TMF
Health Quality Institute
Bridgepoint I, Suite 300
5918 West Courtyard Drive • Austin, TX 78730-5036
Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

May 3, 2007

OMB Human Resources & Housing Branch
ATTN: Carolyn Lovett
New Executive Office Building Room 10235
Washington DC 20503

Re: Important Message from Medicare (IM) (CMS-R-193) associated with CMS-4105-F, the final rule for notification of hospital discharge appeal rights.

Ms. Lovett:

TMF Health Quality Institute (TMF) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient services provided to Medicare patients in the state of Texas. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Staff members here at TMF, involved in the appeals processes, have reviewed the Important Message from Medicare (IM) (CMS-R-193) associated with CMS-4105-F, the final rule for notification of hospital discharge appeal rights. We recommend that the IM (CMS-R-193) be modified to include the name and provider number of the facility in which the patient is admitted. Specifically, the IM should include the name and the provider number that the facility uses for billing with Medicare. This will save valuable time when the patient contacts the QIO for appeal. Patients in appeal situations are frequently anxious and may be confused about the name of the facility, especially one that is a part of a large system, or that has had frequent name changes. Although there is a contact name and number for the facility on the IM, it would simplify the work of the QIO to have this definite identifying information at the beginning of the process

Thank you,

Janis Bryant RN CPHQ

Janis Bryant RN CPHQ
Phone: 512-334-1667
Fax: 1-800-725-6245

Tucson, AZ 85724-5162
Office: 520-694-2729
Fax: 520-694-2014
email: msisson@umcaz.edu

The implementation of Hospital Discharge Appeal Notices will require extensive resources and coordination. We recommend that it be carefully considered whether the first notice to the patient should include the Hospital Discharge Appeal Rights. We have been working for two years on a formalized process where we schedule a discharge one day in advance. We have implemented many strategies to improve this, including a formal patient flow consulting engagement with a highly-rated consulting group. Even with their assistance, we have been able to gain only a 35% accuracy in predicting discharges 1 day in advance. This is due to issues such as placement of patients in a SNF, waiting for test results, complicated cases, patient's condition changes, etc. Please consider these as questions and comments submitted regarding the Detailed Notice of Discharge and Hospital Discharge Appeal Rights.

1. We recommend that a specific limit be set as to the number of times a patient can appeal/refuse to d/c.
2. How will M/C want the days billed to them during the appeal process. Will they want these charges under non-covered?
3. Will there be some type of indicator established for the UB form that shows the discharge notice was issued to the pt?
4. Process seems designed to encourage patients to appeal. Please re-script instructions so that patients understand that this is an option, not an expectation.
5. Please extended the deadline to provide sufficient time to prepare (changes to forms, computer systems, process design, education)
6. The first notice is part of the process. However, the second notice places a huge burden on the hospital and requires added resources. We recommend one notice upon admission.
7. Please allow for the first notice to be delivered and signed during pre-admission.
8. Please provide more specific information and instructions on who the QIO is going to notify at the hospital of their review results.
9. Also, please provide specific instructions on what happens if the patient calls the QIO and does not inform the hospital staff that an appeal has been submitted.
10. Please provide more direction on any specific requirements on the form e.g., Does font need to be a 12 as is used in the DRAFT notice from CMS?
11. On the Detailed Notice of Discharge, the process can be simplified by establishing the Patient ID as the hospital's encounter number.

Thank you.

Marjorie Sisson, Director
Director, Transition Management
University Medical Center
P.O. Box 245162

Tucson, AZ 85724-5162
Office: 520-694-2729
Fax: 520-694-2014
email: msisson@umcaz.edu

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11. On the Detailed Notice of Discharge, the process can be simplified by establishing the Patient ID as the hospital's encounter number.

Thank you.

Marjorie Sisson, Director
Director, Transition Management
University Medical Center
P.O. Box 245162

CARILION
New River Valley
Medical Center

(13)

Date: May 2, 2007

To: The Centers for Medicare and Medicaid Services

From: Clinical Effectiveness Department of Carilion New River Valley Medical Center
Christiansburg, VA 24073

Re: Comments regarding "Important Message from Medicare" and "Detailed Notice of Discharge"

Hospital leaders agree that patients and their families have the right to know about their discharge appeal rights. The difficulty for us lies in the actual carrying out of the process as Medicare has outlined it. Our concerns are as follows:

1. How do we accurately pin-point when a patient is being discharged? The Medicare population by definition is either disabled or 65 and over. Their healthcare course, in the hospital, is not always predictable. For many of them, their hospital stay goes from day-to-day...especially if they are waiting for a nursing home bed. It would be a terrific burden on hospital resources to repeatedly issue the IM in order to make sure the patient receives it within 2 days of discharge.

2. We do provide case management weekend coverage, but it is for patient care issues, certainly not at the level required to provide the second Important Messages from Medicare AND the Detailed Notices of Discharge (if the patient appeals the discharge decision). To meet the requirements of this ruling, I foresee a terrific strain to our system, both departmentally and organizationally.

3. Our facility has limited capacity. Delay in discharge for two days, while an appeal is reviewed, will impact our ability to provide care to those who have greater needs. Our projection is that our psychiatric care unit will be housing patients that should have been discharged, but have appealed. Currently the Commonwealth of Virginia has limited psychiatric facilities. Our Emergency Departments have held patients waiting for a psychiatric bed for up to four days. Does the right of the discharged patient exceed the right of those seriously ill patients seeking care? Also keep in mind that our hospital is reimbursed for inpatient psychiatric patients under the prospective payment system which could result in increased Medicare costs.

As a compromise we feel it would be appropriate to require the initial admission IM to be delivered and signed for, but the second IM before discharge has presented itself as an unnecessary waste of resources and a bother to our patients and their families in time of illness.

Sincerely,

GC Duck

GC Duck, Manager Clinical Effectiveness
CNRVMC

DETAILIED NOTICE OF DISCHARGE

This notice gives you a detailed explanation of why your hospital and doctor (and/or your managed care plan, if you belong to one) believe your hospital services should end on _____, based on Medicare coverage policies and medical judgment. **ACMA Comment:** *We recommend that this sentence should read: "Based on Medicare coverage policies, and in the medical judgment of your doctor, with agreement of the hospital (and your managed care plan, if you belong to one) that you no longer need to be in the hospital."*

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO). **ACMA Comment:** *Please add a clarifier on what a QIO is. This would be helpful as patients won't know what it is and the hospital staff will need a brief standardized explanation for the patient.*

1. The facts used to make this decision: **ACMA Comment:** *We recommend that the term 'facts' be changed to information about your current clinical condition. We suggest the sentence read: Your hospital and physician(s) believe you are ready to leave the hospital based on the your current clinical condition, as described in this section:*

2. Explanation of Medicare coverage policies that we used to determine that Medicare will no longer cover your hospital stay: **ACMA Comment** : *We recommend the following two points:*

a) That hospitals be allowed to customize the form so that operationally there would be a menu of 'coverage policies' with an area for narrative notes. Hospital staff could select the choice(s) and individualize with additional notes. We believe this would ensure that the "primary" justification for discharge is listed and provide more clarity in what information is being used. The potential liability of the accuracy of the information needs to be considered.

b) We further recommend that the sentence be changed to: "Your physician(s), in agreement with the hospital, and health plan, if you have one, made this decision in compliance with the following Medicare coverage policies:"

3. If applicable, Medicare managed care policies, provisions, or rationale used to make this decision: **ACMA Comment:** *If the recommendation outlined in b) above is adopted, this sentence should be deleted.*

If you would like a copy of the Medicare coverage policies or Medicare managed care plan policies used to make this decision, or a copy of the documents sent to the QIO, please call us at {insert hospital and/or plan telephone number}. **ACMA Comment:** *We recommend that the patient be given the phone number for Medicare (1-800-MEDICARE (1-800-633-4227)and/or the plan number, and not the phone number of the hospital. The Medicare Coverage policies are sent to Medicare beneficiaries, are available on the web, and can be discussed by calling the Medicare Hotline. Having the patient call the hospital about coverage policies puts the burden on the hospital, whereas the explanation of Medicare policies by a plan is appropriate.*

An additional comment: It is not clear whose 'logo' should be inserted at the top of the page. The hospital's, CMS's, the QIO. Please clarify.

INTEGRIS
Blackwell
REGIONAL HOSPITAL
710 South 13th
Blackwell, OK 74631-3700
(580) 363-2311

Rex Van Meter
Chief Executive Officer

14

May 3, 2007

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

Dear Ms. Lovett:

As previously requested, we would like to take this opportunity to express our concern with the proposed CMS-4105-F rule regarding Notification of Hospital Discharge Appeal Rights. While we do not have an issue with providing a revised IM to the patient at the time of admission and discharge, we feel that the proposed prohibition to provide this document on the day of discharge provides an added administrative burden to our facility. We do concur that patients should have the right to appeal their discharge but also believe that the patient or his/her representative should bear the responsibility without placing added burden on the facility.

While the proposed rule states that the patient/beneficiary is not required to verify that the notice was given it does require the facility to be able to document that the notice has been delivered. Again we feel that this requirement provides added administrative burden on our facility.

We would request that you review these comments and reconsider implementing this rule prior to July 1, 2007. Thank you for your consideration.

Sincerely,

Rex Van Meter

Rex Van Meter
President
INTEGRIS Blackwell Regional Hospital

INTEGRIS
Clinton
REGIONAL HOSPITAL

P.O. Box 1569
100 North 30th Street
Clinton, OK 73601
580.323.2362
(f) 580.323.8398

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May 3, 2007

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

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We would request that you review these comments and reconsider implementing this rule prior to July 1, 2007. Thank you for your consideration.

Sincerely,

Jerry D. Jones, FACHE
President

glmc
Grenada Lake Medical Center
960 Avent Drive • Grenada, Mississippi 38901-5094
Phone (662) 227-7000

19

May 4, 2007

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

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

Dear Ms. Lovett:

I am writing 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*. While the revision addresses many of the practical problems identified during the first comment period, there continues to be many issues that were not addressed. Despite the revisions, this requirement continues to represent a significant burden on hospitals, especially rural hospitals. The burden is directly related to the timing of the notice. At admission or even shortly thereafter it is nearly impossible to accurately predict a discharge date. In addition, at the point during the stay and prior to discharge that the discharge date can be accurately identified, the staff needed to accurately administer and explain the letter and process may not be available. This person, generally a nurse case manager or social worker, must have the ability to explain medical necessity and the discharge planning process. These staff members require vast education and higher salaries. In addition, utilizing nurses to administer this process takes time and resources away from patient care at a time when nurses are already difficult to recruit and retain.

The process for administering the letter when the patient is not competent is unachievable. A significant number of elderly patients are admitted without a family member or other decision-maker. These individuals do not have fax machines, email, and other high-tech equipment to facilitate the signing and education of the form, especially if the form must be updated frequently. Even telephone consent is difficult in this cases and in-person signing is impossible.

This process must be flexible enough to allow for these situations and for situations where no decision-maker exists.

The process can be implemented effectively, efficiently, and accurately by focusing the process and beneficiary questions on the front-end of the admission. Changing the process in this way will still allow realistic beneficiary expectations about hospital admissions by improving understanding of how decisions are made and how the discharge planning process works. This education could be reinforced at discharge with discharge instructions.

Last, consideration must be given for the majority of patients, who despite careful and extensive explanation become fearful and anxious at a time when undue stress is detrimental to their physical health and healing. Patients, for the most part, do not understand "medically necessary" or admission criteria, but instead want care provided consistent with perceived need. In addition, they do not understand an "expected" or "estimated" date of discharge and feel they are being forced out of the hospital. Some of these patients are so fearful that they will be held financially responsible that they will elect to be discharged at the point of the letter. CMS must bear some of the burden for proactive, pre-admission education of expectations and coverage.

Sincerely,

Charles L. "Chip" Denton
Chief Executive Officer

glmc
Grenada Lake Medical Center
960 Avent Drive • Grenada, Mississippi 38901-5094
Phone (662) 227-7000

17

May 4, 2007

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

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

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Sincerely,

Kathy L. Beck

Kathy L. Beck, RN, MSN, CPHQ
Chief Nursing Officer

HDJN

P. O. Box 71050, Richmond, VA 23255-2050
T 804.967.9604 ▪ F 804.967.2411
www.hdjn.com

Kimberly W. Daniel
Ext. 420
Email: kdaniel@hdjn.com

May 4, 2007

VIA FACSIMILE (202-395-6974) AND U.S. MAIL
OMB Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building
Room 10235
Washington, D.C. 20503

Re: Comment to Final Rule CMS-4105-F

Dear Ms. Lovett:

I am writing to you on behalf of MediCorp Health System ("MediCorp"), located in Fredericksburg, Virginia. MediCorp is a not-for-profit regional health system, comprised of twenty-eight health care facilities and wellness services. After reviewing Final Rule CMS-4105-F, published in the Federal Register on November 27, 2006, MediCorp is concerned about the impact certain aspects of this Rule might have on it and other similar health systems.

Specifically, MediCorp's concerns center on the requirement that, at discharge, patients be shown a copy of the IM notice they signed upon admission. MediCorp feels this is an unnecessarily cumbersome requirement. MediCorp has developed standardized admission and discharge processes to ensure patients receive all required and helpful information and documentation. The Rule will require MediCorp to take part of the admission packet/documentation and to add it to the discharge information packet. Requiring the tracking and transfer of the original signed notice so it is available at discharge as required creates a significant burden and does not seem to improve the care or information provided to the patient. Giving the patient a copy of the IM notice or another original IM notice would be equally effective and much less difficult to accomplish.

As an alternative, MediCorp suggests that providers be given the option to provide the first IM notice to the patient within a specified time period, and give the patient a second IM notice form upon discharge. The result of this practice would be that two signed IM notice forms would be included in the patient's medical record, rather than one. The patient would receive the same information under this practice as he would under the system set forth in the Final Rule, but providers would be relieved of the additional burden of accessing the original signed form at discharge.

INTEGRIS
Bass Baptist
HEALTH CENTER

P. O. Box 3168
Enid, OK 73702
580.233.2300 • (f) 580.233.8802

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VIA FACSIMILE 202-395-6974

May 3, 2007

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

Dear Ms. Lovett:

As previously requested, we would like to take this opportunity to express our concern with the proposed CMS-4105-F rule regarding Notification of Hospital Discharge Appeal Rights. While INTEGRIS Bass Baptist Health Center does not have an issue with providing a revised IM to the patient at the time of admission and discharge, we feel that the proposed prohibition to provide this document on the day of discharge provides an added administrative burden to our facility. We do concur that patients should have the right to appeal their discharge but also believe that the patient or his/her representative should bear the responsibility without placing added burden on the facility.

While the proposed rule states that the patient/beneficiary is not required to verify that the notice was given it does require the facility to be able to document that the notice has been delivered. Again we feel that this requirement provides added administrative burden on our facility..

We would request that you review these comments and reconsider implementing this rule prior to July 1, 2007. Thank you for your consideration.

Sincerely,

Jeffrey S. Tarrant, FACHE
President

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St. Charles Hospital

Questions regarding the new Important Message from Medicare

We are a general hospital with an attached acute rehabilitation facility. When a patient is discharged from the general hospital and admitted to the rehab facility can we have the patient date and sign the IM on discharge and make a photocopy of it for our admission notification upon admission to our rehab facility to be placed on that chart?

Thank you for your anticipated answers to these concerns.

Susan Heinz, RN
Director, Care Management
St. Charles Hospital
200 Belle Terre Rd
Port Jefferson, NY 11777
Phone: 631 474-6877
Fax: 631 476-5551
Email:susan.heinz@chsli.org

Saint Joseph's Hospital
MINISTRY HEALTH CARE
Sponsored by Sisters of the Sorrowful Mother

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April 30, 2007

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

FAX Number: 202-395-6974

RE: CMS-R-193

To Whom It May Concern:

The following comments are submitted by Saint Joseph's Hospital, a 504-bed hospital located in Marshfield, Wisconsin. These comments are in response to the request for further comments on the Detailed Notice of Discharge as published in the April 6, 2007 *Federal Register*. If you have any questions or concerns, please call any of the contacts listed at the end of this letter.

Again Saint Joseph's Hospital (SJH) understands and thanks CMS for their efforts in trying to make sure the Medicare beneficiary is well informed of their rights. The changes made in the final rule (as published in the *Federal Register* on November 27, 2006) did help with some of the administrative burdens we would have otherwise had to undertake.

Although some of the burden has been lifted, SJH still feels that a couple rules if lifted would not affect the level of information the patient receives. We agree that the Important Message from Medicare should be given to the patient upon admission and signed by the patient as recognition of information given. We agree that the patient should receive a copy of this also. We do, however, feel that it is unnecessary for staff to give a copy of that same signed document to the patient prior to discharge.

If the patient has received a copy at the beginning of the stay, the duplicate copy would be repeating a task already performed by hospital staff. After many meetings regarding this subject since the November 27th rule was published, it was felt that nursing would be the staff to give the last copy of this document here at SJH. This was due to the large

number of Medicare discharges daily compared to the Case Management staff ratio to patients.

Nursing is not well versed in Medicare regulations, so would not be able to answer questions completely in most cases. This would then involve getting our Case Managers involved to explain any unclear items for the Medicare beneficiaries. We feel that this second explanation would be very time consuming and again taking the Nurse and the Case Manager away from other work needing to be completed.

If the notice must be again given before discharge, SJH would like to offer a different option. Instead of giving the patient a copy of the original signed Important Message from Medicare, could the Medicare beneficiary receive another unsigned IM. We will have the original signed IM as a part of the Medical Records, but making sure that the signed version is used by the nurse during the discharge process could be a problem. SJH would like to suggest that facilities be able to use new, unsigned Important Message from Medicare forms so that they could be placed in the discharge packet up front and thus would not be forgotten during the lengthy and educational discharge process. Nursing gives many forms and education during this time, so having a new IM form would be the easiest way to make sure the Medicare Beneficiary is properly informed. To pull another form out of the chart in addition to the discharge packet would make it more of a chance that it would be missed.

In closing, we ask that changes still take place to make this less of an administrative burden for hospitals and be what it was intended to be – a time for the Medicare Beneficiary to receive the information they need to make an educated decision about their healthcare.

Sincerely yours,

Saint Joseph's Hospital

And representatives of Saint Joseph's Hospital submitting these comments:

Sharon Kostroski

Sharon Kostroski
Vice President of Quality & Safety
715-387-7220

Julie Rodda

Julie Rodda
Revenue Cycle/Reimbursement Coordinator
715-387-7164

Tammy Pawlicki

Tammy Pawlicki
Manager of Case Management
715-387-7182

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glmc
Grenada Lake Medical Center
960 Avent Drive • Grenada, Mississippi 38901-5094
Phone (662) 227-7000

May 4, 2007

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

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

Dear Ms. Lovett:

I am writing 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*. While the revision addresses many of the practical problems identified during the first comment period, there continues to be many issues that were not addressed. Despite the revisions, this requirement continues to represent a significant burden on hospitals, especially rural hospitals. The burden is directly related to the timing of the notice. At admission or even shortly thereafter it is nearly impossible to accurately predict a discharge date. In addition, at the point during the stay and prior to discharge that the discharge date can be accurately identified, the staff needed to accurately administer and explain the letter and process may not be available. This person, generally a nurse case manager or social worker, must have the ability to explain medical necessity and the discharge planning process. These staff members require vast education and higher salaries. In addition, utilizing nurses to administer this process takes time and resources away from patient care at a time when nurses are already difficult to recruit and retain.

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Last, consideration must be given for the majority of patients, who despite careful and extensive explanation become fearful and anxious at a time when undue stress is detrimental to their physical health and healing. Patients, for the most part, do not understand "medically necessary" or admission criteria, but instead want care provided consistent with perceived need. In addition, they do not understand an "expected" or "estimated" date of discharge and feel they are being forced out of the hospital. Some of these patients are so fearful that they will be held financially responsible that they will elect to be discharged at the point of the letter. CMS must bear some of the burden for proactive, pre-admission education of expectations and coverage.

Sincerely,

A. Keith Neartsill, CPA FHFMA
Chief Financial Officer

FACSIMILE COVER SHEET
Case Management Department

TO: Carolyn Lovett

COMPANY: OMB Human Resources & Housing

FAX:

FROM: Kathy Larson RN

FAX #:

DATE: 5/4/07

PAGES: 2
(including cover sheet)

COMMENTS:

Comments on IM from Medicare

Northwest Medical Center
6200 N. La Cholla Blvd., Tucson, AZ 85741 Phone: (520) 469-8500

5/4/07

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

Regarding: CMS Proposed Revision of Important Message from Medicare and Related Paperwork Requirements

Dear Ms Lovett,

Thank you for the second opportunity to comment on the above proposed rule. This is an incredible undertaking for hospitals. I support the American Hospital Association's recommendations in their response of March 6, 2007.

- The second notice be a newly printed duplicate document given to the patient as a part of the patient's discharge instruction package.
- Annual evaluation of the benefit of the proposal.
- Latitude for hospitals to use any means of communication necessary for the notice process with beneficiary representatives with documentation accordingly.
- On-line availability of translated documents in the 15 most common languages.
- The needed clarifications to the form as suggested by the AHA

The discharge rights for Medicare beneficiaries are already given to patients when admitted to the hospital. The CMS Proposed Revision will just add to the voluminous paperwork patients already receive as well. It seems that at some point during the hospitalization that they, or responsible persons, review the information received at time of admission. Hospitals have their responsibilities and so should Medicare beneficiaries or responsible persons for those beneficiaries.

Sincerely,

Kathy Larson RN, BSN
Utilization Management

NORTHWEST HOSPITAL
& MEDICAL CENTER
1550 North 115th Street, Seattle, WA 98133
(206) 364-0500
www.nwhospital.org

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May 04, 2007

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

Re: Proposed Changes to the "Important Message from Medicare" (IM)

I appreciate the opportunity to provide comments as to how the changes, if implemented, will impact our process and increase administrative time that would be better spent caring for your beneficiaries.

Since August 2003, the IM has not been required to be signed by the beneficiary and a copy retained in the medical record. Rather, the IM is currently given to the patient for their information upon admission. This change was driven by CMS wishes to decrease the amount of paperwork Medicare patients are inundated. As proposed, the IM will be given twice, increasing the paperwork given to your beneficiaries, which goes against the fundamental basis of the OMB's Paperwork Reduction Act.

If the IM is issued and signed by the beneficiary upon admission or within 2 days of admission, it is redundant and a great hardship on staff to coordinate the distribution of the 2nd copy within the proposed time parameters prior to discharge. Distributing the 2nd notice will require substantial coordination of both clinical and clerical staff. The effort just to 'ensure' the patient is aware of their discharge rights when they would have been presented with the information, signed that it was received 1 or 2 days prior appears unnecessarily redundant.

Please reconsider the proposed changes as follows. Reinstitute the practice of having beneficiaries sign and date the IM, a copy then being retained in their medical record. However, eliminate the proposed process of issuing a 2nd notice prior to discharge.

Thank you for you consideration and the opportunity to provide comments.

Sincerely,

Sara Blair

Sara Blair
Patient Access Manager
Northwest Hospital & Medical Center

25

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.

- 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)

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

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

May 6, 2007

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

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

Dear Ms. Lovett,

I appreciate the opportunity to comment on the Centers for Medicare and 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, published on November 27, 2006 in the *Federal Register*.

Currently we do give patients the IM upon admission. This is done by our Registration department and is included with the admission paperwork. In the new law, we will be required to give the patient the IM within two days following admission, and hospital staff must ensure that the beneficiary understands the notice and signs a copy of it documenting when they received and that they understand it. A copy of the signed notice will be given to them at that time. We will then provide another copy of the signed notice no more than two days prior to discharge.

While I understand and appreciate the idea of informing patients about their rights, these new regulations will create a significant additional burden to our hospital.

It will be difficult to reach all Medicare patients with the new IM unless we change several key processes and hire additional staff just to comply with the new law. This comes at a time when we are short of clinical staff and because of economic difficulties in this community are limited in hiring replacements.

It has been suggested that in order to not miss any patients who may be changed from post procedure recovery or observation status to inpatient status that we give all Medicare patients coming to the hospital a copy of the IM. This means a great many patients given

the IM will not need it and may be confused when they are not inpatients about their discharge appeal rights.

If we target only inpatients then it would take a full time staff member to track these patients. One plan being discussed is to wait until the physician says the patient will be discharged within the next two days. Since most physicians do not know that far ahead that the patient will be discharged, we will most often be giving the patient a letter on the day of discharge. We also need to take into account that the patient will need a period of several hours to consider their right to appeal the discharge. This may postpone a patient's discharge time.

In a recent patient satisfaction survey, one of the most common complaints regarding the discharge experience were delays in discharge times. We are currently working on processes to improve that problem but the new law may actually bring about further delays and negate any gains we have made in this area.

In order to comply with the second notification requirement we could give every patient staying more than 2 days a letter every third day. That would ensure compliance with the law and would perhaps avoid some delays in discharge times. However, it would require one full time staff member to see all these patients.

The solution to this issue is not easy and I do understand the importance of making sure patients understand their rights.

Several questions come to mind. Could there be more flexibility in issuing the IM's? Would we be able to give the patient this information upon admission and then give them a copy at the time of discharge? Can there be a pilot study done at selected facilities (especially in urban areas) to find an efficient method of giving the patients information and not burden the hospitals unnecessarily? Could there be a community program for educating everyone who has Medicare about their rights before they become ill and are admitted to a hospital?

Sincerely,

John Clark, RN, BSN

Manager, Integrated Case
Management Department
Good Samaritan Hospital
2222 Philadelphia Drive
Dayton, Ohio 45406

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

(27)

May
Four
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 to Important Message from Medicare and Related Paperwork Requirements (Vol. 72, No. 66), April 6, 2007

Dear Ms. Lovett:

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 and Medicaid Services (CMS) proposed revisions to the Important Message from Medicare (IM). The newly revised IM associated with CMS-4105-F would set forth requirements for how hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights.

We appreciate CMS's attempt to create an enhanced process for informing Medicare beneficiaries of their discharge appeal rights and for incorporating meaningful changes into the proposed process in response to GNYHA's and other previously submitted comments. However, we continue to have a number of lingering concerns with respect to:

- The excessive financial burden that hospitals will encounter as a result of these changes; and
- The fact that hospitals will not have adequate preparation time to implement major changes in admission and discharge procedures and to develop new forms to accommodate the new Medicare requirement.

Accuracy of the Estimated Administrative Burden

We believe that CMS has significantly underestimated the cost burden that hospitals will incur as they endeavor to implement procedural and other changes in order to comply with the requirements of the new process for notifying Medicare beneficiaries of their hospital discharge appeal rights. The CMS estimates do not accurately consider the

specific manpower demands or the additional supply expenses that hospitals will assume. Previously, hospital admission clerks issued the IM at the time of admission; the newly revised CMS process will likely require that hospitals designate more highly paid staff to deliver the IM who are conversant in the areas of regulatory, medical necessity, and discharge planning because of the emphasis on the discharge planning process in the revised IM. In addition, the CMS estimate only takes into account the expense associated with delivering the follow-up IM to 60% of hospital Medicare admissions because it discounts short stay admissions. In fact, CMS should consider the expense associated with issuing the signed copy of the IM to 100% of the Medicare beneficiaries since our membership indicates to us that, as a practical matter, a uniform process must be enacted to ensure all Medicare patients are captured, not just 60% of the admissions or those admissions with lengths of stay of greater than 3 days.

CMS should demonstrate greater flexibility and endorse a more reasonable process for issuing the admission and follow up IM when the Medicare patient has diminished capacity to comprehend the IM. Hospitals will incur significant administrative burdens—which have not been considered in the CMS cost estimates–in order to locate a distant family member or other representative authorized under the CMS standards to receive the notices. This patient population is not insignificant and notably includes patients admitted directly to critical care areas, nursing home residents, and psychiatric patients. With particular regard to this subset of patients, we strongly urge CMS to be cognizant of the administrative burden on providers by relaxing the proposed timeframes for issuing the admission IM. Instead of requiring the admission IM to be issued within 2 days of admission, the timeframe should be waived if a hospital can document reasonable efforts to locate/contact the next of kin. In addition, CMS should endorse more practical signature requirements and accept fax or email confirmation or other telephone documentation of good faith and repeated attempts as acceptable proof of compliance.

GNYHA urges CMS to show greater flexibility and permit hospitals to issue and explain the IM during the preadmission testing visit when an elective inpatient service is planned. Because a significant number of Medicare admissions are elective in nature, it is feasible that this subset of Medicare patients could receive the initial IM at the time of preadmission testing, generally up to a week in advance of admission, rather than waiting until the admission date. Patients are generally more at ease at preadmission testing, are often accompanied by a family member, and therefore better able to assimilate important information about the hospital discharge notice. This approach would be clearly advantageous for the Medicare beneficiary and at the same time assist providers to achieve compliance with the process for issuing the admission IM for a substantial portion of Medicare hospital admissions. Should CMS adopt this particular recommendation it could come with the understanding that hospitals would not be exempted from issuing the follow up IM for short stay elective admissions of three days or less.

Implementation Issues and Clarity of Notice

When CMS implemented the Fast Track Appeal process pursuant to BIPA for post acute care providers, it involved the New York QIO to conduct educational sessions for affected providers regarding the new procedures. To date, we have not received any firm confirmation that CMS will similarly provide this needed education for hospital providers in advance of the July 1, 2007, effective date. Because the implementation timeline is rapidly approaching and the different notices are either still not finalized (i.e., IM and detailed notice) and/or not yet released (i.e., liability notice), we are concerned that providers do not have adequate time to internally prepare and make the significant changes to existing procedures.

Finally, as a matter of format, we ask that CMS consider moving the additional information section currently located on the second page of the IM to the first page to simplify the recording of signatures in order to lower administrative costs and facilitate compliance. We are learning that many hospitals will incur additional expense and will be developing a triplicate form using carbonless or NCR paper to facilitate capturing the patient signatures at admission and prior to discharge on the IM and then retaining the final copy as proof of compliance.

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

My best.

Sincerely,

Kenneth E. Raske
President

Seton Family of Hospitals

May 4, 2007

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

Re: Centers for Medicare & Medicaid Services
[Document Identifier: CMS-10003, CMS-901A and D, CMS-9044, CMS-R-193 and CMS-10066]
Agency Information Collection Activities: Submission for OMB Review; Comment Request
Federal Register / Vol. 72, No. 66 / Friday, April 6, 2007 / Notices Page 17169

Dear Ms. Lovett:

The Seton Family of Hospitals 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.

By way of background, the Seton Family of Hospitals consists of several facilities in Austin and central Texas: four general acute hospitals including the regional trauma center; a children's hospital; an inpatient psychiatric hospital; three community primary care clinics and specialty care clinics that serve the working poor; and two critical access hospitals in outlying counties. Seton has determined that the CMS proposed regulation places a significant increased financial and work burden on our hospitals. Consequently, we respectfully request that OMB require CMS to modify their proposed regulation to reduce the burden.

Hospitals currently 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.

Under the new regulations, which take effect on July 1, the IM will be provided to beneficiaries no later than two days following admission. However, hospital staff will be required to ensure that the beneficiary understands the notice, and signs a copy

of it documenting receipt and their understanding of it. A copy of the signed notice will be given to the patient. 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.

While we agree 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 a patient's understanding of how decisions are made and how the discharge planning process works, the process that CMS will require starting July 1 comes at a heavy price.

Even with CMS's relatively conservative burden estimate included in the paperwork clearance package, CMS projects that the burden on all hospitals will increase more than fourteen fold. Using the CMS formula, Seton estimates the burden on our staff and facilities will increase from 1,252 to 17,969 hours.

Further, the former notice was provided by admissions clerks. The new process will require 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. Seton's average hourly wage for clerks is about $14.50, while the average hourly wage for nurses and social workers is about $26.00. Conservatively, *this single change in regulations alone takes our cost from $18,200 to $434,600 per year.*

Seton Family of Hospitals urges OMB to require 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 believe 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. History is repeating itself in this instance. A similar requirement was adopted by statute when the inpatient prospective payment system was enacted and there were widespread fears of "quicker, sicker" discharges. That did not happen. There also was an earlier requirement that beneficiaries sign for receipt of the notice; that, too, was found to be unnecessary. Both of these earlier requirements were 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. OMB should direct 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.

• ***CMS should post on its 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. The American Hospital Association's research affiliate, the Health Research and Educational Trust, recently 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.

If you have questions about our comments, please contact me or Ed Berger, Vice President, Advocacy & Government Relations, at 512-324-1948 or eberger@seton.org.

Sincerely,

Jesus Garza
Executive Vice President & COO
Seton Family of Hospitals

CARONDELET HEALTH
a member of Ascension Health
1000 Carondelet Drive • Kansas City, Missouri 64114 • 816-943-5678 • www.carondelethealth.org

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

April 18, 2007

To Whom It May Concern:

I am writing with comments related to the new "Important Message from Medicare" and the "Detailed Notice of Discharge " I work for a Catholic Health system, Carondelet Health, that is part of the much larger system, Ascension Health. I am the Director of Case Management for 2 acute care facilities. I have several concerns related to this new proposed regulation, and truly appreciate the additional opportunity to comment.

1. I understand the intent of presenting the IM upon admission, but do not feel that a second copy is necessary. For example, do we have them sign a Consent to Treat form at admission and again at discharge?
2. To present this "2 days prior to discharge", will be impossible to administer and remain in compliance from CMS's point of view. Hospital stays are much shorter now, things progress quickly from the morning to the afternoon. A patient that was still undergoing testing and workup in the morning, may be stable and ready for discharge by early evening. We are being set up for failure to meet the guidelines of the 2 days prior to discharge notification. What will be the ramifications if a hospital is not meeting this regulation?
3. In the medical field where there is already a nursing shortage, we are asking nurses to spend valuable time that will take them away from the actual bedside care, to make copies and present the document to patients a second time. This seems very unnecessary. Our hospital has determined that nursing would be the staff to present the 2nd copy, as discharges occur at any time day or night and they are the front line staff that is first aware of the planned discharges.
4. A concern is that presenting this twice to the patient will confuse the elderly population and do more harm that good.
5. The wording of the regulation states "Hospitals will deliver a copy of the signed notice prior to discharge, but not more than 2 days before discharge." This is very confusing. Can we deliver is on the day of discharge? Or at the time of discharge? Our interpretation is that it could be delivered at the time of discharge. Is this correct?
6. This entire process seems very contradictory to the "Paperwork Reduction Act of 1995".

7. We work under the assumption to treat all patients the same regardless of insurance or ability to pay. By only providing this paperwork to Medicare recipients, we are singling out a certain payor source with required documents. Presently our nurses are not aware of the patient's insurance.

Sincerely,

Cynthia L Burress RN

Cynthia L. Burress RN BSN CCM
Regional Director of Case Management

INTEGRIS Baptist MEDICAL CENTER

EXECUTIVE OFFICE
Attn: 1807010
3300 Northwest Expressway Street
Oklahoma City, OK 73112
405.949.3166 • (f) 405.949.3575

May 3, 2007

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

Dear Ms. Lovett:

As previously requested, we would like to take this opportunity to express our concern with the proposed CMS-4105-F rule regarding Notification of Hospital Discharge Appeal Rights. While we do not have an issue with providing a revised IM to the patient at the time of admission and discharge, we feel that the proposed prohibition to provide this document on the day of discharge provides an added administrative burden to our facility. We do concur that patients should have the right to appeal their discharge but also believe that the patient or his/her representative should bear the responsibility without placing added burden on the facility.

While the proposed rule states that the patient/beneficiary is not required to verify that the notice was given it does require the facility to be able to document that the notice has been delivered. Again we feel that this requirement provides added administrative burden on our facility.

We would request that you review these comments and reconsider implementing this rule prior to July 1, 2007. Thank you for your consideration.

Sincerely,

Chris M. Hammes, FACHE
President
INTEGRIS Baptist Medical Center

hospital given the prior track record as mentioned earlier and do not believe that the American public is not aware of its rights or entitlements, as you are well aware. I believe this will actually deteriorate the ability to provide care and services to the patient as scarce resources will have to be once again diverted from patient care to regulatory mandates. I truly believe the position of CMS is to ensure that patients get good, timely care and that this is provided in a financially responsible mechanism, but I think you have to be aware of the unintentional consequences that, given scarce resources, most likely the patients on the whole will suffer by the lack of case management having resources diverted to fulfill this mandate. I would very much be willing to engage in further conversation regarding this well intentioned, however misguided, mission.

Sincerely,

David Schwartz, DO
Medical Director

Northwest Medical Center

6200 N. La Cholla Boulevard
Tucson, Arizona 85741
Phone: 520-742-9000
www.northwestmedicalcenter.com

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April 30, 2007

The Centers for Medicare & Medicaid Services
OMB Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building
Room 10235
Washington, DC 20503

Fax: 202/395-6974

Re: Medicare Discharge Notices

To Whom It May Concern:

I am the Medical Director for Northwest Medical Center and also provide oversight for the Hospitalist Program at Northwest Medical Center and Oro Valley Medical Center in Tucson, Arizona.

I am in receipt of your plan to provide Medicare recipients a second letter one to two days prior to discharge further reminding them of their rights as to appeal. As you well know, at the time of admission, Medicare patients are given Medicare rights, including their rights to appeal their discharge. To give a second letter one to two days prior to discharge, again re-stating their rights creates a number of problems.

By doing this, you are assuming that patients do not understand their rights; or are incapable of understanding their rights at the time of admission when they sign. I can tell you in the appeal process of patients that have been discharged in the last 12 years, other than one appeal, every one of the denials for continued stays has been upheld by you. I do not see any abuse in this system by the hospital. I believe this is an incredible waste of resources which would better serve your patients, instead of handing out pieces of paper reminding them of their rights which they have already been informed of, that this could be time better spent in managing the patients' care such as discharge planning or in attending to other needs of the patients and their family. This also further creates issues with regards to the appeal process. I can assure you when patients don't want to leave the hospital they are well aware of their appeal time and often will utilize up to the maximum until the time that their appeal has been denied. Unfortunately, we are in a society in which people will take advantage of the additional 24 to 48 hours in the hospital and this further reinforces this. I don't believe that people have been unfairly discharged from the

Wheaton Franciscan Healthcare

Sponsored by the Wheaton Franciscan Sisters

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May 2, 2007

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

RE: Form Number: CMS-R-193 (OMB#: 0938-0692)

Dear Ms. Lovett:

Wheaton Franciscan Healthcare is a health care delivery system with hospitals in the states of Wisconsin, Illinois and Iowa. Wheaton Franciscan Healthcare appreciates the opportunity to comment on the revised Important Message from Medicare form.

In order to streamline the process and assure that patients receive the second notice, we are planning on printing the Important Message from Medicare on a three-ply carbon form. The top copy would go to the patient, the second copy would be delivered to the patient within two days of discharge and the third copy would be placed in the medical record. The three-ply form will cost 40 cents as opposed to plain paper which would cost 4 cents. The 4 cents does not include labor costs for locating the form and then making copies of the form for delivery to the patient.

Given that this from must be scanned into our electronic health record, the form will require a bar code and will have certain margin requirements, as all our forms now do. After a logo is placed on the form, we will still need a larger margin that is on the proposed form. All forms now require a 3/4" in margin. We also place stickers on forms that include the patients name and certain demographic information. This sticker needs to be within the 3/4" margin. We ask that hospitals be required to utilize the content of the form but be allowed to modify some of the formatting, including spacing, as well as where the demographic information and date are placed, so that the form can be compatible with various electronic health record systems.

The "Additional Information" space for additional signature and date lines will be helpful for our documentation purposes. However, given our electronic health record requirements, space for such items is very limited.

Please let me know if you have any questions about our comments. I can be reached at 630-909-6903.

Sincerely,

Julia J. Ward
Vice President, Compliance and HIPAA Services

JJW/

INTEGRIS
Southwest
MEDICAL CENTER

Patricia J. Dorris
President

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May 3, 2007

OMB Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building
Room 10235
Washington, DC 20[illegible]

Thanks!

Dear Ms. Lovet

Patricia

As previously req express our concern with the proposed ital Discharge Appeal Rights. While we o to the patient at the time of admission ar on to provide this document on the day burden to our facility. We do concur ir discharge but also believe that the pa esponsibility without placing added b

While the proposed rule s is not required to verify that the notice was given, it doe able to document that the notice has been delivered. Again, equirement provides added administrative burden on our facility.

We would request that you review these comments and re-consider implementing this rule prior to July 1, 2007.

Thank you for your consideration.

Sincerely,

Patricia Dorris

Patricia J. Dorris
President

.PJD/kk

4401 South Western
Oklahoma City, OK 73109
405.636.7284
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Robert S. Hodges, MSN, RN
Manager, Clinical Resource Management
Midas Certified System Manager

Covenant HealthCare
1447 North Harrison
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Fax- 989-583-1097
Pager- 989-258-7242

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A Promise of Caring, A Commitment to Service.

We are what we repeatedly do, excellence is not an act, but a habit." -
Aristotle

Clinical Resource Management Department **Covenant HealthCare**

Memo

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

From: Robert S. Hodges, MSN, RN
Manager, Clinical Resource Management Department
1447 N. Harrison
Saginaw MI 48602

CC:

Date: 5/1/07

Re: Important Message from Medicare and Detailed Notice of Discharge Comments

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Thank you for the opportunity to comment on these documents.

Regarding the Important Notice from Medicare, CMS-R-193, at this time I feel a block needs to be added to allow patients/family members to initial and date that they have received their second notice.

Regarding the Detailed Notice of Discharge, CMS-R-10066, I feel this document is to vague to be useful to the hospital when attempting to prepare a notice. A format closer to the Hospital Issued Notice of Non-coverage for continued hospitalization may be more appropriate. I feel the instructions provided are vague and for an issue like this there do need to be specific guidelines.

Other questions I have on this notice are:

1. "Explanation of Medicare coverage policies that we used to determine that Medicare will no longer cover your hospital stay." –
    a. Would this include the use of a discharge screen using the utilization management criteria, in our case InterQual?
    b. How much detail is expected? Would a statement that the attending physician feels that you are able to safely move to the next level of care and that you meet the hospitals criteria to move to that next level of care be sufficient?
2. "Medicare managed care policies."

a. I presume this means the private payer policies if a patient has one of the commercial policies available.

b. Will those payers be required to provide the hospital with this information if they make the determination that the patient can move to the next level of care?

c. Will a hospital have to use the guidelines provided by the payer or use their own guidelines to determine appropriateness for transfer/discharge to the next level of care?

d. Also based on this notice and the content it requires, I feel that the staff available to prepare and deliver this notice must be at least at the level of an RN or an RN must be available to assist in preparation of this document along with the attending physician. Has consideration been given to this, especially for weekend and holiday appeals? I anticipate a possible requirement for additional FTE's to support this program or at a minimum a reallocation off existing staff to support the weekend/holiday discharge requirement.

Overall, I feel this will cause an increase in length of stay in the inpatient hospital setting because of the time frames involved should a patient appeal their discharge and that more patients will appeal their discharge simply because they don't feel "ready" to go to the next level of care, or in some cases they do not wish to go to the next level of care.

Thank you for your time and consideration. I will look forward to the final notice and further changes to the implementation of this policy.

Sincerely,

Robert S. Hodges, MSN, RN

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LRMC TVRH

Leesburg Regional Medical Center The Villages Regional Hospital

May 3, 2007

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

RE: (CMS-1003, CMS-901A and D, CMS-9044, CMS-R-193 and CMS-10066) Important Message from Medicare (72 Federal Register 17169), April 6, 2007

Dear Ms. Lovett:

We appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to the Important Message from Medicare (IM), as published in the April 6, 2007 Federal Register.

The first area of concern is with regard to the delivery and signing of the IM. In order for us to comply with providing a beneficiary with a copy of the IM within 2 calendar days of admission and then follow-up with a copy within 2 calendar days of discharge, we would need to involve many departments in the process (Admitting, Nursing, and Case Management). It was estimated that the average time for IM delivery was 12 minutes and the delivery of the copy was 3 minutes. In certain instances where the beneficiary is not in the room because they are having additional tests run or if the beneficiary is unable to comprehend the information (due to competency or language barrier) this time frame could easily increase to over 30 minutes.

We believe that this could become quite a labor intensive and time consuming process not to mention an increased possibility of copy delivery failure. In instances like these, we are especially concerned with the penalties imposed for not providing a copy of the IM a second time?

Also, how should instances where a beneficiary refuses to sign the IM be handled?

Lastly, will multiple translations of the IM be made available (i.e. Spanish etc)?

Respectfully,

Nikisha Bailey
Corporate Compliance Manager

this date. It is important that hospitals be afforded at least 60 days from the time the form is finalized and a Medicare transmittal is issued to be in compliance with the regulations.

Cost of Delivery

CMS has failed to account for the full cost of the preparation of the "Detailed Notice," which CMS estimates will take approximately one hour. MCHC hospitals estimate that the detailed notice will take twice as long as proposed to complete and to deliver to the Medicare beneficiary because of the level of detailed information requested, the need to involve the physician or a hospitalist, and the need to translate clinical information into plain English. The process will take even longer for non-English speaking patients.

Additional Information

Thank you again for this opportunity to review CMS' proposed "Detailed Notice of Discharge" and to offer comments. We would appreciate another opportunity to comment on the notice once CMS has provided examples of completed forms and has provided additional information on the guidelines and Medicare coverage policies hospitals should be referencing.

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

We are concerned that the "Detailed Notice" has been developed based on similar forms used in non-hospital settings that do not easily transfer to an acute care setting and that it does not take into account how inpatient discharge decisions are made. We find the language of the proposed "Detailed Notice" more applicable to services in a non-acute setting or for a specific ambulatory service. For example, reference to describing "the current functioning and progress of this patient with respect to the services being provided" is applicable to home health services, not inpatient care. CMS itself indicates that when it developed the form, it "took into account beneficiary comments made when the detailed notices used in the non-hospital settings for both Medicare Advantage and original Medicare were consumer-tested." CMS makes no reference to testing the proposed "Detailed Notice" in an inpatient setting, which is where the form is expected to be used and which differs significantly from non-acute services.

Proper Completion of Form

It is important to note that in an inpatient hospital setting, a discharge decision is made by the attending physician based on the physician's professional judgment. The discharge decision is not made by the hospital, and it is not made based on a specific Medicare coverage rule or policy. It is unclear to us which specific guidelines CMS expects hospitals to use in completing the proposed "Detailed Notice." In 2005, the Quality Improvement Organization (QIO) for Illinois adopted the Milliman Care Guidelines for non-physician review nurses when screening Medicare cases for referral for physician review. Should hospital case management staff be referring to these guidelines, or to some other national criteria such as those developed by Interqual, when it explains to a Medicare beneficiary why an inpatient stay is no longer necessary?

The guidelines on which acute continued stay is evaluated are clinical and technical in nature. As a result, it is not clear how CMS expects the hospital to complete the proposed "Detailed Notice" since both detailed and specific reasons in plain English are required. Will it be sufficient for the hospital to attach, for example, a copy of the Milliman guidelines relevant to the patient's medical condition and to indicate that these attached criteria are not met?

Examples Needed

It is difficult to evaluate the proposed "Detailed Notice" without some concrete examples. Can CMS develop a set of specific examples of completed forms for several different clinical situations so that hospitals will have a better idea exactly how CMS expects the forms to be filled out? It would be helpful if this could be done in such a way as to allow for additional public comment before the form is finalized.

Implementation Date

The regulations associated with the "Detailed Notice" require that hospitals begin using this new form and new discharge notification procedures July 1, 2007. We are concerned that the "Detailed Notice" and the administrative instructions for its completion will not be finalized with sufficient time for hospitals to modify their internal procedures and train staff by

INTEGRIS
Canadian Valley
REGIONAL HOSPITAL

1201 Health Center Parkway
Yukon, OK 73099
405.717.5000

May 3, 2007

OMB Human Resources and Housing Branch
Carolyn Lovett
New Executive Office Building, Rm. 10235
Washington, DC 20503

Dear Ms. Lovett:

As previously requested, we would like to take this opportunity to express our concern with the proposed CMS-4105-F rule regarding Notification of Hospital Discharge Appeal Rights. While we do not have an issue with providing a revised IM to the patient at the time of admission and discharge, we feel that the proposed prohibition to provide this document on the day of discharge provides an added administrative burden to our facility. We do concur that patients should have the right to appeal their discharge but also believe that the patient or his/her representative should bear the responsibility without placing added burden on the facility.

While the proposed rule states that the patient/beneficiary is not required to verify that the notice was given, it does require the facility to be able to document that the notice has been delivered. Again we feel that this requirement provides added administrative burden on our facility.

We would request that you review these comments and reconsider implementing this rule prior to July 1, 2007. Thank you for your consideration.

Sincerely,

James D. Moore, FACHE
President

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

Re: Revision of Currently approved collection; Medicare and Medicare Advantage Programs; Notification Procedures for Hospital Discharges-Important Message from Medicare

University Hospitals Case Medical Center (University Hospitals of Cleveland) has about 1,000 Medicare discharges a month.
We are a tertiary facility (including 4 adult ICU's) with many emergency transfers from community hospitals.
These patients are acutely or critically ill within the first 2 days of their admission. This is the time period where they would not easily understand an IMM. Providing this with an explanation of the discharge process would require a case manager or social worker, it would also require a change in staffing, resulting in an increase in staff and cost to be able to provide this service on the weekend.

If the patient can not understand, we would then need to contact a family member, friend or guardian who would accept this on the patient's behalf. This is often difficult to determine the appropriate person and to reach that person, and to explain it to them.

From our current experience in providing these letters, they often result in a lot of questions from the patient or family, or both. This would be a very time consuming and costly process. Also due to the acute nature of the illness within the first 2 days of admission, the discharge plan may not be known causing unnecessary concern for the patient/family.

Thank-you for your consideration of the burden this places on the hospital.

Kimberly Littell
Manager, Utilization Management
University Hospitals Case Medical Center

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INTEGRIS Health

May 3, 2007

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

Dear Ms. Lovett:

As Chief Operating Officer of INTEGRIS Health, the largest not-for-profit health care system in the State of Oklahoma, I am writing to express concern with the proposed CMS-4105-F rule regarding Notification of Hospital Discharge Appeal Rights. We do not have an issue with providing a revised IM to the patient at the time of admission and discharge. However, we believe that the proposed prohibition to providing this document on the day of discharge provides an added administrative burden to our hospitals that is unnecessary. We concur that patients should have the right to appeal their discharge, but we also believe that the patient or his/her representative should bear this responsibility. The placement of this added responsibility on hospitals, particularly on small rural hospitals, creates an undue burden on staffs that already fill multiple roles and deal with volumes of paper requirements.

While the proposed rule states that the patient/beneficiary is not required to verify that the notice was given, it does require the facility to be able to document that the notice has been delivered. Again, I urge you to reconsider this requirement which creates added administrative burden on our hospital staffs.

I strongly urge you to review these comments and to reconsider the implementation of this rule prior to July 1, 2007. Thank you for your consideration. I will be happy to discuss this matter further by telephone and can be reached at 405-949-3177.

Sincerely,

C. Bruce Lawrence
Executive Vice President &
Chief Operating Officer

High Point Regional Health System
601 North Elm Street
P.O. Box HP-5
High Point, NC 27261
(336) 878-6000
www.highpointregional.com

May 3, 2007

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

Ms. Lovett:

I am writing to submit comments concerning the proposed change in the processes related to CMS-R-193, the "Important Message from Medicare." The proposed revisions will place unreasonable, additional administrative burdens on hospitals. Using the methodology from CMS to calculate the number of hours needed to follow the proposed processes, I estimate that our Health System will need more than 2,100 hours per year to reach compliance. The proposal does not increase reimbursement to hospitals to compensate for this workload. Due to the complexity of hospital operations, compliance will be difficult in many in many cases. Below are descriptions of just a few of those situations.

Critical care patients: While many of these patients would be able to understand the notice, it would be inappropriate to disturb them for this purpose. Under the proposal, a representative can only sign if the patient is unable to understand.

Patients in isolation: As a former patient who was in isolation, I would have been very upset by someone coming into the room merely for the purpose of providing this notice and obtaining a signature. I would have been quite capable of understanding the notice, so signature by my representative would not have been compliant. Only people providing treatment should enter isolation rooms. It is not appropriate to ask nursing or other direct care givers to deliver the notice and obtain the signature, because they would not have enough knowledge about the appeals process to be able to answer questions. It is also not feasible to train hundreds of care givers to the point where they would be able to answer questions. While the notice does provide the patient with the name and phone number of someone to call with questions, it is not reasonable to expect that coverage 24 hours per day, 365 days per year.

Lack of information about the patient's insurance: Not all patients provide accurate insurance information at the time of admission. This would make it difficult, if not impossible, to meet the 2-day requirement.

A Century of Care 1904-2004

DETAILED NOTICE OF DISCHARGE

Patient's Name: _____ Patient ID Number: _____
Hospital Name: _____
Attending Physician: _____
Date Issued: _____ Time: _____

This notice gives you a detailed explanation of why your doctor and hospital (and/or your managed care plan, if you belong to one) believe you no longer need to be in the hospital. Your discharge from the hospital is scheduled for _____. This decision is based on Medicare coverage policies and your doctor's medical judgment.

This is not an official Medicare decision.

The decision on your appeal will come from your Quality Improvement Organization (QIO). The QIO is the organization that reviews hospital care on behalf of the hospital, Medicare and Medicare health plans. Physicians at the QIO are available to you, your physician, and the hospital and will help determine the best possible plan for you.

☐ The decision to approve your discharge from the hospital is based on your health condition and the following:

☐ Described here is an explanation of Medicare coverage policies (and those of your health plan if you have one) that are used to conclude that your hospital stay will no longer be covered:

☐ More information is available to you:

a) If you would like a copy of the information sent to the QIO related to your discharge from the hospital, please contact the QIO. [insert QIO phone number]

b) If you would like more information on Medicare Coverage policies for your hospital stay please call 1-800-MEDICARE (1-800-633-4227), or your Health Plan number which can be found on the back of your Membership card. _____

c) Should you need help in making these calls, please don't hesitate to ask a hospital representative for assistance. {insert hospital phone number) _____.

We are confident that you will receive a fair and prompt decision and that you will get the best, and most appropriate care available to you.

Patients with no representative: Some Medicare patients do not have a representative, or may have a representative who is not on site. There is no provision about what to do in this circumstance.

Difficulty in contacting the patient's representative: Even if the patient has a representative that is onsite, they certainly are not here at all times. For example, some may only visit after work. Under this proposal, hospital staff will need to "track down" the patient's representative to present the document and to obtain a signature.

Another troublesome aspect of the proposal is the need to deliver a SECOND copy of the notice prior to discharge. This repetitive delivery is just the type of process that organizations try to eliminate as part of efforts to become more efficient. The only people who would have the best idea of when the patient will be discharged are the direct care givers. We do not encourage care givers to know what insurance the patient may have, because it is truly irrelevant to patient care. This process would require someone involved in patient care to recognize an upcoming discharge of a Medicare patient, and to either deliver a copy of the signed notice or to notify someone who has that responsibility. Many of the same problematic situations listed above will occur again at discharge. If the admission part of the process were implemented, then the patient already has a signed copy of the document. Providing a second copy is redundant and unnecessary. At a minimum, this part of the proposed process should be deleted.

This proposal provides minimal time for implementation. Comments must be submitted by May 6, and compliance is expected by July 1. This does not allow adequate time for process changes and training.

It is also important to note that this proposal does nothing to improve patient care. Isn't that the focus we should all have? Aren't there better ways to spend scarce personnel resources?

I would be most happy to discuss any of the above point with you. My contact information is below. Thank you for your consideration of these comments.

Carol D Kendall, RHIA

Carol D. Kendall, RHIA
Compliance Auditor
High Point Regional Health System
Phone: 336-878-6000, ext 2086
Email: ckendall@hprhs.com

High Point Regional Health System
CLINICAL DENIAL MANAGEMENT
PO BOX 2680
HIGH POINT, NC 27261-2680

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

May 3, 2007

Dear Ms. Lovett,

I am writing in response to the proposed changes related to CMS-R-193, the "Important Message from Medicare." I applaud CMS' efforts to notify both Traditional Medicare and Medicare Advantage (MA) beneficiaries of their appeal rights. Unfortunately, the most iniquitous issue facing Medicare beneficiaries is that MA Plans consistently fail to notify their beneficiaries that hospital stays are denied until after discharge. Current MA laws do not afford contracted Providers appeal rights. In stark contrast, Traditional Medicare affords Providers the same appeal rights as the Beneficiary. The proposed IM changes will not protect, nor provide, MA Beneficiaries the same appeal rights afforded Traditional Medicare Beneficiaries until the laws provide both with the same appeal rights even when the MA plan is contracted with the Provider.

The most troublesome aspect of the proposal is the need to deliver a second copy of the notice prior to discharge. The most efficient organizations eliminate redundant and non-value added processes in order to provide the highest quality health care. The proposed revisions place an impossible administrative burden on Providers. Compliance will be an absolutely impossible task. Providers should be allowed to focus more on discharge planning than that the patient receives a second copy of the IM. The second copy requirement should be deleted as two notices does not offer any benefit whatsoever to the patient.

For example, MA plans will continue to notify Providers and Beneficiaries at the time of or after discharge that stays are not covered so providing the second notice prior to discharge will not protect MA beneficiaries. Until MA plans are forced to notify Beneficiaries in real time of denied stays or days, MA beneficiaries will continued to be denied their rights under the law. Unfortunately, most MA beneficiaries are not aware of these issues. MA Plans know the Beneficiary can not be held financially responsible unless notified prior to services being rendered; therefore MA Plans wait until after discharge to provide adverse determination notices, effectively holding the Provider financially responsible for the uncovered stay. MA Beneficiaries are denied a second medical necessity review by a different Physician under current MA regulations while Traditional Medicare beneficiaries and Providers are afforded a 5-step appeal process.

MA laws mandating adverse determination notifications given prior to discharge will protect MA Medicare beneficiaries, not the proposed second IM notice. Furthermore, the second notice requirement would force Providers to increase their focus and limited resources on meeting this requirement instead of meeting the real health care needs of their patients. All Medicare Beneficiaries absolutely should have their appeal rights provided and protected but a second notice will not provide additional protection for Traditional Medicare Beneficiaries and most certainly will not protect the MA Beneficiaries' appeal rights under the current MA laws.

Thank you for your time and consideration in this extremely important matter,

Shiryl Foster RN, MSN, MBA

Shiryl Foster RN, MSN, MBA
Manager, Clinical Denial Management
High Point Regional Health System
Phone: 336-878-6000, ext 2857
Email: sfoster@hprhs.com

OMB Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building, Room 10235
Washington, DC 20503
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Comment on Revisions to Medicare Notices:

As the persons responsible for quality and clinical case management in the Covenant Health system in the Knoxville, Tennessee area we would like to comment on this revision:

We find it a heavy burden on facilities to achieve giving this second notice, and for what purpose? Patients are already receiving the information on admission and if they do not meet inpatient criteria, determined appropriate for discharge and they disagree, they are issued a HINN which provides them three grace days and the opportunity to appeal.

The logistics of accomplishing providing this information prior to discharge burdens an already overworked staff (especially in our smaller facilities) and is one more paperwork initiative that diverts their attention away from the quality hands on patient care we proudly provide.

The Acute Care Quality Council of Covenant Health, Knoxville, Tennessee

Nancy Van Voorhis, RN, CPHQ Fort Sanders Sevier Medical Center, Sevierville, TN
Judi Stindt, RN, BSN, MSN Fort Sanders Regional Medical Center, Knoxville, TN
Missy Sanford, RHIA, CPHQ Parkwest Medical Center, Knoxville, TN
Coletta Manning, RN, MHA, CPHQ Methodist Medical Center, Oak Ridge, TN
Nora Price, RN, BSN, CCM Fort Loudoun Medical Center, Lenoir City, TN

The 2nd notice would be extremely burdensome and costly to facilities in so many ways and makes it difficult to address Administrative Simplification. The NAHAM organization opposes this requirement. However, we would like to recommend instead that the language be changed to state that 'Facilities should only be required to provide a notice to the patient when the patient/guardian disagrees with the discharge decision of the physician. Since the case managers are already involved in their discharge planning, the case managers could provide the 2nd notice at that point. This would seem to be an equitable compromise and one that supports the rights of the Medicare beneficiary.

Respectfully submitted,

Ed Spires, CHAM
President- NAHAM

National Association of Healthcare Access Management
NAHAM

May 4, 2007

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

RE: Comment Period – CMS Proposed Changes to the "Medicare Important Notice" Delivery

Dear Ms. Lovett:

The National Association of Healthcare Access Management would like to voice their collective opinion regarding the proposed change in the provision of the notification to Medicare patients. We are not in favor of the two major proposed changes.

One change requires the signature of the Medicare patient or their representative. This was a previous requirement that CMS agreed to remove due to the impact it would make on hospital providers. Delivery of the notice was a strain on resources in and of itself, but having to track down patients who often are not in their rooms due to procedures, etc., was inefficient for hospital staff. Bringing this requirement back will clearly add additional costs to provide staff to perform the follow up with a patient and/or their representative. The NAHAM organization opposes this requirement. The current method of providing the Notice on admission without a requirement for a signature and only providing additional detail to those patients who need to know meets the intent of legislation. To require a signature and give the patients a copy prior to discharge creates storage and copying costs that have not been considered at all in their calculations and will be extremely difficult to manage in that a large number of these beneficiaries are not capable of signing, live in nursing homes and do not have a guardian who can be accessed to obtain signature.

The second change is the presenting of the Notice of Non-Coverage to the Medicare Beneficiary patients "not more than two calendar days PRIOR to a patient's discharge." Patient Access staff does not review patients' medical charts to identify potential discharges. Discharge planning functions typically reside with case management professionals. Therefore, the issue will be **how to identify** a patient's discharge "**the two calendars days prior to the patient's discharge**" and who will present the 2nd Important Message. Unlike services provided in HHAs, SNFs, CORFs and hospices, in an acute medical setting many factors determine a patient's discharge eligibility. The question becomes, "Will acute medical facilities be expected to not discharge Medicare beneficiaries on the same day they're identified as being eligible for discharge (*sometimes based on receipt of test results in the afternoon*) if the Notice of Non-Coverage was not presented the previous day, therefore adding one day to their LOS?"

Baptist Health
MEDICAL CENTER
Little Rock

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

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

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.

Baptist Health
MEDICAL CENTER
Little Rock

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Little Rock, AR 72205-7299
501 202-2000

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In addition, delivery of the follow up copy of the Important Notice from Medicare also poses an unnecessary financial burden on the hospital. 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

April 23, 2007

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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.