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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.

I hope you find this comment useful as CMS moves forward in implementing this Final Rule. Should you have any questions regarding the foregoing, please do not hesitate to contact me.

Sincerely,

Kimberly W. Daniel

cc: MediCorp Health System

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Becky Sutherland Cornett, Ph.D.
564 Dark Star Ave.
Columbus OH 42330
May 3, 2007

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

Dear Sir/Ms.:

I am writing to comment on the proposed "Detailed Notice of Discharge" (CMS-10066; OMB 0938 – New) discussed in the April 6, 2007 *Federal Register* at pages 17169-17170. The requirements listed in the Notice Instructions accompanying the form are problematic for hospitals and for beneficiaries for the following reasons:

- Bullet #2 "explanation of Medicare coverage policies that we used to determine that Medicare will no longer cover your hospital stay." Physicians and case managers do not use Medicare coverage policy per se to determine when a patient no longer needs an acute-care hospital level of care. Physicians are paid to make very careful, informed decisions about a patient's needs based upon their experiences, the patient's specific circumstances, and research evidence published in the medical science literature, by medical practitioner societies and associations, and local hospital or physician department protocol. The only guidance CMS provides regarding a patient's need for an acute-care inpatient stay is in the *Medicare Benefit Policy Manual*, and that is not very specific. There are no other policies I can find that could be listed for beneficiaries that definitively state when a beneficiary should be discharged to a less restrictive level of care.

- Last statement on the form: "If you would like a copy of the Medicare coverage policies or Medicare managed care plan policies used to make this decision...." Again – what policies are being referenced here? Surely CMS administrators do not want or expect hospitals to copy sections of the *Medicare Benefit Policy Manual* for the beneficiaries!

- Please provide a specific list of policies that CMS believes are applicable so we all know what to use to consider discharge decisions and what to print for beneficiaries to read.

- With these enhanced discharge appeal notice requirements, CMS is creating a potential flood of discharge protests as the Medicare beneficiary population increases, national health policy does not address the growing need for custodial care, SNF stay and payment requirements continue to be so restrictive, there are inadequate provisions for home care, and adult children do not want to bother with their aging parents. Hospitals cannot bear the burden of our failed national health care "system." Please do not punish all acute-care hospitals for the sins of a few rogue hospitals. Go after the hospitals that dump homeless patients on the streets in Los Angeles, not hospitals who in good faith discharge patients based on solid medical criteria (and not Medicare coverage policies).

Thank you for the opportunity to comment.

Sincerely,

Becky Sutherland Cornett

CARILION
New River Valley
Medical Center

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, Manager Clinical Effectiveness
CNRVMC

2900 Tyler Road Christiansburg, Virginia 24073
P.O. Box 5 Radford, Virginia 24141 [illegible]