notice. For example, two days is insufficient for a Friday afternoon or evening admission because the second day after admission is Sunday. In the case of Saturday admissions, the second day after admission would be Monday, making workflow nearly impossible as workers are catching up with weekend activity and new admissions.

- **Provide some flexibility for designating the attending physician for emergency admissions.** For emergency admissions, many hospitals are planning to provide and discuss the notice when they get beneficiaries' consents for treatment. However, the name of the attending physician is often unknown at that time, and the form requires the name of the attending physician to be inserted following the patient's name and ID number. We see two options for solving this problem: 1) allow designation of the attending physician on the form after its receipt and signature for emergency admissions, or 2) omit the designation of the attending physician on the form.

- **Allow provision and explanation of the initial notice during pre-admission testing and registration.** Many of our hospitals would like to incorporate the initial notice into the pre-admission process for elective admissions when beneficiaries are focused on the registration process. This suggestion would clearly help beneficiaries, but it is unclear whether the regulations would allow it.

- **Provide on the CMS' Web site the text of the notice translated into the 15 languages hospitals frequently encounter.** Almost 20 percent of the U.S. population speaks a language other than English at home. Hospitals are required to provide language services for patients with limited English proficiency, but they do not receive compensation for the cost of those services. The size of this population and the vast number of languages that hospital staff encounter make it very difficult for individual hospitals to provide translated

documents. Since the text of this notice cannot be altered by the hospital, the CMS should obtain and provide translations. The Social Security Administration has a list of 15 languages that it uses for such purposes. A recent survey by the Health Research and Educational Trust identified 15 languages that at least 20 percent of hospitals encounter frequently: Spanish; Chinese; Vietnamese; Japanese; Korean; Russian; German; French; Arabic; Italian; Laotian; Hindi; Polish; Tagalog; and Thai.

In conclusion, the MHA is concerned due to the increased administrative burden, staff resources, and cost of this notice on hospitals. The clarifications we have requested are essential for hospitals to be able to effectively implement the new rules and notices. It is also vital that hospitals have sufficient time to review these changes prior to implementation. If you have any questions concerning our comments, please feel free to contact me at (517) 703-8603 or mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein, Senior Director
Health Policy and Finance

American Hospital Association

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May 2, 2007

Ms. Carolyn Lovett
OMB Desk Officer
OMB Human Resources and Housing Branch
New Executive Office Building, Room 10235
Washington, DC 20503

Re: CMS-R-193 (OMB#: 0938-0692) Proposed Revision of Important Message from Medicare and Related Paperwork Requirements (Vol. 72, No. 66), April 6, 2007

Dear Ms. Lovett:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the 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, which were submitted to the Office of Management and Budget (OMB). The proposed new IM would implement the revised regulations requiring hospitals to notify Medicare beneficiaries about their hospital discharge appeal rights, which were published in the November 27, 2006 *Federal Register*.

The 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 more workable, it still would pose a significant burden on hospitals that may counter any additional benefit that beneficiaries might accrue. We are concerned that CMS will be unable to provide hospitals with the final notice language and instructions with sufficient time for hospitals to effectively implement the new requirements by the regulation's July 1 implementation date.

ADMINISTRATIVE BURDEN FOR HOSPITALS

Currently, hospitals generally provide the IM to beneficiaries in their admissions package. The IM explains beneficiaries' rights to have their discharge decisions reviewed by the local Quality Improvement Organization (QIO) if they believe they are being discharged too soon. The notice provides all of the information beneficiaries need to request an appeal and explains that they will not be held financially liable for continued hospital care while the QIO reviews their case.

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Hospitals provide a more detailed notice with specific reasons explaining why hospital care is no longer required when beneficiaries indicate that they are uncomfortable with their planned discharge date.

Under the new regulations, hospitals must provide the IM to beneficiaries no later than two days following admission. Hospital staff must ensure that beneficiaries understand the notice and sign a copy of it documenting when they received it and that they understand it. Then, hospital staff must give the beneficiaries a copy of the signed notice, as well as another copy of the signed notice no more than two days prior to discharge. Hospital staff will be required to give a detailed notice with information about a particular discharge only when a beneficiary requests a QIO review. We believe that focusing the process and beneficiary questions at the beginning 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 annual burden will increase from 208,333 hours to 3,250,000 hours – a more than fifteen-fold increase. And, while admissions clerks provided the former notice to beneficiaries, the new process requires someone with the expertise to explain medical necessity and the discharge planning process – generally a nurse case manager or social worker. The national average hourly wage for clerks is about $12.50, while the average hourly wage for nurses and social workers ranges from $24.00-$28.00. Conservatively, that takes the personnel cost from about $2.6 million to between $78 and $91 million. In addition, hospitals will need to print three-part automatic copy forms for about 13 million admissions per year and train staff in the new requirements, resulting in total costs that will easily surpass $100 million per year. Furthermore, it is unclear whether this new requirement is going to yield sufficient benefit to Medicare beneficiaries to warrant the significant cost and burden increase to hospitals. **Therefore, the AHA recommends that OMB conditionally approve the new form and process and require that CMS perform an evaluation *after* the first year to determine whether the new process has yielded sufficient benefit to warrant this significant increase in administrative costs.**

Far too often, administrative requirements are adopted to address anticipated or perceived problems. For example, Congress enacted discharge rights requirements when the inpatient prospective payment system (PPS) was enacted in response to widespread fears that hospitals would discharge patients prematurely due to the incentives of the PPS to shorten lengths of stay. Those fears of "quicker, sicker" discharges were not realized. Also, an earlier requirement for beneficiaries to sign for receipt of the notice was found to be unnecessary and subsequently eliminated. In short, too many health care dollars are being devoted to administrative and paperwork requirements. Escalating health care costs and the rapid expansion of the Medicare beneficiary population underscore that our country needs more of its health care dollars devoted to bed-side care – not paperwork.

TIMING OF IMPLEMENTATION

It is our understanding from CMS staff that under the best-case scenario, the OMB-approved

notice and instructions would not be available to hospitals until late May or early June. With the July 1 effective date of the regulations approaching, we are concerned that hospitals will have insufficient time to print the new notices, prepare written internal policies and instructions and train staff prior to July 1. If even less time is available, we believe they will be unable to meet the July 1 date. And, if the approved notice and instructions are not available by July 1, we do not know what instructions to give our members, since they cannot use a notice that OMB has not approved. **Consequently, the AHA urges OMB to give hospitals a minimum of 60 days before they are required to implement the new requirements.**

ISSUES REQUIRING CLARIFICATION PRIOR TO IMPLEMENTATION

As the AHA and state hospital associations have worked with hospitals on pre-implementation planning, we realized that the list of issues needing clarification has grown from those identified in our March 6 letter to CMS. **The AHA recommends that OMB require CMS to address the following issues and clarifications in its instructions prior to releasing and implementing the new notice:**

- **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.** The AHA and others raised this issue during the comment period 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 notice in cases where a beneficiary's representative may not be immediately available. However, CMS failed to include such guidance in the instructions for the first draft revised notice offered for comment on January 5 or in the second revised instructions submitted to OMB. In March, we urged CMS to allow hospitals any means of communication necessary to conduct the notice process with beneficiary representatives (telephone, fax, email, etc.) and allow record notations when using these alternatives to in-person notice. Conversations with CMS staff suggest that hospitals that follow their usual protocols in dealing with patient representatives on official documents and forms that must be signed will be in compliance as long as they document their methods. We urge OMB to ensure that CMS clarifies this issue in the final instructions.

- **Provide some flexibility on the timing of the first notice to accommodate late Friday and Saturday admissions.** Hospitals participating in a recent teleconference on implementation issues expressed concern that they would be unable to provide notices to patients admitted on weekends when hospital case managers and discharge planners do not work. Although they are on call for immediate problems, it would be impractical to call them in to explain the initial notice. In discussing ways to address the problem, two options emerged. One is to allow scripted registration staff to provide the initial notice and answer typical questions. In cases where the questions require discussion with a case manager or discharge planner, CMS could allow for follow up in the early part of the next work week. Another option is to simply provide an extra day to provide the initial notice. For example, two days is insufficient for a Friday afternoon or evening admission because the second day after admission is Sunday. In the case of Saturday admissions, the second day after admission would be Monday, making workflow nearly impossible as workers are catching up with weekend activity and new admissions.

- **Provide some flexibility for designating the attending physician for emergency admissions.** For emergency admissions, many hospitals are planning to provide and discuss the notice when they get beneficiaries' consents for treatment. However, the name of the attending physician is often not known at that time, and the form requires the name of the attending physician to be inserted following the patient's name and ID number. We see two options for solving this problem: 1) allow designation of the attending physician on the form after its receipt and signature for emergency admissions, or 2) omit the designation of the attending physician on the form.

- **Allow provision and explanation of the initial notice during pre-admission testing and registration.** Many of our hospitals would like to incorporate the initial notice into the pre-admission process for elective admissions when beneficiaries are focused on the registration process. This suggestion would clearly help beneficiaries, but it is unclear whether the regulations would allow it.

- **Provide on CMS' Web site the text of the notice translated into the 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 patients with limited English proficiency, but they do not receive compensation for the cost of those services. The size of this population and the vast number of languages that hospital staff encounter 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. 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 that identified 15 languages that at least 20 percent of hospitals encounter frequently: Spanish; Chinese; Vietnamese; Japanese; Korean; Russian; German; French; Arabic; Italian; Laotian; Hindi; Polish; Tagalog; and Thai.

In conclusion, this new process adds significant time and cost for hospitals. The clarifications we have requested are essential for hospitals to be able to effectively implement the new rules and notices.

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

Sincerely,

Rick Pollack

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Cc: Bonnie Harkless (CMS)