Attachment 300 (1)

UPMC University of Pittsburgh Medical Center

Corporate Care Management/Resource Center

Quantum One Building
Fourth Floor
2 Hot Metal Street
Pittsburgh, PA 15203

June 5, 2006

VIA Electronic Submission

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

Dear Sir or Madam:

On behalf of the University of Pittsburgh Medical Center (UPMC) we are submitting our comments and concerns regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (71 FR 17052, 4/5/2006) "Medicare Program; Notification Procedures for Hospital Discharges." UPMC comprises 19 hospitals and a network of other care sites across a 29-county service area: doctors' offices, cancer centers, outpatient treatment centers, specialized imaging and surgery facilities, in-home care, rehabilitation sites, behavioral health care, and nursing homes. All care management activities within UPMC are coordinated by the corporate care management department to ensure consistent policies and procedures are in place.

Our Directors of Care Management and Physician Advisors have serious concerns about this proposed rule and request that it be withdrawn. We believe that the impact of this proposed rule is not minimal to acute care facilities, but instead places additional administrative and financial burdens on healthcare staff, requires unnecessary extensions of patient stays and is redundant to current notification requirements. Within our organization issuance of Hospital Notices of Non-coverage (HNN) and Notice of Discharge and Medicare Appeal Rights (NODMAR) falls within the scope of the care management department at each of our facilities and contrary to CMS position on the minimal impact to acute care facilities, we recognize that adding the issuance of the two-step discharge notification for acute care hospitals would require expenditure of additional resources and be an administrative burden to all involved. Staffing would need to be adjusted to have resources available on weekends and after hours. Turnover rates within care management nationally are extremely high as case loads are increasing but FTEs are not. Adding additional administrative burden to an already taxed workforce will contribute to the unnecessary loss of advanced practice staff. Feedback from UPMC professionals that have had experience with this requirement in both the home health care and skilled nursing environments agree that to mandate this process within acute care facilities is not reasonable.

The estimation of 60-95 minutes for the two-step process to be completed is a gross underestimation of the resources that will need to be allocated to this process. Given the numerous changes with Medicare and the recent confusion surrounding patients passively enrolled in Medicare Advantage Plans, this additional change will add to the chaos that currently exists for the Medicare population.

Given the rapidly aging population and challenges faced by acute care hospitals to care for this population, it is not practical to expect that hospitals can be compliant with the requirement to provide the discharge notice 24-hours prior to discharge. In the event of a 1 day length of stay the

notification would need to be provided at the time of admission. For patients with longer lengths of stay the physician decision to discharge the patient will depend on test results and response to treatment; therefore, the predictability within 24 hours will be difficult to assess in many cases.

Furthermore, in the event that a decision has been made to discharge the patient, but the 24-hour notification has not been given, is it the expectation that facilities will need to increase the overall length of stay to comply with this regulation? These additional 24-hours in the hospital may place the patient at risk for infection and/or an adverse event.

Lastly, there has been no guidance as to how patients with altered level of consciousness, decreased mental capacity, and/or language barriers should be addressed. In these situations the estimated time to comply will significantly increase. Additional education and resources to ensure patients are adequately informed and understand these forms will need to be put in place.

The content of the documents that will be required for this notice is not significantly different than what is currently contented in HNN or NODMAR documents. It is not clear what the added value to the beneficiary would be in the new process. Medicare beneficiaries and their families are already under a significant amount of stress and have had difficulty understanding the changes in Medicare coverage in the last several years. Implementation of this proposal will only add to the state of confusion that already exists as it will not be possible to accurately predict discharge given the amount of clinical variables that ultimately determine the patient's stability for discharge.

We strongly believe that the process that is currently in place to issue a HNN or NODMAR is appropriate. The proposal does not provide justification to do away with an already efficient process to add to the administrative burden and increased resource utilization for Medicare beneficiaries. The cost to implement this rule and resource that would need to be allocated to comply with this regulation can be better spent in enhancing services for Medicare and Medicare Advantage members and/or in addressing the many underinsured or uninsured Americans.

Respectfully submitted on behalf of UPMC and UPMC Care Management,

Charlene Redman RN, MSN
Director, Corporate Care Management
UPMC| University of Pittsburgh Medical Center

And

Paul Stimmel
Sr. Special Projects Manager, UPMC

Attachment #305

June 5, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Dear. Dr. McClellan:

RE: CMS-4105-P

I write to you today on behalf of Saint Luke's Health System (SLHS) in Kansas City, Missouri. SLHS is made up of eleven hospitals, several physician groups, and other medical services organizations. Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule, "Medicare Program; Notification Procedures for Hospital Discharges" appearing in the Federal Register, Vol. 71, NO. 65, on Wednesday, April 5, 2006.

We have many concerns about this proposed rule. Most important, it will affect the quality of care for outpatients, by potentially and unnecessarily extending their length of stay. It will also place an administrative burden on our hospitals that greatly outweighs the would-be benefits reported in the proposed rule.

Provisions of the Proposed Rule
We understand CMS's intent to standardize the discharge process for Medicare beneficiaries, but the requirement to give patients (or their representatives) one-day notice is not always practical. For example, the decision to discharge a patient often is not made until the morning after an uneventful night and it is determined that the patient no longer requires inpatient care. This is not an exceptional circumstance, but standard practice in today's world of healthcare. If it is then required that the patient be given one-day notice of discharge, the result would be an additional day of stay, increased costs for that stay, and a reduction of efficiency for the hospital and physician.

In our largest facility, Saint Luke's Hospital of Kansas City, a tertiary care facility, our average length of stay is 5.4 days. Since lengths of stay are short and patient conditions can stabilize quickly, it is very difficult to predict a discharge one day in advance. As an alternative, we recommend that patients be notified by noon on the day of expected discharge, with a deadline of 5:00 PM if the patient wishes to appeal the discharge. This provides the patient ample time to consider the discharge and notify the Quality Improvement Organization if they decide to seek an expedited appeal. Furthermore,

many patients are discharged from the hospital in 1 or 2 days, shortly after the patient has received their "Important Message from Medicare" (IMM) information during the admission process. In these very common situations, the requirement that a patient receive one-day notice before discharge would increase the length of stay by 50 to 100 percent.

In addition, we believe the proposed rule will add redundancy to the current requirements and create an unnecessary burden on hospitals. The current process (providing the IMM, followed by the "hospital-issued notice of noncoverage (HINN)" if concern or disapproval of the discharge is expressed by the Medicare beneficiary) is more than sufficient to protect the rights of the patient. Because the average length of stay at Saint Luke's Hospital is just over 5 days, the patient will receive an individual form communicating virtually the same information just received only a few days earlier, only serving to duplicate documents and increase the burden on the providers.

Collection of Information Requirements

Section 405.1205 Notifying Beneficiaries of Discharge From Inpatient Hospital Level of Care

In this section, CMS estimates, "that it would take hospitals 5 minutes to deliver each notice" of impending discharge. We feel this estimation is inaccurate and does not take into consideration the level of explanation that may be necessary for patients to fully understand what it entails. Also, if the patient is not the official representative responsible for making decisions, the amount of time it could take to reach that person and obtain an approval signature may be an additional day.

Conclusion

We value and understand the efforts of CMS to provide a consistent approach to the discharge and appeal process for Medicare beneficiaries from various types of healthcare providers. Likewise, we take very seriously our obligation to provide the highest quality of care and consideration for our patients. However, the proposed rule will have serious negative impacts for hospitals and beneficiaries. We respectfully urge CMS to maintain the current process which already provides notification to Medicare beneficiaries by means of the IMM, and a further detailed notice if the beneficiary expresses disapproval of the discharge decision. We support the American Hospital Association and the Association of American Medical Colleges recommendation that a national workgroup of affected parties be convened if CMS desires to further examine discharge planning issues.

If you have questions concerning these comments, please do not hesitate to contact me or Jodi Faustlin at rfaustlin@saint-lukes.org, or 816-932-8160.

Sincerely,

G. Richard Hastings, FACHE

(3)

Submitter : Dr. Steven Strongwater **Date:** 06/05/2006

Organization : UConn Health Center/John Dempsey Hospital

Category : Hospital

Issue Areas/Comments

Background

Background

We believe that the current process to provide the IMM followed by a hospital-issued notice of noncoverage (HINN) if a beneficiary expresses dissatisfaction with an impending discharge sufficiently protects the rights of Medicare beneficiaries. As the proposed rule acknowledges, the IMM provides much of the same information about appeal rights as the proposed standardized discharge notice. (71 Fed. Reg. at 17054). The only real difference between the notice being proposed and the IMM is that the IMM is provided earlier in the stay and not in an individualized form. However, unlike stays in post-acute facilities, Medicare patients generally are in the hospital for slightly over 5 days, on average (MedPAC June 2005 Data Book, Chart 8-6). Thus a need for beneficiaries to receive a second notice only days after receiving the IMM is unnecessary and could be confusing to patients.

We also respectfully disagree with the Agency s five minute estimate of the time associated with delivering the notice. This estimate does not reflect the time that would be required to explain the notice to the beneficiary or explain why they have to sign for it. In addition, if the patient is not capable of understanding and signing the notice, the hospital would need to deliver the notice to the patient s representative and obtain a signature. This undoubtedly would add time and effort that is not reflected in CMS s estimate.

GENERAL

GENERAL

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled Medicare Program; Notification Procedures for Hospital Discharges 71 Fed. Reg. 17052 (April 5, 2006). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; and the nation s medical students and residents.

We have serious concerns about this proposed rule. It is redundant to current requirements, would result in unnecessary extensions to length of stay, and would be unduly burdensome on hospitals. We respectfully urge the Agency to maintain the current process which already provides beneficiary notification procedures by means of the Important Message from Medicare (IMM) notice and a detailed notice if the beneficiary expresses dissatisfaction with the discharge decision. We support the recommendation of the American Hospital Association (AHA) that if discharge planning issues need to be addressed, a national workgroup of affected parties should be convened. See Attached.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

We appreciate CMS s attempt to accommodate the the greater volatility of hospital discharge patterns, by requiring that hospitals deliver the standardized notice to beneficiaries one day prior to the day of discharge, rather than the two-day prior requirement for post-acute care providers. However, a one-day requirement will not solve the volatility problem.

It often is impossible for a hospital to know 24 hours in advance whether a patient will be discharged. First and foremost, the discharge decision is made not by the hospital, but rather by the patient s physician who determines, based on the patient s clinical status, that hospital level care is no longer needed. These decisions often are made on the morning of the day of discharge, after the physician confirms that the patient s medical status no longer requires inpatient care, and may be reinforced by an event-free prior overnight period. This process is particularly common for the complex and severely ill patients often treated in teaching hospitals whose health status can change quickly and whose discharge determination may require the concurrence of multiple treating physicians.

In light of this common discharge practice, the one-day prior requirement would result in hospitals providing an extra day of inpatient care when beneficiaries would no longer need it. Not only would this outcome result in significant and unnecessary costs to hospitals, which run counter to the efforts by hospitals and policymakers alike to find ways to improve efficiencies in hospitals, it also would be at odds with the desires of many beneficiaries who wish to expedite the discharge process.

For teaching hospitals with large volumes of patients, many of whom are complex, the financial implications could be staggering. For example, one member hospital estimated that the discharge decision is not made until the day of discharge for approximately 20 percent of its patients. This would result in approximately 2400 patients being kept in the hospital an extra day, with concomitant costs of over a million dollars for this institution alone. For a hospital that is at full occupancy (which is not uncommon for major teaching hospitals), this would also mean a delay for new patients being admitted. This latter outcome not only has financial consequences to the hospital, but also potentially has quality of care consequences for patients, particularly those who have come through the emergency department and must be housed in that department until an inpatient bed becomes available.

Regulatory Impact

Regulatory Impact

Under the proposed rule, hospitals must comply with a two-step notice process in connection with the termination of Medicare coverage for services provided during an inpatient hospital stay. Prior to discharging any Medicare beneficiary, hospitals would be required to deliver on the day before the planned discharge a standardized notice to each Medicare beneficiary whose physician agrees with the discharge decision. The notice would inform each beneficiary when Medicare

coverage ends and financial liability for continued services begins, and would explain the beneficiary s appeal rights. The second step is triggered if the beneficiary disagrees with the decision to terminate services. In such cases, the hospital would be required to deliver a detailed notice providing specific information about the decision to terminate services. The proposed process would extend to hospitals the process that currently is required of post-acute care providers, such as home health agencies (HHAs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs) and hospices.

CMS-4105-P2-307-Attach-1.WPD

Attachment #314 (4)

New Hampshire Hospital Association

June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare Program: Notification Procedures for Hospital Discharges Proposed Notice of Rule Making, CMS-4105-P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)

Dear Dr. McClellan:

On behalf of the New Hampshire Hospital Association (NHHA), with its 26 acute care hospital members, we appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

The NHHA believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. Also, there has been no compelling case for the need to implement this change. Therefore, the NHHA does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process.

This letter includes our specific comments on the proposed rule and addresses several issues.

- The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns.

- The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an

increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.

- The hardcopy signature and recordkeeping requirements are counter to hospitals' movement to electronic medical records and federal efforts that encourage an even faster conversion.

Background
The notice states that CMS developed the current two-step notice process for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices largely in response to litigation involving Medicare managed care enrollees who were unaware of benefit and coverage limitations in these settings. The notice also states that CMS wishes to implement the same two-step process for Medicare hospital inpatients.

Hospitals already follow a two-step process for notifying Medicare beneficiaries of their appeal rights by providing the IMM at admission and a detailed notice when a beneficiary believes he or she is being asked to leave the hospital too soon. This new notice would create a three-step process. For an average Medicare length of stay of six days, a three-step process is unreasonable. Congress required the IMM so that beneficiaries would know their discharge rights at admission and in anticipation of "quicker and sicker" discharges under the inpatient prospective payment system (IPPS) – an expectation that did not materialize. Furthermore, the timing for hospital discharges and, therefore, the potential subject of an appeal or Quality Improvement Organization (QIO) review, generally concerns the length of the beneficiary's stay related to medical necessity, not availability of hospital benefits.

Provisions of the Proposed Rule
The rule proposes that hospitals deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hardcopy of the signed or annotated notice indefinitely.

There are several problems with the proposed approach.

- *Physicians, not hospitals, make discharge decisions.* The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation and, for most hospitals, by the Joint Commission on Accreditation of Healthcare Organizations standards. In both cases, those standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate

care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.

- *It is virtually impossible to know with certainty the discharge date a day in advance.* Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. That determination is based on test results and clinical indicators, such as whether a patient is free of fever. Patients generally know their expected day of discharge (often from before admission in the case of elective admissions), which is then adjusted as necessary to reflect their condition during the discharge planning process. There may be an expected discharge date of Thursday for example, but if the patient develops a fever the evening before, the discharge date will be postponed until that fever is gone.

- *By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences.* The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. In some cases, the discharge order might be written the night before, but CMS' proposal requires that the notice be delivered "by the close of business" which is defined as the end of the administrative day. An evening discharge order would not enable a discharge notice to meet that standard, even if staff were available to prepare and deliver it.

  To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost 13 million hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would impose a significant burden on hospitals. And for many patients, they would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.

The NHHA recommends that CMS withdraw the proposal and retain the current requirements. If there are specific issues with the discharge planning process that need to be addressed, we recommend that CMS convene a national workgroup comprised of hospital, physician, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures affect the various parties, and ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights.

Collection of Information and Recordkeeping Requirements
The notice's language and the process for preparing, delivering and documenting receipt are problematic. Some of the troubling requirements are spelled out in the proposed regulation and others in the paperwork clearance package sent by CMS to the Office of Management and Budget (OMB). Those issues include:

- *At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless.* The proposal would require that the beneficiary or a representative sign a copy of the discharge notice documenting its receipt and their understanding of it. The paperwork clearance package submitted by CMS to the OMB indicates that it must be provided and maintained in hard copy, with no provision for electronic alternatives. Since care and discharge plans must be documented in the patient's medical record, this requirement is unnecessary and counterproductive.

- *The alarmist language of the proposed generic discharge notice (which was included in the paperwork clearance package) could cause a beneficiary to doubt whether the planned discharge is appropriate.* The notice never mentions that the discharge decision would be based on whether the beneficiary requires hospital-level care, could safely go home, or needs to receive post-acute care in another setting. The notice could lead to requests for more detailed and unnecessary notices and appeals which hospitals and the QIOs would then have to review. The notice focuses solely on a termination of Medicare payment and financial liability for the beneficiary if they do not appeal by noon the day after the notice is received. Also, by repeatedly stressing that the beneficiary can stay in the hospital during an appeal without any financial liability – no matter the outcome of the QIO review – the notice would likely encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based on medical necessity.

- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons why services are no longer reasonable or no longer covered by Medicare, and specifically cite the relevant Medicare rule or policy that applies to the beneficiary's case. Direct input from the physician, a resident, or a hospitalist would be required to complete this notice, but they likely would not be able to cite specific applicable Medicare coverage policies; hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria.

- *The estimated cost and burden of the proposal is grossly understated.* CMS believes to prepare and deliver the generic discharge notice to a patient will take five minutes, but this does not include the time needed to explain the notice or why it must be signed. It also does not reflect the additional time and effort required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent. Nor does it reflect the manpower and capital costs to maintain hard copy files of the signed copy for 13 million or more admissions a year for an indefinite period of time. The most significant cost, however,

is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge (as explained above). Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals for the reasons cited above.

We believe this price is too high just to ensure consistency with requirements designed for very different operating environments. If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice. If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. More paperwork does nothing to improve care – it simply consumes resources that would be better devoted to direct patient care. **The NHHA recommends that the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.**

The NHHA appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me or Paula Minnehan, VP, Finance and Rural Hospitals at (603) 225-0900 or pminnehan@nhha.org

Sincerely,

Mike Hill

Michael Hill
President

(5)

Submitter : **Ms. Holly French** **Date: 06/05/2006**

Organization : **Newman Regional Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

June 5, 2006

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

RE: File Code: CMS-4105-P
Medicare Program: Notification Procedures for Hospital Discharges
Proposed Notice published in the Federal Register of April 5, 2006
(71 FR 17052 17062)

I realize that CMS is trying to provide more information to patients by proposing this rule but it is not practical.

The current process already adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services.

It will be very difficult to provide the proposed notices. From a practical point, just trying to find the patient in the room due to tests and procedures can be almost impossible. A delay in a procedure or communication can cause a delay in discharge. If for some reason we can not talk to the patient because their family might be present, the discharge can again be delayed.

The proposed discharge notice invites or encourages unwarranted appeals and longer lengths of stay.

The true costs associated with this proposed requirement are grossly understated. In addition, it will not add value to the patient.

For the aforementioned reasons, along with others, we encourage you to reject this Discharge Notification Proposal.

Sincerely,

Holly R. French
Chief Financial Officer

(6)

Submitter : **Ms. Kathie Butcher** **Date: 06/05/2006**

Organization : **Newman Regional Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

June 5, 2006

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

RE: File Code: CMS-4105-P
Medicare Program: Notification Procedures for Hospital Discharges
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The proposed discharge notice invites or encourages unwarranted appeals and longer lengths of stay.

The true costs associated with this proposed requirement are grossly understated. In addition, it will not add value to the patient.

For the aforementioned reasons, along with others, we encourage you to reject this Discharge Notification Proposal.

Sincerely,

Kathie J. Butcher, RHIA
Assistant Administrator for Quality Services

Attachment #317

(1)

Little Company of Mary Hospital
and Health Care Centers

June 2, 2006

TO: Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850
Submitted electronically: http://www.cms.hhs.gov/eRulemaking

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted by email: Paperwork@cms.hhs.gov

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P
Submitted by email to: carolyn_lovett@omb.eop.gov

RE: File Code: **CMS-4105-P**
Medicare Program: Notification Procedures for Hospital Discharges
Proposed Notice published in the *Federal Register* of April 5, 2006
(71 FR 17052 – 17062)

These comments are written by Little Company of Mary Hospital in Evergreen Park, Illinois in response to the referenced notice of proposed rulemaking which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process currently used by other service providers, specifically non-acute care.

These proposed changes would place significant administrative and financial burdens on hospitals and beneficiaries. Providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary longer lengths of stays creating additional patient throughput challenges for patients that are in need of acute care hospital services.

Kindly consider the following in regard to this proposed rule:

- There is an already existing process that already informs beneficiaries of their Medicare appeal rights. ("Important Message from Medicare") as well as the Hospital Notice of Non-Coverage (HINN) for patient-specific notices to patients when inpatient criteria is no longer met.
- The proposed discharge notice process used for Skilled Nursing Facilities, Home Health agencies and Rehabilitation facilities is not appropriate for use in an acute hospital setting.
- A generic discharge notice will invite unwarranted appeals as well as longer and unnecessary lengths of stay.
- Generic and detailed hospital discharge notices are delivered hard-copy. The administrative costs to deliver such notices to all Medicare beneficiaries would be substantial. (refer to below for specifics)

The estimate for this hospital to deliver the proposed notices using fiscal year 2005 data, would be as follows:

Annual cost to deliver generic notice	= $ 85,112
Conservative annual cost to deliver detailed notice	= $202,227
Realistic annual cost to deliver detailed notice	= $490,248

There will also be expected longer lengths of stay which are estimated as follows, again using fiscal year 2005 data:

Conservative estimate for expected longer LOS	= $11,999,160
Realistic estimate for expected longer LOS	= $16,239,465

Finally, the issuing of these letters requires staff to witness, document and discuss with patients and families at level of detail that is time-intensive. Additional staffing will be required weekdays and weekends in order to ensure timely delivery of the required notices and adequate explanation of its implications

We thank you for your consideration of these comments as well as the opportunity to respond to this proposed rule. If you need any additional information or have any questions regarding the issues raised in these comments, please contact me at 708-229-5710, e-mail jshere@lcmh.org.

Sincerely,

Joann Shere
Director, Case Management
Little Company of Mary Hospital

Submitter : Ms. Ronald Ashworth **Date:** 06/05/2006

Organization : Sisters of Mercy Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P2-318-Attach-1.PDF

Attachment
#318

MERCY

SISTERS OF MERCY
HEALTH SYSTEM

June 2, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: "Medicare Program; Notification Procedures for Hospital Discharges"

The Sisters of Mercy Health System is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. We have a significant number of inpatient stays and rely heavily on Medicare as a major payor for those services. We are writing to provide comments in areas of concern relating to the proposed rule. Thank you for considering our comments.

Specifically, we offer the following comments:

Provisions of the Proposed Rule

In this rule, CMS proposes that hospitals be required to provide a standardized discharge notice on the day before the planned discharge from any inpatient hospital stay. While this requirement is similar to the one already in place for other setting types (SNF, Home Health, and Comprehensive Outpatient Rehabilitation Facilities), acute care settings encompass a different patient mix. Typically, discharge date predictions are much more complex for patients in acute care settings. While discharge dates for patients in the acute care settings could be estimated, they may not be as accurate in this type of setting due to extremely short stays, unpredictability of discharge decisions by the physician or unforeseen complications/events. This creates a real risk of providing duplicative discharge notifications. We believe providing duplicative discharge notifications (revised for estimated discharge date only) would be administratively burdensome. We believe this practice would also cause unnecessary concern and/or confusion from the patient. Therefore, Mercy requests that CMS not implement the requirement to provide advance discharge notification. However, if CMS implements the requirement for advance discharge notification, we request that CMS specifically address the duplicative discharge notification risk in the proposed regulations. We believe it should be noted that if the estimated discharge date is revised, and the discharge notification has already been provided, a revised discharge notification is not required. For example, if a patient is scheduled to be discharged on Tuesday and the notification is provided on Monday, but the physician does not discharge the patient until Friday, Mercy should not have to reissue the discharge notification in light of the new Friday discharge date.

Currently hospitals are required to provide patients with 'Important Message from Medicare" pamphlet at time of admission. With the proposed discharge notice, hospitals are concerned this requirement may confuse patients with short lengths of stay as there may be times the standardized discharge notice is provided to the patient the same day (or within a day or two) of the "Important Message from Medicare" pamphlet. In addition to causing confusion for patients, it may also require additional time for hospital personnel to handle patient questions relating to the issuance of this newly required discharge notice, increasing the administrative burden of this requirement. If CMS implements the advance discharge notification requirement, we propose that CMS make this an "optional" rather than "mandatory" requirement for patients with estimated discharge dates within 3 days of admittance into the hospital inpatient setting to avoid any such patient confusion.

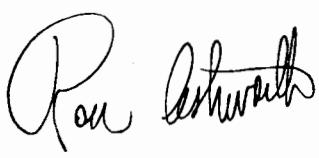
Hospitals may also face additional challenges when applying this requirement as it may not be "adopted" for all patients due to other payor expectations. Lack of consistent requirements for all payor types, can increase administrative time necessary to implement this new requirement as it may only be applicable for our Medicare patient population. Therefore, if CMS implements the advance discharge notification, we would request that CMS mandate this as a standard notification that all other payors must follow.

One additional concern that hospitals may face will be those instances where the patient is not capable of comprehending or making decisions regarding their treatment. In the event a patient does not have anyone "available" (either power of attorney or family members visiting regularly), we request that the requirement for providing this discharge notice be waived for two reasons. We believe it would be administratively burdensome to identify the appropriate contact to which to mail the discharge notice information. There could also be questions regarding whether or not the discharge notice was given to the "most appropriate" patient contact. We also believe it is CMS' intent to provide this information in a timely manner. Mailing information to the appropriate patient contact would prevent hospitals from meeting CMS' intended timely requirements and therefore would not provide any additional benefit to the patient. Therefore, we respectfully request this be specifically identified as an exception to any notification requirements implemented as a result of the final regulations.

As you can see, we have significant concerns with the advance discharge notification as proposed by CMS. We strongly suggest CMS reconsider this provision or at least consider the changes we have discussed above.

Thank you again for considering our comments. Should you have additional questions you may contact Bill Colletta at 314-364-3525.

Sincerely,



Ron Ashworth
President / Chief Executive Officer

Lancaster General Hospital

June 5, 2006

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

RE: CMS-4105-P

Dear Sir/Madame:

In conjunction with The Hospital & Healthsystem Association of Pennsylvania (HAP) Lancaster General Hospital (LGH) appreciates this opportunity to comment on the proposed rule in **"Medicare Program; Notification Procedures for Hospital Discharges,"** as published in the April 5, 2006, *Federal Register.*

As published, the proposed rule requires general acute care hospitals, long-term acute care hospitals, rehabilitation hospitals, and other specialty hospitals to provide written notice to Medicare patients (beneficiaries and Medicare Advantage enrollees) of hospital non-coverage decisions and/or hospital discharge on the day before coverage ends and/or the planned hospital discharge. Additionally, the rule provides for an expedited review process through the state's Quality Improvement Organization (QIO). If the patient decides to exercise the expedited review, the hospital and/or Medicare Advantage plan must provide the beneficiary/enrollee with a detailed explanation for the reasons for non-coverage and/or hospital discharge decision. The published rule states that the Centers for Medicare & Medicaid Services (CMS) is proposing these revisions to existing requirements to match the notification and review requirements required of home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and in some circumstances, hospices.

LGH believes that CMS has proposed a solution that is not operationally workable in its attempts to improve the hospital discharge planning process and that the proposed rule does not support how care is delivered in hospitals. Nor does it address the physician-patient relationship or that the decision to discharge is determined by the physician and the patient. It should be noted that there are other existing federal regulations that indicate the expectation that hospitals do not differentiate care provided to patients based on financial class. To require a 24-hour notice only for Medicare and Medicare Advantage patients requires these patients to be treated differently during the course of rendering care to all patients on a unit.

While CMS was well intentioned in proposing this rule in response to concerns raised by consumer advocacy groups with respect to hospital discharge planning processes, this rule

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will have many unintended consequences for the health care delivery system as a whole and will complicate other critical issues including patient flow, hospital capacity, emergency department crowding, emergency department diversions, and additional dissatisfaction for frontline nurses who will be burdened with more paperwork rather than providing care to patients. Additionally, the proposed rule serves to confuse the terms non-coverage with decisions about hospital discharge.

Operational Implications

- LGH agrees with HAP that the proposed rule is unclear as to whether the hospital would still be required to provide the "Important Message from Medicare" at admission. It appears that this requirement would continue to exist under the proposed rule. Hospitals already have a two-step process in place where they are required to provide the "Important Message from Medicare" to patients upon hospital admission and a notice on how to request a review/determination when the patient disagrees with hospital discharge. This new process that adds a third step for Medicare beneficiaries where the average length of stay is less than six days is unreasonable and potentially very cumbersome, confusing and burdensome for patients in the hospital 72 hours or less. CMS should consider taking appropriate enforcement measures against those hospitals that fail to adhere to the current process rather than mandate more steps in the process.

- Except for a small percent of uncomplicated patients who are undergoing a procedure with a fairly predictable postoperative course, it will be difficult if not impossible to deliver an advance written notice the day before "planned" discharge. For the majority of patients receiving hospital care, it is difficult to predict with certainty whether patients will be cleared for discharge until the actual day of discharge. This is particularly true for complex medical and surgical patients admitted with co-morbidities and chronic disease whose care is also being managed by a team of other physicians. While patients may be aware of the kinds of issues that must be addressed or under control to warrant discharge, they or their physician often cannot know precisely when those parameters will be met to warrant discharge. When a physician determines that a patient is clinically stable and safe for discharge, the right thing to do is to discharge the patient in a timely manner, and NOT wait for a "defined" 24-hour notice before discharge. Essentially, the majority of decisions regarding discharge are made the evening before the day of discharge or the morning of discharge, and if hospitals proceed with discharging a patient in a timely manner it would be almost impossible to comply with the proposed requirement of 24-hour notice.

- There are numerous situations when it would be impossible for hospitals to provide the necessary and appropriate care for patients and be in compliance with the proposed rule. For instance, if a psychiatric patient in a freestanding psychiatric facility has a medical emergency requiring admission to a general acute care hospital, the patient must be discharged immediately and transported to the medical facility for treatment. Similarly, there may be circumstances where a general acute care hospital needs to discharge the patient to another acute care hospital because that hospital provides services or higher levels of care than what can be provided in the original hospital of admission, (e.g., moving a patient from a community hospital to an academic medical center or children's specialty hospital). These situations often preclude a 24-hour notice and should be exempted from the provisions in the rule. Another common occurrence is when a patient is awaiting placement in a skilled

nursing facility, rehabilitation unit/hospital, and/or psychiatric unit/hospital. In some Pennsylvania communities, it is particularly difficult to move patients from the acute care facility to other levels of care, since there is a moratorium on adding skilled nursing beds and psychiatric beds. The change in federal reimbursement for rehabilitation hospitals has also impacted the numbers of rehabilitation beds available for patient placement. As a result, many hospitals are waiting for notification from another health care facility that a bed has become available to accept a patient from the acute care hospital. Under these circumstances, hospitals have to move quickly to discharge the patient in order to secure the bed placement at the other facility. It would not make sense to postpone the discharge in order to provide a 24-hour notice and risk losing the placement, particularly since hospitals have been discussing the placement with the patient and patient's family.

- Another concern with the 24-hour notice requirement is the fact that plans for discharge can change depending upon a patient's medical stability. This means that hospital staff may provide a discharge notification in anticipation of a patient's discharge, but if the patient deteriorates, the discharge could be postponed. Subsequently, when the patient's discharge is planned, another 24-hour notice would be required. In essence hospitals may be providing several generic notices in order to be in compliance.

- It is problematic that the proposal requires hospitals to provide a notice of non-coverage on behalf of Medicare Advantage plans. This places hospitals in a position to explain to a patient that the Medicare Advantage plan determined that their hospitalization would no longer be covered when in some instances the hospital may disagree with that determination. It also appears that the hospitals would then be required to follow-up with a second generic notice to the same patient when the hospital determines the patient is ready for discharge. The delivery of multiple notices to patients by hospital staff would be confusing to patients and families.

- It is likely that **the** majority of the generic written notices could not be provided to patients until after the actual discharge order is written by the patient's attending physician. To comply with the 24-hour notice provision, this would mean that patients would end up staying at least one additional day in the hospital to comply with the rule even though discharge is appropriate and medically indicated. Further, in situations where the attending physician has discharged the patient and a notice has not been given by the hospital in accordance with the proposed rule, hospitals are not certain that they could legally require a patient to stay in order to be compliant with the proposed rule, particularly if the physician refuses to issue any medical orders since he/she has technically discharged the patient from the acute care hospital.

- Increasing the hospital length of stay to comply with the proposed rule will result in holding up placement of emergency admissions, add to overcrowded situations in hospital emergency departments, and cause unnecessary ambulance diversions in communities across this country. This proposal has the potential to add to the already difficult problems being faced in our hospital's emergency departments.

- At LGH it is probable that provision of the advance notice could fall to nurses because the volume of discharges will be beyond the current case management and financial office staffing capabilities. Hiring additional staff in these departments solely for 24/7 provision of the notice is not feasible in the current economic climate. Adding more paperwork to case managers and direct care nurses will create job dissatisfaction among nurses at a time when hospitals are working to decrease paperwork by nurses so that they can better spend their

time in efficient plan of care facilitation and direct patient care. Given the national workforce shortage for nurses, we should be looking at ways to decrease the administrative burden on nurses and not increase it. Even the most diligent nurse may end up failing to give an advance written notice to the patient because of the multitude of other tasks and patients for whom they provide care.

Financial Implications

- Extending the length of stay for many Medicare patients by at least one day in order to comply with the requirement to provide advance written notice 24-hours before discharge will create capacity issues that could lead to decreased patient satisfaction.

- LGH supports the HAP conclusion that the CMS estimate regarding the percentage of patients who would request an expedited review is seriously underestimated. Initially, there may be a small percentage of patients who request an expedited review, but once it becomes common knowledge among Medicare patients that the hospital stay can be extended by at least another day until the review can be completed, the percent of patients requesting an expedited review will be well beyond the 1-2 percent of patients estimated by CMS. Per HAP, home health agencies report that more patients view the request for an expedited review as automatic because the patients know that they will continue to receive health care services while their case is under review and are at no personal financial risk while the review is taking place regardless of the decision rendered. Today's Medicare population is more knowledgeable about their rights and has access to better education resources.

- The following as presented by HAP is a detailed list of the variables involved in the delivery of the notice. LGH agrees that the rule does not accurately estimate the time it will take to deliver the notice to patients and costs associated with the proposed rule.
- We are concerned that the estimated time of five (5) minutes to provide, explain and obtain the patient's signature on the form is a significant underestimation of the time that will be required to provide the advance notice. Additionally, CMS must account for:

    - the costs and time associated with the printing of the forms, including purchasing duplicate forms or copying the form to demonstrate that all the required information is on the form and that the patient has signed the form;
    - the time required to assemble the forms with other documents;
    - the time required to coordinate with physicians and other care professionals to establish when the advance notice can be delivered;
    - the actual time to explain the form to the Medicare beneficiary and/or Medicare beneficiary's family and to get the form signed;
    - the time to assist the Medicare beneficiary or the family to request an expedited review by the QIO;
    - the time required for the filing of the notices in the medical record;
    - the costs associated with the copying of medical records sent for review to the QIO, including the possible purchase of fax machines that allow for efficient faxing of large volumes of documents;
    - the upfront costs associated with researching and providing the specific language required to be cited in the detailed notice of explanation;
    - the costs associated with having more financial office staff, discharge planners, social workers, and/or case managers available to deliver these notices to Medicare patients or the overtime that will be incurred by hospitals in order to have all the

documents delivered to patients or the QIO in the timeframes as proposed in this rule;

- the costs associated with training nurses and other health care professionals who would need to deliver the notices;
- the costs associated with the maintenance and storage of these documents for a period of years.

In short, CMS has proposed a rule that creates another unfunded mandate for hospitals across the country.

- An additional concern is the complex and detailed process required for the detailed explanation which must describe any applicable Medicare coverage rule, instruction or Medicare policy, including citations to the applicable Medicare policy rules or information about how the beneficiary may obtain a copy of the Medicare policy. Hospital staff will require ongoing training in the Medicare policies that they would need to cite to be in compliance with the proposed rule. Further, the detailed notice must contain facts specific to the beneficiary and relevant to the coverage determination that are sufficient to advise the beneficiary of the applicability of the coverage rule or policy to the beneficiary's case. And finally, the hospital must give the detailed notice to the beneficiary by the close of business on the day that the hospital is informed by the QIO that the QIO has received a request for an expedited determination from the beneficiary. The requirement for the provision of a detailed notice is not something that heretofore has been done routinely by hospitals.

Coverage Determinations versus Discharge

- Another concern is that the proposed rule fails to make a clear distinction between decisions by a Medicare Advantage plan to discontinue coverage for hospitalization versus a physician's decision to discharge a patient. In §422.620 of the proposed rule, it states, "Before any discharge from the inpatient level of care, the hospitals must deliver valid written notification of non-coverage of the Medicare Advantage organization's or hospital's discharge decision to the enrollee". HAP would argue that if notification is required to be provided to Medicare Advantage enrollees, that it be the responsibility of the Medicare Advantage plans to provide both the generic notification and the detailed notification. This process makes the most sense because it is the Medicare Advantage plan that is in the position to make a decision regarding non-coverage that could ultimately impact a Medicare patient's financial liability. If the treating physician disagrees with the Medicare Advantage plans' decision of non-coverage, then a patient would continue receiving inpatient treatment and there would be no discharge. Therefore, it is not necessarily the discharge notification that is critical, but the notice of non-coverage which is determined by the Medicare Advantage plans and therefore should be communicated directly by the plan and not hospital personnel.

- Additionally, as proposed, hospitals could be in a position of having to provide a notice of non-coverage on behalf of the managed care plan even though the patient is not being discharged from the hospital and then turn around at the time of discharge and give yet another notice. HAP and LGH believe that this could be confusing to Medicare patients, especially when both notices would have to be provided by hospital staff. Additionally, the hospital may also disagree with the decision made by the Medicare Advantage hospital non-coverage decision and plan to appeal that determination through provider appeal mechanisms. Consequently, the hospital would be placed in an awkward position to have to deliver and explain notices of non-coverage on behalf of Medicare Advantage plans.

Language in the Forms

- The hospital community has shared concerns about requiring hospitals to place their hospital logos on the "Generic Notice of Non-coverage" and the "Detailed Explanation of Non-coverage." Hospitals are not making decisions regarding non-coverage; therefore, the notice should not indicate that it comes from the hospital. Specifically, the generic notice states, "Your hospital and/or Medicare Advantage (MA) plan have determined that Medicare probably will not pay" is an inaccurate statement since hospitals do not make determinations regarding Medicare coverage.

- Under the section "You Have the Right to Request a Review," the generic notice states, "if you request an immediate review, you will not have to pay for any services." Again, this appears to be inaccurate since the proposed rule indicates that when a patient requests an immediate review, the patient would not incur any additional financial liability for services received before being notified of the independent reviewer's decision other than regular cost-sharing for which the patient would be liable.

Other

- The proposal requires that the beneficiary or their representative sign the advance notice form in order to document its receipt and their understanding of the notice. From a purely logistical perspective, this requirement works at cross-purposes with the movement to electronic health records. The paperwork clearance package submitted by CMS to the Office of Management and Budget (OMB) indicates that the record must be provided and maintained in hard copy and that they are not making any provision for electronic alternatives.

- Finally, hospital care, including the discharge process, does not solely occur Monday through Friday, 8 to 4. The rule describes that access to the Quality Insights Organization (QIO) needs to be during the business hours of the QIO. To require hospitals to implement a process to protect beneficiary's rights without also addressing the required access to dispute resolution does not protect the patient or the provider. It would not work for the QIO to only be available during business hours. HAP and DVHC understand that QIOs have already increased hours of operation to deal with expedited review requests for home health agencies and skilled nursing facilities, but they are currently not adequately resourced to deal with an increased demand for such reviews from hospitals

LGH supports the following HAP recommendations:

- CMS should modify the existing "Important Message from Medicare" to clearly delineate procedures available to patients who disagree with planned discharge from the hospital or a decision made by a Medicare Advantage plan for hospital non-coverage.

- CMS should consider convening a stakeholder group in concert with national hospital associations, key professional groups, and consumer advocacy groups to develop a

better perspective of the various constituency group concerns and how best to address these concerns about discharge planning. A review and revision of current hospital discharge planning provisions in the Medicare hospital Conditions of Participation and surveyor interpretative guidelines would be more productive than overlaying these requirements on what is already in existence.

- CMS should establish a pilot/demonstration project to assess the ability for hospitals to comply with the plan for providing critical information regarding discharge and patient rights and responsibilities to Medicare patients.

In the event that CMS decides to proceed with enforcing a process for Medicare Notification Procedures for Hospital Discharges, LGH agrees with HAP's suggested modifications to the proposed rule for consideration by CMS:

- For Medicare Advantage patients, HAP strongly recommends that it be the Medicare Advantage plans' responsibility for communicating information regarding non-coverage. Specifically, HAP thinks and LGH agrees that Medicare Advantage plans should be responsible for preparing both the Generic Notice and the Detailed Explanation (when necessary) and should deliver such notices to patients. Further, CMS should consider modifying the forms to distinguish between decisions made by Medicare Advantage plans for hospital non-coverage and decisions made by hospitals for patient discharge.

- In light of the workflow in hospitals, HAP and LGH urge CMS to build flexibility into the requirements for Medicare notification procedures for hospital discharges. We recommend that CMS allow hospitals to deliver the generic notice during the course of care as opposed to 24-hours in advance.

- HAP and LGH recommend the elimination of the 24-hour requirement for patients who have a length of stay of three days or less. The "Important Message from Medicare" could be revised to make patient rights and pertinent discharge information more visible as previously recommended.

- If CMS' final rule includes the requirement of a 24-nour notice, HAP and LGH recommend that CMS provide for exceptions to the notification requirement such as when a patient requires an emergency discharge to another general acute care hospital for more complex medical/surgical care; emergency transfer from a psychiatric facility to a general acute care hospital for an acute medical problem; and discharge from acute care to a rehabilitation, psychiatric or skilled nursing facility when the general acute care hospital has been waiting for an available bed in one of those facilities.

- CMS also must require the QIO to be available 24 hours a day, 7 days a week so that patients have access to a dispute resolution process.

HAP along with LGH appreciate the interest that CMS has in receiving comments on this proposed rule and believe that CMS has a legitimate interest in ensuring that Medicare beneficiaries have access to an expedited determination review process when they disagree with hospital discharge, termination of hospital services, or when a Medicare Advantage plan determines that the plan will not cover the hospital stay. However, the rule as proposed would create operational problems for hospitals and result in increased lengths of stay that will negatively impact others' access to patient care. Additionally, CMS has not carefully considered the financial implications of what it is proposing on hospitals or the potentially confusing aspects of mingling decisions made by Medicare Advantage plans about hospital non-coverage versus hospital decisions to discharge the patient in this rule.

HAP and LGH recommend that the current process should be retained with consideration given to modifying the current "Important Message from Medicare" to make it much more explicit about procedures available to patients who disagree with planned discharge from the hospital or a decision made by a Medicare Advantage plan for hospital non-coverage.

Should you have any questions regarding the comments submitted by HAP or LGH, please feel free to contact Lynn Leighton, Vice President, Professional and Clinical Services, HAP at (717) 561-5308 or by email at lgleighton@haponline.org or Stephen Olin, MD, **FAAFP**, Lancaster General Hospital Case Management Physician Advisor at (717) 544-4061.

Sincerely,

Stephen T. Olin, M.D., **FAAFP**
Physician Advisor and Medical/
Quality Management Coordinator

Submitter : Mrs. Leigh Miller **Date:** 06/05/2006

Organization : AnMed Health

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

CMS states the notice process is 5 minutes. This time frame is understated as the process includes preparation and delivery of the notice. Not all seniors have the mental faculties to understand notices and have appointed a representative to take care of these type matters. That person may not always be present with the patient and must be contacted for notification, again, requiring time for proper notice.
The current process with the Important Message at admission serves the purpose of providing notice at discharge of the right to appeal. Our discharge planners work with the patient and family from the day of admission to inform them of discharge plans.

Attachment #333

(11)

CHA CONNECTICUT HOSPITAL ASSOCIATION

June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS – 4105 – P
Mail Stop C4 – 26 – 05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **Medicare Program: Notification Procedures for Hospital Discharges Proposed Notice of Rulemaking, CMS – 4105 – P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)**

Dear Dr. McClellan:

Please accept these comments from the Connecticut Hospital Association (CHA) on behalf of its thirty not-for-profit acute care hospital members regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule: Medicare Program; Notification Procedures for Hospital Discharges (CMS – 4105 – P). The proposed rule concerns a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients the day before their discharge. This new notice would be in addition to the Important Message from Medicare (IMM) given at admission that already provides an explanation of Medicare discharge appeal rights, and a more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

This proposal does not account for some of the practical processes related to how patient care decisions are made in a hospital setting and how the discharge planning process works. Also, there has been no compelling case for the need to implement this change. Therefore, CHA does not believe CMS should proceed with these changes without a more thorough examination of the process.

This letter includes our specific comments on the proposed rule and addresses several issues.

- The proposed discharge notice process is unnecessarily burdensome because it is inconsistent with standard discharge planning and physician discharge order patterns.

- The language of the proposed generic discharge notice could cause beneficiaries to doubt the appropriateness of the planned discharge. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.

- The hardcopy signature and record keeping requirements are contrary to hospitals' movement to electronic medical records and federal efforts that encourage an even faster conversion.

Background

The notice states that CMS developed the current two-step notice process for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices largely in response to litigation involving Medicare managed care enrollees who were unaware of benefit and coverage limitations in these settings. The notice also states that CMS wishes to implement the same two-step process for Medicare hospital inpatients.

Hospitals already follow a two-step process for notifying Medicare beneficiaries of their appeal rights by providing the IMM at admission and a detailed notice when a beneficiary believes he or she is being asked to leave the hospital too soon. This new notice would create an unreasonable three-step process. Congress required the IMM so that beneficiaries would know their discharge rights at admission and in anticipation of "quicker and sicker" discharges under the inpatient prospective payment system (IPPS) – an expectation that did not materialize. Furthermore, the timing for hospital discharges and, therefore, the potential subject of an appeal or Quality Improvement Organization (QIO) review, generally concerns the length of the beneficiary's stay related to medical necessity, not availability of hospital benefits.

Provisions of the Proposed Rule

The rule proposes that hospitals deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hardcopy of the signed or annotated notice indefinitely.

There are several problems with the proposed approach.

- *Physicians, not hospitals, make discharge decisions.* The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation, the Joint Commission on Accreditation of Healthcare Organizations standards and Connecticut state law.

These standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.

- *It is virtually impossible to know with certainty the discharge date a day in advance.* Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. That determination is based on test results and clinical indicators, such as whether a patient is free of fever. Patients generally know their expected day of discharge (often from before admission in the case of elective admissions), which is then adjusted as necessary to reflect their condition during the discharge planning process. There may be an expected discharge date of Thursday for example, but if the patient develops a fever the evening before, the discharge date will be postponed until that fever is gone. There are fundamental differences between the discharge process in hospitals as compared with the process used by home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices that make the proposed rule inappropriate for hospital settings.

- *By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences.* The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. In some cases, the discharge order might be written the night before, but CMS' proposal requires that the notice be delivered "by the close of business" which is defined as the end of the administrative day. An evening discharge order would not enable a discharge notice to meet that standard, even if staff were available to prepare and deliver it.

  To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. This would impose a significant financial burden on hospitals, and many patients would be compelled to stay in the hospital when they want and are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could exacerbate patient backlog in the Emergency Department (ED) and contribute to increased ED diversions because of the number of patients who would be kept in the ED waiting for an open inpatient bed.

Based on these facts, CHA recommends that CMS withdraw the proposal and retain the current requirements. If there are specific issues with the discharge planning process that

need to be addressed, we recommend that CMS convene a national workgroup comprised of hospital, physician, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures affect the various parties, and ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights.

Collection of Information and Record Keeping Requirements

The notice's language and the process for preparing, delivering and documenting receipt are problematic. Some of the troubling requirements are spelled out in the proposed regulation and others in the paperwork clearance package sent by CMS to the Office of Management and Budget (OMB). Those issues include:

- *At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless.* The proposal would require that the beneficiary or a representative sign a copy of the discharge notice documenting its receipt and their understanding of it. The paperwork clearance package submitted by CMS to the OMB indicates that it must be provided and maintained in hard copy, with no provision for electronic alternatives. Since care and discharge plans must be documented in the patient's medical record, this requirement is unnecessary and counterproductive.

- *The language of the proposed generic discharge notice (which was included in the paperwork clearance package) could cause a beneficiary to doubt whether the planned discharge is appropriate.* The notice never mentions that the discharge decision would be based on whether the beneficiary requires hospital-level care, could safely go home, or needs to receive post-acute care in another setting. The notice could lead to requests for more detailed and unnecessary notices and appeals that hospitals and the QIO would then have to review. The notice focuses solely on a termination of Medicare payment and financial liability for the beneficiary if they do not appeal by noon the day after the notice is received. Also, by repeatedly stressing that the beneficiary can stay in the hospital during an appeal without any financial liability – no matter the outcome of the QIO review – the notice would likely encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based on medical necessity.

- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.* The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons why services are no longer reasonable or no longer covered by Medicare, and specifically cite the relevant Medicare rule or policy that applies to the beneficiary's case. Direct input from the physician, a resident, or a hospitalist would be required to complete this notice, but they likely would not be able to cite specific applicable Medicare coverage policies; hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria.

- *The estimated cost and burden of the proposal is grossly understated.* CMS believes to prepare and deliver the generic discharge notice to a patient will take five minutes, but this does not include the time needed to explain the notice or why it must be signed. It also does not reflect the additional time and effort required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent. Nor does it reflect the manpower and capital costs required to maintain hard copy files of the signed copy for the high volume of admissions each year. The most significant cost, however, is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge (as explained above). Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals for the reasons cited above.

CHA believes this price is too high merely to ensure consistency with requirements designed for very different operating environments. If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice. If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. More paperwork does nothing to improve the quality of care – it simply consumes resources that would be better devoted to direct patient care. CHA recommends that the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.

Sincerely,

Patrick J. Monahan II
General Counsel and Vice President, Patient Care Regulation

PJM:mb
By E-mail

cc: Melissa Musotto, Office of Strategic Operations and Regulatory Affairs
Carolyn Lovett, Office of Information and Regulatory Affairs

Submitter : Mrs. Catherine Sprouse **Date:** 06/05/2006

Organization : Altoona Regional Health System

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please consider the following comments in regards to the MEDICARE PROGRAM: NOTIFICATION PROCEDURES FOR HOSPITAL DISCHARGES - PROPOSED Rule. This proposed rule would require hospitals to comply with a two-step notice process when discharging patients from the hospital level of care. I am responding on behalf of an acute care hospital. I work as Director of Case Management. All utilization review and discharge planning activities are performed by members of the Case Management Department. I feel that the requirements of the proposed rule are unreasonable, inefficient and confusing. Requiring what amounts to a 3-step process for Medicare beneficiaries where the average length of stay is less than six days, is unreasonable. It is even more cumbersome, confusing and burdensome for patients in the hospital 72 hours or less. It will be difficult, if not impossible, to deliver an advance written notice the day before "planned" discharge. If we are to comply with the 24-hour notice, patients will be staying an additional day in the hospital in order to comply with the rule. This increase in length of stay will result in a delay in placing emergency admissions into beds and add an additional burden to our overcrowded emergency department. The delivery and execution of these notices will at times be delegated to staff nurses who do not totally understand the process and will perceive this as an additional burden. Patients will be asked to process this additional information at a time when they are least able to comprehend or act on the information. If anything, it will produce more confusion and anxiety in our patient population. I feel the estimated time of five minutes to provide, explain and obtain the patient's singature on the form has been grossly underestimated.

In closing, I would like to state that I feel all of the information regarding appeal rights in the discharge process whould and could be addressed succinctly in the "Important Message from Medicare" which is given to all Medicare Patients at the time of a hospital admission.

Catherine Sprouse, RN
Director of Case Management

(13)

Submitter : Mrs. Lynn Leoce **Date:** 06/05/2006

Organization : Adventist Health System

Category : Nurse

Issue Areas/Comments

Background

Background

Regulations currently exist that notification of pending discharge to patients or representative. Notifications via HINN, ABN, Utilization review, and JCAHO standards provide adequate regulation and provisions for patient notification of discharge status.

GENERAL

GENERAL

This proposed rule would make notification very difficult for short stay patients and when notification of discharge(by the physician)does not occur until the of discharge. Since many physicians defer to their consultants for prior to discharge, this presents difficulty with timing their responses and appropriate discharge notification. The delay in discharge as a result from such notification would make time of discharge and discharge facilitation an even more complex process than currently exists. This would lead to increased and extended emergency room wait times, and a hospitals inability to appropriatley manage patient discharges and throughput in a timely fashion.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Existing regulations address discharge plan and notification: Discharge planning must be included in the patient's medical record for use in establishing an appropriate discharge plan. The patient and/or representative must discuss the plan prior to discharge. In addition, hospitals must arrange for implementation of discharge plan, reasses patient's discharge plan based on care needs as appropriate, and provide counsel to patient and family members to prepare them for alternate level of care.

14

Submitter : Ms. Torona Stokes **Date:** 06/05/2006

Organization : Redmond Regional Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Background

Background

I believe that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact both financially and operationally that the proposal would have on hospitals. Also, there has been no compelling case for the need to implement this change. Therefore, GHA does not believe CMS should proceed with these changes without a more thorough and realistic examination of the process.

This letter includes our specific comments on the proposed rule and addresses several issues.

7 The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns.

7 The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.

7 The hardcopy signature and recordkeeping requirements are counter to hospitals movement to electronic medical records and federal efforts that encourage an even faster conversion.

GENERAL

GENERAL

I recommend that CMS withdraw the proposal and retain the current requirements. If there are specific issues with the discharge planning process that need to be addressed, we recommend that CMS convene a national workgroup comprised of hospital, physician, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures affect the various parties, and ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The rule proposes that hospitals deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hardcopy of the signed or annotated notice indefinitely.

Regulatory Impact

Regulatory Impact

The notice states that CMS developed the current two-step notice process for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities and hospices largely in response to litigation involving Medicare managed care enrollees who were unaware of benefit and coverage limitations in these settings. The notice also states that CMS wishes to implement the same two-step process for Medicare hospital inpatients.

Hospitals already follow a two-step process for notifying Medicare beneficiaries of their appeal rights by providing the IMM at admission and a detailed notice when a beneficiary believes he or she is being asked to leave the hospital too soon. This new notice would create a three-step process. For an average Medicare length of stay of six days, a three-step process is unreasonable. Congress required the IMM so that beneficiaries would know their discharge rights at admission and in anticipation of "quicker and sicker" discharges under the inpatient prospective payment system (IPPS) an expectation that did not materialize. Furthermore, the timing for hospital discharges and, therefore, the potential subject of an appeal or Quality Improvement Organization (QIO) review, generally concerns the length of the beneficiary s stay related to medical necessity, not availability of hospital benefits.

(15) Attachment #351

PROVENA
Saint Joseph Medical Center
WE ARE BUILDING **EXCELLENCE**
333 North Madison Street • Joliet, Illinois 60435
(815) 725-7133 • www.provenasaintjoe.com

June 5, 2006

TO: Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850
Submitted electronically: http://www.cms.hhs.gov/eRulemaking

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted by email: Paperwork@cms.hhs.gov

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P
Submitted by email to: carolyn_lovett@omb.eop.gov

RE: File Code: **CMS-4105-P**
Medicare Program: Notification Procedures for Hospital Discharges
Proposed Notice published in the *Federal Register* of April 5, 2006
(71 FR 17052 – 17062)

Summary of Comments

I am writing on behalf of Provena Saint Joseph Medical Center, Joliet, Illinois. We appreciate the opportunity to provide comments on the above referenced notice of proposed rulemaking, which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process similar to what is currently in place for other Part A providers.

We have a number of serious concerns with the proposed rule, chiefly among them, the significant administrative and financial burdens this would place on hospitals and the negative impact that would result for both Medicare beneficiaries and non-Medicare patients. CMS has completely underestimated the information collection costs and has failed to recognize the financial impact of the proposal on the overall healthcare delivery system. It is our belief that providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary and longer hospital stays, thus creating significant throughput issues for hospitals by challenging their capacity limitations and threatening their ability to treat other patients who need acute care services.

The Metropolitan Chicago Healthcare Council estimates the average Chicago-area hospital will incur an estimated $205,000 - $410,000 annually just for the time to deliver the proposed discharge notices, with the anticipated longer length of stay costing the average hospital an estimated $9.9 - $13.3 million annually.

Specific comments, which are explained in greater detail in this letter, include:

- The current process adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services.
- The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not appropriate in an acute care hospital setting.
- The proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations.
- The proposed generic discharge notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources and jeopardizing the ability of hospitals to meet the acute care needs of other patients.
- The hardcopy signature and recordkeeping requirements are at odds with federal efforts to encourage electronic medical records.
- The cost estimates for delivering generic and detailed hospital discharge notices are grossly understated.

There are also a number of unanswered questions, particularly with respect to situations where a discharge is no longer appropriate due to a change in the beneficiary's health status after the generic notice has been issued.

Provena Saint Joseph Medical Center recommends that these issues be taken into consideration and that any outstanding questions be fully considered prior to entertaining a change of any kind to current hospital discharge notice procedures. In addition, we recommend that a national multi-disciplinary workgroup be convened to assist CMS in better understanding hospitals' day-to-day operational procedures and to ensure that any proposed revised procedures better balance hospital and program administrative costs with beneficiary rights.

Background

Current Process

Hospitals currently deliver the "Important Message from Medicare" to all Medicare beneficiaries at the time of admission, and they provide a hospital-issued notice of non-coverage (HINN) to beneficiaries in the original Medicare program who are dissatisfied with a pending discharge. In the case of Medicare Advantage plan enrollees, the responsibility for notification rests with the MA organization, which uses a "Notice of Discharge and Medicare Appeal Rights" (NODMAR) if the patient disagrees with the MA organization's discharge decision or its plans to discontinue coverage of the inpatient stay. Although CMS proposed changes to the hospital discharge notice process in 2001, these changes were not implemented, and hospital responsibilities remained unchanged when final rules were published in 2003 and 2004. (17053)

Comments

The current process adequately informs beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services. Hospitals already follow a "two-step" process for notifying Medicare beneficiaries of their appeal rights through use of the "Important Message from Medicare" and the HINN. The "Important Message from Medicare," which is given at admission to all Medicare beneficiaries, clearly outlines the beneficiary's discharge and Medicare appeal rights and explains how to appeal a discharge decision if the beneficiary believes he or she is being asked to leave the hospital too soon. Congress specifically required the "Important Message from Medicare" to ensure that Medicare beneficiaries know their discharge rights, and it was imposed in response to concerns with "quicker and sicker" discharges under the Medicare inpatient prospective payment system – an expectation that did not materialize.

Individual patient discharge decisions are made by the attending physician responsible for the patient's care. The hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharged timely, collaborates with the physician to expedite the discharge process. Occasionally, the physician is reluctant to discharge a patient, or the beneficiary or the beneficiary's family is reluctant to make a decision regarding post-acute care. Beneficiaries and their families have an inherent financial interest in delaying post-discharge decisions since their out-of-pocket costs are generally greater in a nonacute setting. The HINN is an effective vehicle for prompting action by both the physician and the patient's family.

Provisions of the Proposed Rule – Proposed Two-Step Notice Process

CMS Proposal

CMS proposes to establish a "two-step" discharge notice similar to the process in effect for SNFs, HHAs, CORFs, and hospices because this process is "helpful to beneficiaries" and is not "overly burdensome to providers or Medicare Advantage organizations" (17053). CMS argues that beneficiaries in an inpatient hospital setting should have the "same notice of appeals rights to which other beneficiaries are entitled," and explains that the proposal "would provide a more consistent approach to communicating appeal rights" to all Medicare beneficiaries in all settings. (17053) CMS reiterates that the proposed rule "is intended only to provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings." (17054)

The "two-step" process would require hospitals to deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date where the patient's physician agrees with the discharge. This notice, which includes limited patient-specific information, would be delivered "as soon as the discharge decision is made" (17054), and would require the hospital to obtain the beneficiary's signature to acknowledge receipt. If the patient disputes the discharge, the hospital would be required to deliver a more detailed discharge notice similar to that used in other Part A settings. The current HINN and NODMAR forms for discharge would be eliminated (although HINNs would still be used for preadmission situations and other instances where the physician does not concur with a discharge decision). CMS believes the detailed discharge notice would be necessary in "relatively rare situations." (17054) The beneficiary would be instructed to contact the QIO if the discharge is disputed, and if this notice is made prior to noon on the day after receiving the notice, the beneficiary would have no financial liability until at least noon on the day after the QIO's decision is issued. Hospitals would have responsibility for generic notice delivery to all Medicare beneficiaries and for detailed notice delivery to those in the "original" Medicare program; however, Medicare Advantage organizations would retain responsibility for delivery of only the detailed notice to their enrollees.

Comments

The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not appropriate in an acute care hospital setting. CMS has offered no compelling reasons why hospitals should adopt the same discharge notice process as other Part A providers. Medicare beneficiaries already have the same appeal rights for services in various settings. Hospitals are required to provide the "Important Message from Medicare" at the time of admission, which is a form that is not required in other settings. The "Important Message from Medicare" outlines the beneficiary's discharge and appeal rights, and it is not clear what is to be gained, other than uniformity, for hospitals to adopt the additional proposed notification procedures. It is not necessary to have the same procedures for patients already at home who are receiving notice that periodic home health services will soon end and for inpatient hospital patients who need to be discharged and physically moved to another setting because they no longer meet acute care criteria. Hospitals rely on clinical criteria outlined by Interqual or Milliman to determine whether a patient should be treated in an acute care setting.

Acute care hospitals, by definition, have a short length of stay, which continues to decline due to technological advances and the availability of less-expensive post-acute services. For hospital fiscal years ending in 2004, the average hospital length of stay for Medicare patients in the Chicago CBSA was 5.5 days. Because of a short length of stay, discharge planning in a hospital setting frequently begins at the time the Medicare beneficiary is admitted to the hospital. Patients admitted for elective procedures may have a general idea about their expected length of stay, although this is adjusted during the actual stay as the patient's condition responds to the care provided. Hospital social work, discharge planning, and care management staff work closely with the physician throughout a patient's stay to convey to the beneficiary length of stay expectations, to explore post-discharge options, and to assist with post-discharge arrangements.

The proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations. The generic notice erroneously indicates that the hospital determines that Medicare will not pay for the hospital stay after the discharge date on the form. The detailed notice also indicates that the hospital has determined that Medicare coverage for the hospitalization "should end." This type of language does not accurately recognize the role of the physician, and it creates an unwarranted barrier in the hospital/patient relationship. Discharge decisions are made by

physicians, not hospitals. The physician may document an anticipated discharge or write a discharge plan, but generally does not make a discharge decision until the day of discharge. The discharge order entered into the patient's record at that time is the discharge decision. The physician may give discharge approval pending certain clinical criteria being met, e.g. test results being negative or within specified limits, or absence of a fever.

The proposed discharge notice process will add at least one additional day to every Medicare stay since CMS requires that the notice be given to the beneficiary at least one day in advance of discharge and since the generic notice cannot be delivered until after the discharge decision is made and documented by the physician and the specific date of discharge is entered on the notice. Although the hospital is working closely with the physician and patient to monitor care and a pending discharge throughout the patient's stay, it is not possible to accurately identify the date of discharge one day in advance for every Medicare patient.

We are concerned with the duplicative effort for hospitals to deliver a patient-specific discharge notice to patients with short stays of one to three days. Consider a two-day stay: The "Important Message from Medicare" would be provided on day one, then the generic discharge notice offering similar appeal instructions would be provided on day two for a planned discharge on day three.

We are also concerned with inadequate staff available at hospitals to deliver a patient-specific generic notice to every Medicare patient. Ideally the notice should be delivered by trained case management staff who are familiar with Medicare regulations regarding notice delivery, appeal rights, and clinical implications. Weekend staffing would be required to appropriately meet Medicare's proposed one-day notice requirement. Although hospitals understand their responsibilities to be adequately staffed, this is a tremendous challenge when faced with shortages of trained case management staff and limited personnel budgets.

The proposed generic discharge notice invites unwarranted appeals and longer lengths of stay, thus consuming valuable hospital resources and jeopardizing the ability of hospitals to meet the acute care needs of other patients. The language of the generic discharge notice, particularly the repeated references to "an immediate review," will raise doubt in the beneficiary's mind with respect to whether the discharge is appropriate. It basically invites beneficiaries to appeal. Hospitals find that families of some Medicare beneficiaries will take advantage of every opportunity to appeal a discharge decision, especially when there is no financial penalty to do so. Most if not all of the one to six annual HINNs issued by MCHC member hospitals were appealed. It is our belief that the vast majority of the proposed generic notices will be appealed. The reality is that many Medicare patients do not want to leave the hospital, not because they are not medically ready to be discharged, but because the acute hospital setting offers a more emotionally secure and comfortable environment than they will find at home or in a post-acute healthcare setting. Other beneficiaries resist discharge because a bed has not become available in a non-acute setting of their choice (although beds are available elsewhere).

The proposed notice emphasizes that the beneficiary's "hospital services will continue to be paid for during the review." This is the only sentence in the two-page proposed notice that is underlined. By highlighting the lack of financial penalty, the message to beneficiaries and their families is that there is no reason not to appeal, even if the patients are medically ready for discharge. This is just the opening that some patients' families are looking for.

While patients may have nothing to lose financially by appealing a discharge decision, hospitals stand to incur significant additional administrative and patient care expenses should the proposed discharge notice procedures be finalized. It is Provena Saint Joseph Medical Center's belief that providing a patient-specific discharge notice to every Medicare

beneficiary will lead to unnecessary and longer hospital stays while discharge decisions are being appealed. This will create significant throughput issues for the hospital, which do not have unlimited capacity, longer Medicare stays, combined with current high occupancy rates, will threaten the hospitals' ability to treat other patients who need acute care who are waiting for available beds. We envision back-ups in hospital emergency departments, and the possibility of some hospital EDs being on by-pass, and thus being unable to readily meet the healthcare needs of their communities, including non-Medicare patients.

It is important to recognize that although beneficiaries are advised that "hospital services will continue to be paid for during the review," hospitals will not actually be paid more for Medicare patients who stay longer. Although additional valuable hospital resources would be used for patients who unreasonably request an immediate review, no additional payment will be made to the hospital under the Medicare inpatient hospital prospective payment system to compensate the hospital for the additional costs incurred.

The hardcopy signature and recordkeeping requirements are at odds with federal efforts to encourage electronic medical records. CMS would require that hospitals deliver hard copy discharge notices; no provisions are made for alternative uses of information technology for either the generic or detailed notices. Hospitals would also be required to maintain the signed or, in the case of the patient's refusal to sign, annotated hard copy of the discharge notice. This short-sighted approach fails to recognize the current steps hospitals are taking to implement cost-effective electronic health information record-keeping formats and the strong commitment that the current Administration has made to electronic health records.

There are a number of questions that are not addressed in the notice of proposed rulemaking: If the hospital provides a discharge notice, but discharge is postponed because the patient develops a fever the night before the expected discharge, is the generic notice formally rescinded, and is another generic notice then required, with both steps possibly occurring on the same day? Is another notice required when a discharge is dependent on certain test results, which do not come back with the appropriate values, so discharge is delayed? What are the specific communication and documentation procedures CMS expects hospitals to follow when delivering the proposed discharge notices to a beneficiary's family who does not reside locally? What allowances are made in the proposed discharge notice process for patients who progress faster than anticipated so they are clinically ready for discharge earlier than planned? Will the QIOs be provided enhanced funding for additional staffing so appropriate access and services are available seven days a week?

Collection of Information and Recordkeeping Requirements

CMS Estimates

CMS argues that the proposed hospital discharge notice process "would enhance the rights of Medicare beneficiaries without imposing any significant or undue financial burdens on hospitals." (17057) It reiterates that it does not anticipate there to be "a significant financial impact on individual hospitals." (17058) CMS estimates it would take hospitals five minutes to deliver the generic discharge notice to each Medicare beneficiary. CMS further estimates that two percent of Medicare beneficiaries will request an immediate review (a number that CMS considers "high"), resulting in an estimated 60-90 minutes of additional effort by the hospital to prepare the detailed notice and associated records for the patient and the QIO. Based on a $30 per hour rate (again, a number that CMS considers high if non-clinical staff are used for any task such as copying medical records), CMS estimates overall annual costs of complying with the proposed requirements of $7,075 per hospital.

Comments

The cost estimates for delivering generic and detailed hospital discharge notices are grossly understated. The CMS estimates are based on faulty assumptions, and they fail to properly take into account a number of significant costs related to the delivery of the proposed discharge notices.

- **Explanation of generic notice, appeal rights, and securing patient signature from a competent Medicare patient** – Under the proposed discharge notice procedures, hospital case management or discharge planning staff would be responsible for identifying when a discharge decision is made by the physician, completing the generic discharge notice with patient-specific information, obtaining any necessary interpreter services, explaining the content and purpose of the generic notice to the beneficiary, answering the beneficiary's questions, securing the beneficiary's signature on the form to acknowledge understanding and receipt, and copying the signed form for the beneficiary. MCHC hospitals estimate that it would take an average of 25 minutes, as opposed to the five minutes estimated by CMS, to prepare and deliver the generic discharge notice to a Medicare patient who is competent and able to understand the form. At $30 per hour, this is $12.50 per beneficiary, for an average annual administrative cost of $60,000 for a hospital in the Chicago/Naperville/Joliet CBSA.

- **Valid receipt of notices for incompetent patients and obtaining guardianships** - The proposed estimated delivery costs for the generic notice fail to account for situations where the patient is not competent, family members are unavailable, or guardianship through court order is required. Unfortunately the families of some Medicare patients deliberately avoid contact with the hospital during the patient's stay. It could take several hours or days to locate the beneficiary's family. The $12.50 cost estimated above to deliver the generic notice could easily be $50-125 or more per beneficiary for incompetent patients.

If the family cannot be located, it may take up to a week by the time guardianship is obtained. MCHC member hospitals report that guardianship is currently required for one Medicare patient per month, with up to three or four patients per month requiring guardianship for inner city hospitals. These figures would increase under CMS' proposal. Securing guardianship typically adds a week to the patient's hospital stay, at an estimated cost to the hospital of more than $10,000 per patient for these additional days. The legal fees for the guardianship itself are estimated at $2,000-5,000 per occurrence.

- **Effort to prepare detailed notices and work with QIO** – CMS failed to account for the full cost of the preparation of a detailed notice and the review by the QIO in estimating the time to deliver the detailed discharge notice. MCHC hospitals estimate that the detailed notice would take at least three hours to complete and deliver to the Medicare beneficiary because of the level of detailed information requested and the need to translate clinical information into plain English. The process will take even longer for non-English speaking patients. At $30 per hour, this is at least $90 per detailed notice. With a very conservative one-third of beneficiaries appealing their discharges, the average Chicago-area hospital will bear a minimum annual cost of $145,000 to prepare and deliver the detailed notice. If the vast majority of beneficiaries request an immediate review as we anticipate (say, 80 percent), this direct annual cost per hospital increases to $350,000.

  Unlike the current HINN, which makes a generic statement that the inpatient services are not medically necessary or the patient's condition could be safely treated in a

non-acute setting, the proposed detailed notice requires the hospital to outline the patient-specific facts used to determine that Medicare coverage should end, to provide detailed and specific reasons why services are no longer reasonable or are no longer covered by Medicare, and to provide specific citations for Medicare coverage rules or policies that are specific to the beneficiary's individual case. Hospitals expect that direct input from the physician, a resident, or a hospitalist will be required to complete the detailed notice and that they will not be able to cite specific applicable Medicare coverage policies. Hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria, not on a specific Medicare coverage rule or policy.

The QIO review process will require interviews with at least three key individuals (the director of UR/case management, the physician, and the social worker or QIO liaison), two of whom are hospital employees. Based on current experience, each of these discussions will take 10-15 minutes. The annual costs of these interviews alone for the average Chicago hospital are estimated to be $24,000-$87,000, depending on the length of the conversations and the number of beneficiaries requesting immediate reviews.

- **Additional length of stay** – MCHC member hospitals estimate that the proposed requirement to provide a patient-specific generic discharge notice would add at least one day to each Medicare beneficiary's stay, and the requirement to issue a detailed notice would add a minimum of two days to the stay. We also believe that the generic notice will prompt most Medicare beneficiaries to seek an immediate review. Using an average cost per day of $1,525, and assuming a very conservative one-third of beneficiaries request an immediate review, we estimate that CMS' proposed discharge notice procedures will cost the average Chicago-area hospital $9.9 million just from the additional length of stay. Based on 80 percent of Medicare beneficiaries requiring a detailed notice, this figure climbs to $13.3 million per year for the average Chicago-area hospital.

- **Additional staffing needs** – The costs estimated above are for the direct costs of preparing and delivering the generic and detailed discharge notices. Additional costs would be incurred for hospital staff to witness and document valid delivery of the notices by telephone to patient representatives. Hospitals will incur yet additional costs for interpreter services, which can be significant at certain hospitals that have a disproportionate share of non-English speaking patients. Hospitals would also face additional costs for weekend or on-call staff who would be required for timely delivery of the required notices.

- **Rework by hospital staff to secure post-discharge placement** - Another expense hospitals will face when more beneficiaries appeal their discharges is rework necessary to locate and secure an available bed in a non-acute setting. For example, an isolation bed may be available in a nursing home on the day of expected discharge, but by the time the QIO review is complete, the bed is no longer available, and the search begins anew.

Recommendations

Provena Saint Joseph Medical Center recommends that CMS not implement the proposed discharge notice procedures. We suggest that prior to making any changes to current hospital procedures for notifying Medicare beneficiaries of their appeal rights and issuing HINNs, CMS needs to better understand hospital operations and to develop more realistic

estimates of the administrative and financial burden of the proposed requirements on hospitals.

Provena Saint Joseph Medical Center also recommends that CMS convene a national workgroup comprised of hospital, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures impact the various parties, and to ensure that any proposed revised procedures truly balance hospital and program administrative costs with beneficiary rights. We would be happy to make recommendations for hospital staff to participate as members of this workgroup.

Further Information

Thank you again for the opportunity to review CMS' proposal and to offer comments. If you have any questions about the issues raised above or you need any additional information, please feel free to contact me at (815) 773-7005, email nancyasulzberger@provenahealth.com

Sincerely,

Nancy A. Sulzberger RN, BSN, MN
Director of Care, Quality & Risk Management

cc: Jeff Brickman
Linda Charley
Lon McPherson

Attachment #353

June
Five
2006

VIA E-MAIL

(16)

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

RE: Proposed Rule CMS-4105-P, Notification Procedures for Hospital Discharges
Background
Provisions of the Proposed Rule
Regulatory Impact

To Whom It May Concern:

Greater New York Hospital Association (GNYHA) represents more than 175 not-for-profit and public hospitals in New York State, New Jersey, Connecticut and Rhode Island. We welcome the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) notice of proposed rulemaking (NPRM), CMS-4105-P, Notification Procedures for Hospital Discharges.

The NPRM proposes a two-step process whereby Medicare beneficiaries will receive a standardized, generic notice of discharge 24 hours in advance of the scheduled discharge and a detailed notice if the patient disputes the discharge. GNYHA supports CMS's efforts to create a simplified process for issuing standardized notices so that Medicare Advantage (MA) and original Medicare beneficiaries receive the same, single detailed notice. However, we are concerned that the two-step process CMS is proposing will have a number of unintended consequences, in some cases to the detriment of the Medicare beneficiary, the very party it seeks to protect. Our concerns are as follows:

- We believe it is unrealistic to expect that hospital staff will be able to reliably predict a patient's discharge date in advance in order to comply with the CMS proposed rule that a standardized, generic notice be issued to original Medicare and MA beneficiaries or authorized representative the day before discharge. We believe that in trying to comply, the two-step process will be confusing and unnecessarily alarming for the Medicare beneficiary.

- We believe the cost calculations for the two-step process grossly underestimate the actual financial impact and fail to consider the extreme administrative burden that will be imposed on providers to comply.

Our recommendations are as follows:

- CMS should not proceed with its proposed requirement and instead should retain the current discharge appeals process. CMS should explore avenues to strengthen the process associated with the Important Message from Medicare (IMM) that is issued on or about the time of admission.

- CMS must institute an adequate oversight mechanism that addresses the problem of MA plans a) circumventing the hospital discharge appeals process and b) habitually authorizing inadequate levels and amounts of post-acute care services. This should include that MA plans share the costs associated with all beneficiary appeals and additional penalties whenever a MA plan impairs the timeliness of the appeals process.

- CMS should convene a working group to review and revise the content of the nine different hospital-issued notices of noncoverage (HINN) letters so the notices can be consolidated and the formats uniform.

Timing of Generic Discharge Notice

The basic premise that discharge from an acute care setting can be predicted a day in advance of the actual discharge date is impractical and flawed. Hospital length of stay has over time been reduced to the point where a significant portion of hospital admissions is comprised of relatively short lengths of stay of three days or less. It is this subset of admissions that would pose the greatest challenge to hospital providers. GNYHA has firsthand knowledge of the difficulties involved since New York State regulations similarly have attempted to impose this requirement for non-Medicare beneficiaries, with only marginal success. The experiences recited by GNYHA hospital discharge planners underscore the logistical difficulties and staff concerns that patients' perceptions of their care experience could be adversely impacted.

Hospital discharge planners report that as a practical matter, the decision to discharge a patient is a relatively last-minute determination made by the attending physician on the day of discharge. While there are many discussions between the patient and doctor (and the entire interdisciplinary team of caregivers) about impending discharge and ensuring that the appropriate post-acute care services are in place, actual physician concurrence (i.e., a signed discharge order) for all intents and purposes is not executed until the day of discharge because physicians wish to be satisfied that the patient's condition is appropriate for discharge at that actual time. It is our experience that patients and their doctors amply manage the discharge process and hospital discharge planners serve to enhance that relationship by ensuring the adequacy and safety of the discharge plan. We note that the fact that the vast majority of patients do not dispute their discharges is a testament that the existing process works effectively. We strongly believe that the balance of interests is already appropriate and that introducing cumbersome administrative protocols will not achieve additional benefit.

Notwithstanding the practical aspect of the written discharge order, a significant percentage of hospital admissions are of relatively short duration. Imposing this requirement would mean that staff would have to deliver a notice of discharge essentially on admission for short-stay hospitalizations (at the same time the -IMM is issued) even before a condition has been ruled out. In certain circumstances it is likely that the discharge notice will be issued inappropriately

when a predicted discharge does not occur and instead a condition is ruled in. Receiving an ill-timed notice or duplicative notices in all likelihood will end up being confusing and unduly alarming for the Medicare beneficiary. In this regard, the proposed process does not balance the beneficiary's need to be informed at an appropriate time. Since the proposed requirement would be redundant to the IMM, likely adversely impact the consumer, and create a requirement that providers will be unable to fulfill, we strongly urge CMS to leave the current process unchanged.

Recommendation:

CMS should not proceed with its proposed requirement that a standardized, generic notice be issued a day in advance of discharge. Instead, CMS should retain the current discharge appeal process and strengthen the process for issuing the IMM that is delivered on or about the time of admission.

Medicare Advantage and Hospital Discharge Planning

GNYHA, the American Hospital Association, and others have submitted numerous comments to CMS in response to prior proposed rules with regard to the longstanding, objectionable behavior of MA organizations and the hospital discharge process. It is well documented that plans do not issue the NODMAR and instead habitually reduce or deny payment to hospitals. This is contrary to CMS's notation in the proposed rule (pg. 17053) that the MA organization is required to issue a NODMAR when it no longer intends to cover the inpatient stay.

Based upon past experience, we are very doubtful that MA organizations will comply with the proposed two-step process and issue a timely detailed notice, particularly when the plan has no financial risk for delays it creates in the discharge appeals process. This is often the case with non-participating providers or where participating providers are reimbursed case rates from a plan. We note that because most MA plans do not staff their Medical Management departments on weekends, the two-step process will further delay the discharge appeals process when a weekend o r ho liday is inv olved. E ven m ore t roubling a re t he r eports by ho spital dis charge planning staff that certain MA plans chronically authorize inadequate amounts of post acute care service such that when a patient's condition requires a certain level of service, the plan limits the amounts and types of care it will pay for. While the patient can appeal the MA plan's adverse service determination, it is an unsettling and arduous process that can take six to 10 days until the Independent Review Entity issues a determination. As CMS correctly no tes, the hospitalized patient is appropriately afforded financial protections while awaiting the outcome of an appeal, but on the flip side, the hospital typically receives no additional reimbursement during this prolonged process and the patient is made to wait for the decision when he or she should be proceeding to the next appropriate level of care. If CMS is to protect the best interest of the Medicare beneficiary and the providers that render care, it has to create sufficient regulatory oversight so that the MA plan shares in the financial consequence when it prolongs the appeals process and creates discharge planning delays. CMS cannot divorce itself from these well-known issues and we respectfully urge that it establish a mechanism that will deter MA plans from this persistent and unacceptable practice. As noted above, there is clearly a need for CMS direction to plans when enrollees are hospitalized in non-contracted providers. We believe it is equally important for CMS to get involved when MA contractor practices lack integrity and work against

the best interest of efficiency and an optimal patient experience, and therefore ask that CMS address these issues for providers that have contracts with MA plans as well.

Recommendation:

CMS must institute an adequate oversight mechanism to prevent MA plans from a) circumventing the hospital discharge appeals process and b) habitually authorizing inadequate levels and amounts of post acute care services. MA plans should share the costs associated with all beneficiary appeals and in curr additional penalties when it delays the appeals process.

Uniformity of Notices

We appreciate CMS's attempt to create uniformity by trying to adapt the same discharge notice process that applies to HHAs, SNFs, and CORFs to the hospital setting, but this new process falls short of its goal. It will not consolidate the nine different hospital issued notices of noncoverage (HINN) in a meaningful manner. As a practical matter, the new standardized, generic notice seemingly will only replace the HINN letter issued for continued stay when the physician concurs. Accordingly, it will simply add another letter format and introduce a different appeals process to that which currently exists, thereby failing to achieve the consistent approach that it seeks.

Recommendation:

CMS should convene a working group to review the content of the current collection of HINN letters and focus on consolidating and creating uniformity in the notices in a meaningful fashion.

Estimate of Financial and Administrative Burden

We believe that CMS has significantly underestimated the financial and administrative burdens associated with the proposed two-step process for the following reasons:

- CMS expects that the standardized, generic form can be issued in five minutes, but has not taken in account a variety of factors including the additional time that will be required to explain the notice and to answer patient and/or family questions.

- CMS has not considered the intensive effort that will be required to pursue the signature of the authorized representative when the patient is not capable of comprehending and signing the standardized, generic notice. This is often the case when a nursing home resident is hospitalized. We do not believe CMS has accounted for the additional outreach and work effort by hospital staff to solicit written consent (e.g., repeated phone calls) nor the cost associated with overnight mailing and/or faxing the generic and detailed notices.

- It is very likely that this proposed two-step process will prolong hospital length of stay, especially in those circumstances when the discharge is not known in advance and the notice is issued on the day of discharge, thereby permitting the patient an extra day. If one calculates the impact of increasing hospital length of stay by just one day in 25% of the eligible cases, the fiscal impact is significant.

- Indeed, hospital Case Management departments will incur additional costs to increase staff coverage during weekends and after hours to ensure compliance with issuance of the generic and detailed notices.

- While CMS calculates 60-90 minutes in which to prepare the chart, we do not believe this reflects the cost the hospital incurs to refer the discharge appeal through the UR process. This typically requires that a Physician Advisor be consulted (at a significant hourly rate) to review the chart and document impressions and comments. Nor does CMS include the time involved and the cost of providing copies of the medical record and other related materials to the beneficiary.

- In addition, CMS's requirement that the detailed notice include the applicable Medicare coverage guidelines, instructions, and/or policies will add to the expense of issuing the detailed notice. In some instances this may mean that providers will need to research and identify applicable regulation, Medicare Coverage Manual citation, or related resources. If the citation is for some reason inaccurate or incomplete, will a technical denial be issued and the hospital faced with additional unfunded days?

- Finally, as previously discussed, CMS has not calculated the hospital cost when the MA organization causes delays in the discharge appeals process or authorizes inadequate post-acute care services and prolongs a hospitalization for appeal purposes.

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

cc (via e-mail): Office of Strategic Operations and Regulatory Affairs, Regulations Development Group
Office of Information and Regulatory Affairs, Office of Management and Budget

Attachment #357

TRINITY HEALTH

(17)

June 5, 2006

West Michigan Finance Shared Services
1820 44th Street SE
Kentwood, MI 49508

Mark B. McClellan, M.D., PH.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Medicare Proposed Discharge Notice
CMS-4105-P

Dear Administrator McClellan:

Battle Creek Health System (23-0075), Mercy General Health Partners (23-0004), and Saint Mary's Health Care (23-0059) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled "Medicare Program: Notification Procedures for Hospital Discharges" 71 Federal Register No 65, starting page 17052 dated April 5, 2006.

"Provisions of the Proposed Rule"

The proposed rule states that the hospitals would be required to provide the standardized notice on the day before the planned discharge from any inpatient hospital stay for patients in the original Medicare or Medicare Advantage programs. For one to three day stays, this essentially means that the discharge papers would have to be handed to the patient upon admission. This would be burdensome on the admissions process. The admissions area would now have to start explaining the discharge procedure to patients before they are even treated. The estimate of five minutes is understated. **The patients will get the feeling of being kicked out of the facility before being treated.** The ramifications would be additional stress and undo worry to the patient.

Second, on longer stays, the attending physician usually does not determine discharge status until the day of discharge. By requesting the hospitals to notify the patient 24 hours before would put undo burden on the hospital. It would mean a radical change in procedures and getting physicians to notify the hospital the day before possible discharge. A patient's condition can change drastically in 24 hours for the better or worse. This could change the physician's orders. If a determination cannot be made until the morning of discharge, a hospital will be required to delay the release of a patient due to this notification requirement. The delay in discharge will decrease patient satisfaction and unnecessarily increase the cost of the stay. As reimbursement rates for most Medicare stays do not cover cost already, there will be additional financial strain on the facility. In addition, when beds are in short supply, this delays treatment for other patients who are in need of admission.

The hospital is also being required in this rule to keep a signed copy of the additional paperwork to keep on file or to document the refusal to sign. This is additional cost to the facility with additional storage costs and goes against CMS policy to move to electronic medical records.

The detailed notice that will be required if a patient decides to an expedited review will also be burdensome. **It is the physician's determination to discharge,** however the hospital is responsible for not only detailing the physicians reason for the discharge but must also include the applicable Medicare coverage rule; this document is becoming a legal brief. To expect that a discharge planner or nurse would be able to complete all of this documentation without extensive input from other areas (physicians, patient accounting, reimbursement etc) in 60 – 90 minutes appears to be underestimated.

Even though the proposed rules have changed since the original inception in 2001, the burden on the hospitals is too great for little gain. As an alternative, modifying the Important Message from Medicare

(IMM) would achieve the CMS objective. This revision could include a highlighted, bolded section explaining patient discharge appeal rights. This would be sufficient for many hospital inpatients as it is impossible to predict the discharge date prior to having the proper information on the well being of the patient.

Again, I appreciate the opportunity to provide comments to CMS regarding the proposed discharge notice. If you have any questions on this comment letter, I can be reached at (616) 643-3569 or at marsylkp@trinity-health.org.

Respectfully,

Kay Marsyla
Senior Reimbursement Specialist
Trinity Health West Michigan Finance
Shared Services

18

Submitter : Mr. Thomas Tynan **Date:** 06/05/2006

Organization : Society for Social Work Leadership in Health Care

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

Social workers and others in healthcare are taxed with the awesome responsibility of assisting individuals at very difficult and trying periods in their lives. They therefore require the time and attention needed to address their clinical needs. Adding another piece of paper to an already voluminous amount of documents that need to be read, sometimes interpreted and signed by the patient, in our view, diverts needed resources from the effort to provide care, treatment and assistance to patients. We share the view of other professional healthcare organization that the CMS estimate (5 minutes) of the amount of time expended for the provision of the second step notice is grossly understated. Given the time required for delivery of the document, explanation and discussion of the letter s intent and to respond to questions posed by patients in their families the process would take at least 20-30 minutes. Patients who have language barriers or are unable to communicate due to their medical condition would require even greater expenditures of time.
One outcome from this new rule will be more unnecessary appeals by patients or their families who wish to extend the hospital staff for the 2 or 3 days necessary to resolve an appeal. Hospital resources such as hospital beds are often at a premium. CMS has prided itself on its efforts to prevent unnecessary acute care hospital days. This new rule would have the opposite effect.

GENERAL

GENERAL

The Society for Social Work Leadership in Health Care recommends that the CMS proposed discharge notice procedures not be implemented. The current process already protects the rights of Medicare patients to appeal a physician s discharge physician. As an organization dedicated to advocating for the rights of our clients, we propose that the patient s interests would be much better served by eliminating CMS rules such as the three day hospital stay requirement to be eligible for skilled nursing facility benefits.

Our Society (SSWLHC) would welcome any opportunity to participate in any dialogue or workgroups to enable CMS to achieve its goal of protecting the rights of its beneficiaries while at the same time avoiding any negative impact on the utilization of valuable healthcare resources and on the caregiver/patient relationship. Thank you for allowing us the opportunity to comment on CMS-4105-P.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The new proposed requirements under CMS-4105-P and in particular the two-step notice process in our view would, in addition to imposing significant administrative costs on hospitals, potentially undermine the partnership between caregivers, such as social workers and the patients and their families. This partnership is critical to produce the best possible clinical outcomes and to effect an optimal transition from acute to the next level of care. The second step that requires hospitals to provide written notice of discharge one day prior to discharge may suggest to patients that criteria for the discharge date was determined by the GMLOS or other financial considerations rather than medical/clinical criteria. Such a misunderstanding would change the dynamics of the relationship from collaborative to adversarial.

Regulatory Impact

Regulatory Impact

Patients already receive notice of their rights to appeal a discharge decision as prescribed by the Important Message from Medicare . Needing to provide a second notice is at best redundant and at the very worst intimidating to patients and their families. It is difficult to understand what can be gained by the second letter. It presumes that all patient discharges are predictable. Often the physician may be awaiting a laboratory result or other diagnostic indicator to make his or her final decision regarding discharge. Would we keep the patient in the hospital an extra day solely on the need to provide 24 hour prior notice? If a planned discharge needs to be postponed, do we issue another letter? How do we reassure the patient that his or her benefits will not be cut off?

MedStar Health

Michael C. Rogers
Executive Vice President
Corporate Services

June 5, 2006

VIA Electronic Transmission to www.cms.hhs.gov/eRulemaking

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS-4105-P

RE: Medicare Program: Notification Procedures for Hospital Discharges; Proposed Rule: CMS-4105-P

Dear Dr. McClellan:

These comments on the above referenced proposed rule are submitted on behalf of MedStar Health and its affiliated organizations which include, among others, the Washington Hospital Center, Georgetown University Hospital and the National Rehabilitation Hospital located in the District of Columbia, and Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital in Maryland. MedStar Health is a private, non-profit organization with over 100,000 Medicare hospital inpatient discharges annually.

MedStar Health would like to focus comments on the impact of the 24 hour advance notice requirement of the proposed rule, and the regulatory impact that will result. The case management professionals at our hospitals believe that the 24 hour notice requirement will result in a large number of additional and mostly unnecessary patient days. The 24 hour requirement will also require far more additional staff time than CMS has anticipated. There are also significant downstream impacts affecting patient access. As a result, we believe that CMS has underestimated the regulatory impact on hospitals. We therefore suggest that the 24 hour requirement be eliminated or modified as described below.

24-Hour Provision of the Proposed Rule Will Result in Additional, Unnecessary Patient Days

The most significant concern from an operational/patient care point of view is the 24 hour notification requirement prior to discharge for the delivery of the generic notice. The 24 hour advance notice requirement provision requires that hospital staff accurately predict an acute care discharge 24 hours in advance so that the generic notice can be delivered one day prior. This prediction requirement in an acute care setting is very difficult, and will necessarily result in unanticipated discharges that do happen and thus must be delayed. Acute care hospitalization has a less predictable treatment course than other patient care facilities. While anticipating the date of discharge may be fairly routine for many uncomplicated surgical patients, it is very difficult for most

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of our medical patients and our complicated surgical patients. Our hospital staff conservatively estimate that it can accurately predict the discharges 24 hours in advance for most of the uncomplicated surgical patients, and about 40% of medical patients and the more complicated surgical patients. Given our mix of patients, this means that 25% of our Medicare discharges would not be accurately predicted, possibly as many as 50% by other estimates.

This will result in additional patient days that may not be medically necessary. For example, a physician decides that a patient can go home today, but this was not anticipated yesterday as a discharge by staff. Because the patient was not given the generic notice one day prior to discharge, the notice is given today, and patient must wait until tomorrow to be discharged. **Our hospitals conservatively estimate that this could apply to 20% of all Medicare discharges. This would result in about 22,000 additional patient days annually, just in our seven hospitals.** The cost of these patient days could be devastating.

In addition, coordination issues with the QIO will contribute to additional delays. The QIO has not traditionally been open on nights and weekends. An appeal of a discharge decision filed near the end of the 24 hour period might not be heard until the following day. If that is near the end of the day, it could add more than one day to the length of stay. Similarly, a Friday or Saturday appeal may not be heard by the QIO until Monday, increasing length of stay by more than one day. To minimize the impact on extended stays, the QIO would have to be available on evenings and weekends.

24-Hour Provision of the Proposed Rule Will Require Additional FTEs

As a result of the 24 hour requirement, additional staff time will be needed to handle the process and related paperwork, including tracking the planned and unplanned discharges, physician and staff education, and compliance monitoring. In addition, because discharges are difficult to predict, some anticipated discharges may not happen, and the generic notices that were delivered will have to be retracted. For example, a discharge is expected for the following day, and the Medicare notice is delivered to the patient. The patient's status changes, and the discharge is delayed. Because the patient will likely be concerned about payment for services being cut off, staff will visit the patient, retract the notice, and answer questions as needed to minimize patient anxiety. Our hospitals estimate that this could apply to 5% of all Medicare discharges. Multiple notices provided to patients within a very short time frame will require careful follow-up. Many hospitals will not be able to impose these requirements on already overburdened nursing staff, and will instead use dedicated staff for the notifications as well as the administrative duties. **For the larger hospitals with a significant Medicare population, we estimate two dedicated FTEs will be needed.**

Other factors support our belief that dedicated FTEs will be required rather than marginal nurse staff time, as long as the 24 hour requirement remains part of this proposal. We believe that a number of patients will require more staff time than that estimated, such as patients with dementia, those that do not have family to help with explanations, and those that request additional information before making a decision about an appeal. In addition to the 2% of patients that will appeal the discharge decision, another 2% might request additional information but not follow up with an appeal. Finally, our hospital staff believe that the estimate of 2% appeals, while reasonable, is conservative, and could be as high as 4%.

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24-Hour Provision of the Proposed Rule Will Impact Patient Access

Another important concern is the downstream impact of these extra patient days on access to other services. One major reason for emergency department overcrowding is the lack of inpatient beds during peak census times. Thus, admissions from the emergency department will be affected by the additional Medicare patient days, and ambulance diversions could increase. Also, discharge planning is often time sensitive and will be impacted by this requirement. Because there is often a narrow window of opportunity for placement of the elderly in other settings such as skilled nursing facilities, discharges delayed by a day or more may disrupt these placements, affecting the hospitals, our patients and their families, as well as the availability of those placements. Long term care facilities will simply take another patient off their waiting list.

Regulatory Impact

CMS bases its estimate of the regulatory impact on hospitals on these assumptions: (a) 5 minutes for delivering the generic notice to all Medicare discharges, (b) 90 minutes to fill out and deliver a detailed notice to (c) two percent of the beneficiaries and enrollees that will appeal or ask for additional information, (d) at a cost of $30 per hour incremental staff time, and (e) 6,000 affected hospitals. The result is a national impact of about $42,500,000. However, the regulatory impact is far greater than CMS suggests, when considering the effect of the additional patient days from the 24 hour notice requirement, and the dedicated staff that would be required in many hospitals. At MedStar Health's six acute general hospitals alone, 12 dedicated FTEs and 22,000 additional patient days at $1,000 per day is well over $22 million. Nationally, based on a conservative estimate that one FTE per hospital in 6,000 affected hospitals would be needed (two in larger hospitals, while in smaller hospitals the CMS assumption using marginal nursing time for administering these notices might be appropriate), shows that the CMS estimate of $42.5 million is grossly underestimated. Adding the impact of the additional patient days incurred for 20% of 12.5 million discharges, at a cost of $1,000 per day, would be staggering.

Recommendation

MedStar Health recommends that the 24 hour advance notification requirement be eliminated, and the generic notice delivered in another way. The 24 hour advance notification requirement could be eliminated if the generic notice can be delivered in another way to inform beneficiaries of their rights in a more appropriate setting. Elderly patients, often on pain medication and other drugs in the 24 hour period prior to discharge from an acute hospital stay, may actually be unfairly burdened with the timing of this information. Medicare should instead consider delivering this information well in advance through one or more means. A reminder could be provided at the time of admission, at the same time as the "Important Message from Medicare", with a discharge sheet reviewing their appeal rights and responsibilities, with names of people to contact once the discharge notice is provided, and informing them that they may have only a short time to decide on the appeal. Having patients or family sign for the receipt of the this information would ensure that the message was delivered. Given the usually short time frame of hospital admission, there is considerable benefit to consolidating messages. A public educational campaign directed to all beneficiaries that focuses on the rights of beneficiaries upon discharge could also prepare beneficiaries by

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notifying them of their rights at a time more conducive to understanding and discussion with family. Alternatively, a four hour advance notice rather than the 24 hour advance notice requirement, combined with the notice on admission, could help reduce the negative impact of the proposed rule.

MedStar Health believes that another method of informing beneficiaries of their rights would continue to address a beneficiary's need to be informed about appeal rights, in a more appropriate manner and time, and avoid the burdens on hospitals, patients and their families imposed by the proposed approach. Providing for the unique needs of hospitalized patients, keeping their length of stay as short as possible, and informing them well in advance of their discharge rights at admission rather than waiting until just before discharge, is more helpful to beneficiaries than is providing uniformity in process between hospitalized patients and other provider types.

Sincerely,

Michael C. Rogers
Executive Vice President, Corporate Services

cc: Kenneth A. Samet
Michael J. Curran
Lawrence M. Beck
James F. Caldas
Joy M. Drass, M.D.
Edward A. Eckenhoff
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Nebraska Hospital Association

June 5, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare Program: Notification Procedures for Hospital Discharges Proposed Notice of Rule Making, CMS-4105-P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)

Dear Dr. McClellan:

On behalf of the Nebraska Hospital Association (NHA), its 85 member hospitals, and the 36,000 individuals we employ, I appreciate the opportunity to comment on the proposed rule concerning the notification procedures for hospital discharges. The proposed rule would require hospitals "to provide a standardized notice on the day before the planned discharge from any inpatient hospital stay." This new notice would be in addition to the Important Message from Medicare (IMM) given at admission, which already provides an explanation of Medicare discharge appeal rights.

The NHA believes that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting, how the discharge planning process works, and the real impact – both financially and operationally – that the proposal would have on hospitals. The NHA does not believe CMS should proceed with these changes without conducting a more extensive analysis of the current processes. A stronger case justifying the need for the proposed changes should be developed before proceeding.

This letter includes our comments on several issues contained within the proposed rule.

- The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns.

- The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.

- The hardcopy signature and recordkeeping requirements are counter to hospitals' movement to electronic medical records and federal efforts that encourage an even faster conversion.

Background
Hospitals are already following a two-step process for notifying Medicare beneficiaries of their appeal rights by providing the IMM at admission and a detailed notice when a beneficiary believes he or she is being asked to leave the hospital too soon. This new notice would create a three-step process. For an average Medicare length of stay in Nebraska of 5.3 days, a three-step process is unreasonable. Congress required the IMM so that beneficiaries would know their discharge rights at admission and in anticipation of "quicker and sicker" discharges under the inpatient prospective payment system (IPPS) – an expectation that did not materialize. Furthermore, the timing for hospital discharges and, therefore, the potential subject of an appeal or Quality Improvement Organization (QIO) review, generally concerns the length of the beneficiary's stay related to medical necessity, not availability of hospital benefits.

Provisions of the Proposed Rule
The rule proposes that hospitals deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hardcopy of the signed or annotated notice indefinitely.

There are several problems with the proposed approach.

- Physicians, not hospitals, make discharge decisions. The notice repeatedly refers to hospitals making discharge decisions. Hospitals cannot discharge patients without a physician's discharge order. Hospitals operate a discharge planning process that is governed by Medicare conditions of participation and, for some hospitals, by the Joint Commission on Accreditation of Healthcare Organizations standards. In both cases, those standards require the early initiation of the process, involvement of the patient and family in the planning, timely notice of expected discharge date, and arrangements for post-acute care. Hospitals also operate utilization management and quality improvement programs to ensure appropriate care in the appropriate setting. But these activities that support care planning and discharge decisions should not be confused with the actual discharge decision process.

- It is virtually impossible to know with certainty the discharge date a day in advance. Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. That determination is based on test results and clinical indicators, such as whether a patient is free of fever. Patients generally know their expected day of discharge (often from before admission in the case of elective admissions), which is then adjusted as necessary to reflect their condition during the discharge planning process. There may be an expected discharge date of Thursday for example, but if the patient develops a fever the evening before, the discharge date will be postponed until that fever is gone.

- By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer

needs it, with significant financial, operational and patient care consequences. The discharge decision is the discharge order, which generally does not get executed until morning rounds the day of discharge when the physician confirms that the patient's physical status no longer requires inpatient care. In some cases, the discharge order might be written the night before, but CMS' proposal requires that the notice be delivered "by the close of business" which is defined as the end of the administrative day. An evening discharge order would not enable a discharge notice to meet that standard, even if staff were available to prepare and deliver it.

To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care. Most hospitals paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. With almost eighty thousand hospital admissions in Nebraska a year, an extra inpatient day for each admission at an approximate cost of $1,780 per day would impose a significant burden on hospitals. Many patients would be compelled to stay in the hospital when they are medically able to go home. For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty.

The NHA recommends that CMS withdraw the proposal and retain the current requirements. If there are specific issues with the discharge planning process that need to be addressed, we recommend that CMS convene a national workgroup comprised of hospital, physician, beneficiary, CMS, and QIO representatives to ensure a full understanding of how current and proposed procedures affect the various parties, and ensure that any revised procedures truly balance hospital and program administrative costs with beneficiary rights.

Collection of Information and Recordkeeping Requirements
The notice's language and the process for preparing, delivering and documenting receipt are problematic. Some of the troubling requirements include:

- At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless. The proposal would require that the beneficiary or a representative sign a copy of the discharge notice documenting its receipt and their understanding of it. The hospital would be required to maintain a hard copy, with no provision included for electronic alternatives.

- The alarmist language of the proposed generic discharge notice (which was included in the paperwork clearance package) could cause a beneficiary to doubt whether the planned discharge is appropriate. The notice never mentions that the discharge decision would be based on whether the beneficiary requires hospital-level care, could safely go home, or needs to receive post-acute care in another setting. The notice could lead to requests for more detailed and unnecessary notices and appeals, which hospitals and the QIOs would then have to review. The notice focuses solely on a termination of Medicare payment and financial liability for the beneficiary if they do not appeal by noon the day after the notice is received. Also, by repeatedly stressing that the beneficiary can stay in the hospital during an appeal without any financial liability – no matter the outcome of the QIO review – the notice would

likely encourage appeals and extended stays that are a matter of convenience for the beneficiary or the family, rather than based on medical necessity.

- The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions. The proposed detailed notice would require that the hospital outline the patient-specific facts used to determine that Medicare coverage should end, provide detailed and specific reasons why services are no longer reasonable or no longer covered by Medicare, and specifically cite the relevant Medicare rule or policy that applies to the beneficiary's case. Direct input from the physician, a resident, or a hospitalist would be required to complete this notice, but they likely would not be able to cite specific applicable Medicare coverage policies; hospital discharge decisions are based on whether the beneficiary meets acute inpatient clinical criteria.

- The estimated cost and burden of the proposal is greatly understated. The proposed rule states "we estimate that it would take hospitals 5 minutes to deliver each notice." However, this does not include the time needed to explain the notice or why it must be signed. It also does not reflect the additional time and effort required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent. Nor does it reflect the manpower and capital costs to maintain hard copy files of the signed copy for eighty thousand or more admissions a year for an indefinite period of time. The most significant cost, however, is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge. Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals for the reasons cited above.

The NHA believes this price is too high just to ensure consistency with requirements designed for very different operating environments. If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice. If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. More paperwork does nothing to improve care – it simply consumes resources that would be better devoted to direct patient care. **The NHA recommends that the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.**

The NHA appreciates the opportunity to comment on this proposed rule. To discuss any questions, please contact David Burd, Director of Finance, at (402) 458-4904.

Sincerely,

Laura J. Redoutey

Laura J. Redoutey, FACHE
President

INGALLS HEALTH SYSTEM

ONE INGALLS DRIVE
Harvey, IL 60426
(708) 333-2333

Attachment #374

(2)

June 5, 2006

TO: Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850
Submitted electronically: http://www.cms.hhs.gov/eRulemaking

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Regulations Development Group
Attn: Melissa Musotto
CMS-4105-P, Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted by email: Paperwork@cms.hhs.gov

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, DC 20503
Attn: Carolyn Lovett, CMS Desk Officer, CMS-4105-P
Submitted by email to: carolyn_lovett@omb.eop.gov

RE: File Code: **CMS-4105-P**
Medicare Program: Notification Procedures for Hospital Discharges
Proposed Notice published in the *Federal Register* of April 5, 2006
(71 FR 17052 – 17062)

Summary of Comments

We are writing on behalf of Ingalls Memorial Hospital ("Ingalls") and its Medical Staff. Ingalls is a 563-bed general acute care hospital located in Harvey, Illinois, with an organized Medical Staff of approximately 425 physicians. We appreciate the opportunity to provide comments on the above referenced notice of proposed rulemaking, which would establish new requirements for hospital discharge notices under the original Medicare fee-for-service and Medicare Advantage programs and would introduce a "two-step" notice process similar to what is currently in place for other Part A providers. Ingalls appreciates and understands the CMS quest for uniformity, as

well as the legitimate desire to fully protect the rights of the Medicare beneficiaries, and we agree with these goals; however, we think the CMS rule could be designed in a manner as to achieve the same goals (uniformity and notice) while not unnecessarily extending length of stay and over-burdening staff. Of great concern to Ingalls (as a hospital with approximately 45% Medicare patients) is the potential, due primarily to social and family issues, for patients and family members to "game" the system and extend their stay in the hospital a day or longer because they have no disincentive not to do so.

Background

Ingalls Current Process

Ingalls currently delivers the "Important Message from Medicare" to all Medicare beneficiaries at the time of admission, and provides a hospital-issued notice of non-coverage (HINN) to beneficiaries in the original Medicare program who are dissatisfied with a pending discharge. For Medicare Advantage plan enrollees, the responsibility for notification rests with the MA organization, which uses a "Notice of Discharge and Medicare Appeal Rights" (NODMAR) if the patient disagrees with the MA organization's discharge decision or its plans to discontinue coverage of the inpatient stay.

Comments

The current process was designed to inform beneficiaries of their Medicare appeal rights and encourages appropriate use of hospital services. Congress specifically required the "Important Message from Medicare" to ensure that Medicare beneficiaries know their discharge rights, and it has worked well.

Individual patient discharge decisions are made by the attending physician responsible for the patient's care, but the hospital continually assesses whether the patient meets acute inpatient criteria, and if a patient is not being discharged timely, collaborates with the physician to expedite the discharge process. At times, the physician is reluctant to discharge a patient, or the patient's family is reluctant to make a decision regarding post-acute care. Sometimes putting a mother or father into a long term care facility can be a traumatic experience. Decisions get delayed due to social and family factors. The HINN has been effective in prompting action by both the physician and the patient's family in certain circumstances. We are extremely concerned that the new rule will provide the opportunity to buy time and delay discharge when no legitimate basis for appeal exists. We see such delays happen all the time now, and we are concerned the proposed process would only increase such delays.

Provisions of the Proposed Rule – Proposed Two-Step Notice Process

CMS Proposal

CMS proposes to establish a "two-step" discharge notice similar to the process in effect for SNFs, HHAs, CORFs, and hospices because this process is "helpful to beneficiaries" and is not "overly burdensome to providers or Medicare Advantage organizations" (17053). CMS reasons that beneficiaries in an inpatient hospital setting should have the "same notice of appeals rights to which other beneficiaries are entitled," and explains that the proposal "would provide a more consistent approach to communicating appeal rights" to all Medicare beneficiaries in all settings. (17053) CMS reiterates that the proposed rule "is intended only to provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings." (17054)

The "two-step" process would require hospitals to deliver a standard notice of non-coverage to every Medicare beneficiary on the day before the planned discharge date where the patient's physician agrees with the discharge. This notice, which includes limited patient-specific information, would be delivered "as soon as the discharge decision is made" (17054), and would require the hospital to obtain the beneficiary's signature to acknowledge receipt. If the patient disputes the discharge, the hospital would be required to deliver a more detailed discharge notice similar to that used in other Part A settings. The current HINN and NODMAR forms for discharge would be eliminated (although HINNs would still be used for preadmission situations and other instances where the physician does not concur with a discharge decision). **Discharge could be delayed at least one full day just to give the notice.**

Comments

The proposed discharge notice process used for SNFs, HHAs, CORFs, and hospices is not well suited for the acute care hospital setting. The current process, however, does work well, and CMS has offered no compelling reason, other than uniformity, for standardizing the process. Hospitals are required to provide the "Important Message from Medicare" at the time of admission, which is a form that is not required in other settings. The "Important Message from Medicare" outlines the beneficiary's discharge and appeal rights.

Acute care hospitals have a short length of stay, which continues to decline. Because of a short length of stay, discharge planning in a hospital setting frequently begins at the time the Medicare beneficiary is admitted; however the actual discharge time is sometimes not known until the day of discharge, due to lab test results or other factors that change rather quickly.

The proposed discharge notice process is not consistent with the timing of physician decision-making and with hospital operations. The generic notice erroneously indicates that the hospital determines that Medicare will not pay for the hospital stay after the discharge date on the form. The detailed notice also indicates that the hospital has determined that Medicare coverage for the

hospitalization "should end." The language is potentially misleading, so that the patient could assume the hospital has made the discharge decision, not the physician. Discharge decisions are made by physicians, not hospitals. The physician may document an anticipated discharge or write a discharge plan, but generally does not make a discharge decision until the day of discharge. The discharge order entered into the patient's record at that time is the discharge decision. The physician may give discharge approval pending certain clinical criteria being met, e.g. test results being negative or within specified limits, or absence of a fever.

The proposed discharge notice process could add at least one additional day to every Medicare stay since CMS requires that the notice be given to the beneficiary at least one day in advance of discharge. The generic notice cannot be delivered until after the discharge decision is made and documented by the physician and the specific date of discharge is entered on the notice. It is not possible to accurately identify the date of discharge one day in advance for every Medicare patient (and remember 45% of our patients are Medicare beneficiaries).

The proposed generic discharge notice invites longer lengths of stay, thus consuming valuable hospital resources. The proposed notice emphasizes that the beneficiary's "hospital services will continue to be paid for during the review." This is the only sentence in the two-page proposed notice that is underlined. By highlighting the lack of a possible financial penalty to the patient, the message to beneficiaries and their families is that there is no reason not to appeal, even if the patients are medically ready for discharge. This is just the opening that some patients' families are looking for when a difficult social, or personal situation exists.

The hardcopy signature and recordkeeping requirements are at odds with federal efforts to encourage electronic medical records. CMS would require that hospitals deliver hard copy discharge notices; no provisions are made for alternative uses of information technology for either the generic or detailed notices. Hospitals would also be required to maintain the signed or, in the case of the patient's refusal to sign, annotated hard copy of the discharge notice. This short-sighted approach fails to recognize the current steps hospitals are taking to implement cost-effective electronic health information record-keeping formats and the strong commitment that the current Administration has made to electronic health records.

Recommendations

First, Ingalls asks that CMS not implement the proposed discharge notice procedures as currently described. Before making any changes to current hospital procedures for notifying Medicare beneficiaries of their appeal rights, CMS needs to better understand hospital operations and the burden the proposed requirements may impose on hospitals in increased length of stay.

Ingalls would be happy to participate in a national workgroup comprised of hospital, beneficiary, CMS, and QIO representatives to ensure full understanding of how current and proposed procedures impact the various parties, and to ensure that any proposed revised procedures truly balance hospital, operations and beneficiary rights.

Sincerely,

Kurt E. Johnson
President and Chief Executive Officer

Dr. Bohdan Iwanetz
President of the Ingalls Memorial Hospital Medical Staff

cc: American Hospital Association
Illinois Hospital Association

(22) Attachment #375

Finance

23400 Michigan Ave.
Suite 900
Dearborn, Michigan
48124

313.586.5303

Oakwood

June 1, 2006

Mark McClellan, M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: ***Medicare Proposed Discharge Notice***
CMS-4105-P

Dear Dr. McClellan:

Oakwood Healthcare, Inc. (OHI) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed notification procedures for hospital discharges under both original Medicare and the Medicare Advantage program. The proposal would apply to all hospitals and require them to provide Medicare patients with a short, standardized discharge notice on the day before the planned discharge. **Since the decision is made by the physician, frequently during morning rounds, OHI believes this proposal would be unnecessarily burdensome for both patients and hospitals and that it is out of sync with standard discharge planning and physician discharge order patterns.**

Background

Currently, hospitals are required to provide patients with the Important Message from Medicare (IMM) that includes generic information upon admission. This required notice provides a general statement of a beneficiary's rights as a hospital patient and their discharge and appeal rights. Hospitals are required to provide a notice of non-coverage to Medicare beneficiaries who express dissatisfaction with an impending discharge. This notice informs the patient that inpatient care is no longer required and that the beneficiary will be financially liable for hospital care beyond the second day following the date of the notice.

Under the recent proposal, the CMS would continue to require hospitals to provide patients with the IMM. However, the proposal would eliminate the current hospital-issued, general notice of non-coverage, replacing it with a two-step patient specific notice process for hospital discharges, similar to the process for post-acute facilities. Under the proposed rule, hospitals would be required to provide Medicare patients with a standardized discharge notice 24 hours prior to a planned discharge and a more detailed notice if the patient appeals the discharge decision. The proposed notice would be in addition to the Important Message from Medicare (IMM) that hospitals are required to provide to Medicare patients upon admission.

OHI has several key concerns regarding the proposed discharge notice as summarized below:

Intent of the Proposed Rule

The intent of the proposed rule is not clearly defined. The CMS has not provided evidence to demonstrate that patients of Home Health Agencies, Skilled Nursing Facilities, or other post-acute facilities have benefited from a two-step notice process. The notice also fails to provide evidence that the proposed two-step process will benefit hospital inpatients, hospitals, or the CMS, which is particularly concerning since the policy will have a significant impact on beneficiaries and hospitals. Generally, based on hospital experience in discussing discharge matters with Medicare patients, many Medicare beneficiaries are confused by issuance of multiple documents regarding their rights. As proposed, the discharge notice will further increase confusion and stress experienced by beneficiaries particularly given their state of illness and upcoming transition to a lower level of care. We believe that this proposal would cause consternation among beneficiaries rather than benefit them and create the potential for them to believe their planned discharge date may be inappropriate. This could result in distrust in physicians and hospitals and lead to requests for more detailed notices and appeals than are warranted, resulting in additional burden on both hospitals and Quality Improvement Organizations (QIOs).

Increased Administrative Burden

The proposed policy would create an additional administrative burden for OHI to develop a process for determining the discharge date and communicating it to the patient, physicians, and discharge planning staff. In its estimated regulatory impact, the CMS only included the time it would take to deliver a notice to each inpatient, estimating this would take 5 minutes per patient and 60-90 minutes for each patient that appeals the discharge decision. The CMS estimate does not include time required to prepare the notice, explain the notice or why beneficiaries have to sign for it. In addition, it does not reflect the staff time and capital costs incurred by hospitals to maintain hard copy files containing the signed copies for all Medicare admissions. There are approximately 25,700 Medicare inpatient discharges throughout OHI on an annual basis.

Predictability of Discharge Date

Since patient discharge is often dependent upon specific test results, such as elimination of an infection and its associated fever, it is often difficult to predict when the discharge will occur. The discharge decision is made **solely** by the physician, frequently during morning rounds after reviewing test results, patient medical records, and determining the patient no longer requires inpatient care. The proposed policy would require that hospitals know the discharge date at least one day in advance of the actual discharge. As a result, in many cases, it would result in hospitals being required to keep the patient an extra day to allow 24 hours after issuing the discharge notice. In addition, the CMS estimates that 2 percent of patients will appeal, which provides them with at least 3 additional days in the hospital. Increasing the length of stay for

these patients would result in a significant increase in hospital costs which could result in bed shortages when occupancy levels are high. This in turn, would reduce accessibility to inpatient care for beneficiaries who would be required to wait until a bed became available. Although this notice is required in the post-acute setting, OHI believes it is inappropriate for the CMS to require a discharge notice 24 hours prior to discharge in an inpatient acute care setting. Post acute care providers generally have a longer term relationship with patients, making the discharge notice seem more appropriate. In addition, the medical conditions of patients in the post acute setting is typically much more stable than in the inpatient acute setting.

Discharge Decision

OHI believes it is inappropriate for the CMS to penalize hospitals by requiring a discharge notice one day prior to the actual discharge since the discharge decision is made by the physician, not the hospital. As indicated above, the discharge decision is the discharge order, which generally does not get executed until morning rounds on the day of discharge when the physician confirms that the patient's medical condition no longer requires inpatient care. While some patients may know their expected length of stay prior to admission for scheduled procedures, it is adjusted based upon the individual patient's response to treatment and their specific medical conditions. For other admissions such as heart attack, stroke, falls that result in a fracture, or other emergencies, the expected LOS or discharge date is unknown at time of admission.

Timing of Notice

There are a variety of logistical issues related to the timing of the notice, such as when the discharge is postponed due to a fever spike or complication the night before the expected discharge, or when the average stay is one or two days. The CMS' supporting rationale for the 24-hour notice is based entirely on what they have done in the post-acute setting, which differs operationally from the inpatient acute setting. For patients in Diagnosis Related Groups (DRGs) that typically have a length of stay (LOS) of one to two days, OHI would be required to deliver both the IMM and the standardized discharge at admission. This could result in further confusion and concern for beneficiaries and increase distrust of the healthcare delivery system and lead them to believe their planned discharge is inappropriate.

Impact on Hospital Length of Stay (LOS)

If OHI kept 10 percent of its estimated 25,700 annual Medicare patients an additional day and 2 percent of Medicare patients an additional 3 days due to appeals, OHI would experience an increase in length of stay of 4,112 days, with no additional Medicare payment. In its proposal, the CMS failed to consider the potential impact on LOS, and additional cost to hospitals, which is a significant concern. During a time when over 50 percent of Michigan hospitals already lose money providing care to Medicare beneficiaries, an increase in LOS would further threaten the financial viability of OHI and patient access to care. In addition, this notice could impact quality outcome reporting, public reporting and potentially pay-for-performance reimbursement since it would increase the length of stay.

Electronic Health Records

The proposed policy would require manual signatures by Medicare beneficiaries or their representatives, documenting its receipt and their understanding of it. This requirement is contrary to the CMS' desired movement to electronic health records. The paperwork clearance package submitted by the CMS to the Office of Management and Budget (OMB) indicates that it must be provided and maintained in hard copy and that they are not making any provision for electronic alternatives.

Summary

In conclusion, OHI strongly opposes this policy due to its significant impact on hospitals and Medicare beneficiaries. As indicated above, **OHI cannot support the proposed policy due to the:**

- impact on hospital length of stay which will have a negative financial impact for hospitals and likely result in bed shortage issues for hospitals where occupancy levels are high
- increased administrative burden on hospitals
- inability to predict discharge date 24 hours in advance, prior to having patient test results and monitoring the patient's specific medical condition and response to treatment
- fact that the physician, **not the hospital**, is solely responsible for the discharge decision
- confusion it will cause for Medicare beneficiaries, which will increase distrust
- fact that it is contrary to the CMS' desired movement to electronic health records

If the CMS is concerned about providing patients with a discharge notice, **OHI supports that the CMS modify the Important Message from Medicare (IMM) to achieve the CMS objective.** This revision could include a highlighted, bolded section explaining discharge appeal rights. We feel that this would be sufficient since for many hospital inpatients, it is impossible to predict the discharge date prior to having test results.

Again, OHI appreciates this opportunity to provide comments to the CMS regarding this proposed discharge notice. We believe that, with the incorporation of our suggested recommendations, Medicare beneficiaries will be able to receive the information they need regarding their discharge from the inpatient hospital setting without undue administrative burden or the potential increase to a patients' length of stay. If you have questions on this comment letter, please contact me at (313) 586-5303.

Sincerely,

Robert Plaskey
Corporate Director, Reimbursement

Attachment #377

(23)

DCHA
District of Columbia
Hospital Association

1250 Eye Street, NW • Suite 700 • Washington, DC 20005-3930
Tel: (Office) 202/289-4925 • (Cell) 202/528-2721 • Fax: 202/371-8151 • E-mail: okubasik@dcha.org • Web: www.dcha.org

June 5, 2006

Centers for Medicare & Medicaid Services
Attention: CMS-4105-P
P.O.Box 8010
Baltimore, MD 21244-1850

Dear Sir/Madam:

CMS has proposed regulations calling for all original Medicare and Medicare Advantage patients to get a "generic hospital discharge notice" that should be issued the day before discharge and that informs the patient/family that Medicare benefits will be terminated for the current hospital stay on the following day. If the patient or family representative does not believe that the patient is ready for discharge, the patient/family can appeal the discharge decision to the QIO. The discharge and therefore financial liability will be delayed until the QIO's decision is made.

As with the proposed rule issued in the Federal Register on January 24, 2001 (66 FR 7593), we anticipate this new requirement will be a significant administrative burden on hospitals in a health care environment that has many situations that can make determining a definitive date of discharge extremely difficult. Our hospitals are encouraged to use InterQual's Acute Level of Care Criteria to evaluate the patient's clinical presentation, monitoring and therapeutic services, and clinical stability appropriate for discharge. We are frequently unable to anticipate 24 hours in advance of when the patients will be clinically appropriate for discharge from an acute care setting. Some of our hospitals estimate that they would not be able to predict at least 20% of their daily Medicare discharges. If this resulted in 10 to 20 patients not being discharged and we conservatively estimated an additional costs at $1,000/day per patient, the lost revenue and additional costs to our DC hospitals would be in the millions of dollars. With many of these hospitals are already on the margin financially, this can have a devastating impact.

Below are some examples where it may be difficult for our hospitals to comply with the requirements of this proposed rule. We would like to get further clarification on what will be the expectation by hospitals in these circumstances realizing that many of these examples present an additional financial cost that hospitals will incur as a result.

Example #1: An elderly patient, who just had a total hip replacement 3 days ago, is scheduled for discharge tomorrow. Someone is going to deliver a "generic hospital discharge notice" that as of tomorrow Medicare would no longer cover the patient's hospital stay but, if the patient does not believe he/she is ready for discharge, the patient can appeal the decision to the local QIO. If patient appeals decision, discharge could be delayed 2 days. If the patient were to go to a rehabilitation facility, those plans, too, would be put on hold. The hospital would incur the additional cost of this additional patient day.

Example #2: A patient received notice yesterday that physician planned to discharge patient today. Yesterday, the patient received the notice. Today patient had a temperature and physician now does not want to discharge patient. In this circumstance, it is unclear what the process would be for informing the patient of the retracted notice.
In addition, the notice will need to be re-issued later when patient again to be discharged. All of this will need documentation by a hospital staff person.

Example #3:
Most patients who are hospitalized for uncomplicated surgical procedures are generally prepared for the discharge date and would not contest the discharge.

However, it is very difficult to predict the exact discharge date for most of our medical patients and our complicated surgical patients. An example of this would be a patient with severe congestive heart failure requiring careful fluid management. A discharge decision is difficult because of the precariousness of fluid balance. A physician may be very concerned and decides to add another drug and monitor the patient over night because the physician is unsure if the patient can go home. But when the physician comes in the next day and decides that the patient can indeed go home, the patient is covered by Medicare and has to get notice one day prior to discharge. So, the notice is given and patient stays an extra day per Medicare protocol.

Example #4: A patient comes to the hospital from a nursing home and has dementia. The family will have to be contacted about the discharge notice that is not a problem if they are involved, but many of these patients' families are difficult to contact.

Example #5: In situations where patients are scheduled for 1-2 stay hospitalizations, there is a lack of clarity in whether or not hospitals will need to provide these patients notices upon admission?

The District hospitals have a large Medicare population. With tens of thousands of Medicare patients that are treated annually, each one of these patients will need a notice of discharge letter 24 hours in advance. Evening, weekend and holiday discharges will be especially problematic because of lower staffing levels. The hospital will need to

engage additional staff to keep up with the notices - neither Nursing nor Clinical Resource Management/Social Work departments will be able to support this volume with deliveries and subsequent appeals and retractions. In addition to the extra time it will take to deliver each notice, explain each notice, and obtain a signature on each notice (taking at least 15 – 30 minutes per notice depending on the patient's capabilities), it will take as much time to explain the advance notice process to each physician for each notice.

We also anticipate that with a new Medicare regulation, we will be monitored so during the first year our hospitals will expect to be audited with reports to which, if compliance is found lacking, will require additional response and documentation.

There has been some discussion among our hospitals about alternatives that would be less burdensome on hospitals such as having patients sign the "Important Message from Medicare" information or another way of delivering this notification upon admission or another consistent point in the patient care process.

Here are some additional areas to consider that were submitted by various member hospitals:

1. What impact will a two-step notification process have on a patient in observation status, but then converts to an acute care admission by the second day? Will an additional day be added to facilitate a notice 24 hours prior to discharge? (Example: a Laminectomy was required).
2. Some surgical patients with relatively short length of stays (joint replacement) are often receiving pain medication 24 hours prior to discharge. What degree of understanding/comprehension is feasible for such surgical patients? Family and or POAs are often involved but not available at the time when the notice should be delivered.
3. This process and information is too complicated for the elderly patient. They are just trying to comprehend the New Medicare D benefit. Consider a simpler approach: Medicare patients could receive, at the time of admission, a discharge sheet reviewing their "rights".
4. Require all Medicare participating physicians to have an information packet that describes their rights and the function of the QIO.
5. Could Medicare provide public service announcements that focus on beneficiary rights rather than handing them letters?
6. During a health care provider current and projected shortage, who will be realistically available to distribute these notices 7 days a week?
7. How do we handle the case in which the patient is ready for discharge and return to a nursing facility, however a bed is not available at the facility when the 24 hour notice of discharge is to be given?
8. With the addition of this notice and additional steps in the discharge process, there is concern over a greater chance for process breakdown.
9. What educational tools are available to convince the physicians to communicate to the patient and hospital staff 24 hours in advance of a discharge?
10. Will this process not ultimately penalize the hospitals, as they will need to delay many discharges by a day in order to provide 24 hour notices?

Thank you for the opportunity to provide these comments. If you would like to discuss these comments with us further, please feel free to contact me at (202) 289-4925 or by email at okubasik@dcha.org.

Sincerely,

Olivia Wong Kubasik

Olivia Wong Kubasik
Vice President for Policy Development
District of Columbia Hospital Association

Attachment #394

(24)

UNIVERSITY of IOWA HOSPITALS & CLINICS

University of Iowa Health Care

University of Iowa Hospitals and Clinics

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June 5, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Service
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Via electronic comment: http://www.cms.hhs.gov/eRulemaking

Attention: CMS–4105–P

Dear Dr. McClellan:

The University of Iowa Hospitals and Clinics (UIHC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled, *"Medicare Program; Notification Procedures for Hospital Discharges"* 71 Fed. Reg. 17052 (April 5, 2006). It is our opinion that this proposed rule is redundant with current requirements, could result in unnecessary extensions to length of stay, and would be unduly burdensome on hospitals.

Frequently hospitals do not know 24 hours in advance whether a patient will be discharged. Such decisions are often are made on the morning of the day of discharge, after the physician confirms that the patient's medical status no longer requires inpatient care, and may be reinforced by an event-free prior overnight period. This process is particularly common for the complex and severely ill patients treated in teaching hospitals like the UIHC, where a patient's health status can change quickly and whose discharge determination may require the concurrence of multiple treating physicians. Compliance with the "one-day prior" requirement could necessitate hospitals providing an extra day of inpatient care when beneficiaries would no longer need it. Not only would this outcome result in significant and unnecessary costs to hospitals, it would also be at odds with the desires of many beneficiaries who wish to expedite the discharge process. In addition, during times when our hospital is at full occupancy, this could also mean a delay for new patients being admitted.

The UIHC believes that the current process of providing the "Important Message from Medicare (IMM)" followed by a "hospital-issued notice of noncoverage (HINN)" if a beneficiary expresses dissatisfaction with an impending discharge sufficiently protects the rights of Medicare beneficiaries. We also respectfully disagree with CMS's five minute

estimate of the time associated with delivering the notice. This estimate does not reflect the time that would be required to explain the notice to the beneficiary or explain why they have to sign for it. In addition, if the patient is not capable of understanding and signing the notice, the hospital would need to deliver the notice to the patient's representative and obtain a signature. This undoubtedly would add time and effort that is not reflected in CMS's estimate.

The UIHC strongly encourages CMS to maintain the current process which already provides beneficiary notification procedures by means of the IMM notice and a detailed notice if the beneficiary expresses dissatisfaction with the discharge decision. In addition, we would support convening a national workgroup of affected parties if discharge planning issues need to be addressed.

Thank you for your consideration of these comments. Should you have any questions, please feel free to contact me at donna-katen-bahensky@uiowa.edu or (319) 356-3155.

Sincerely,

Donna Katen-Bahensky
Director and Chief Executive Officer

June 5, 2006

Duncan Regional Hospital
P.O. Box 2000
Duncan, OK 73534

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare Program: Notification Procedures for Hospital Discharges Proposed Notice of Rule Making, CMS-4105-P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)

Dear Dr. McClellan:

The Duncan Regional Hospital in Duncan, Oklahoma appreciates the opportunity to comment on the proposed rule concerning a new notice of Medicare discharge appeal rights that would have to be given to all Medicare hospital inpatients one day before their discharge. This new notice would be **in addition to** the following existing communications:

- The" Important Message from Medicare" (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights, and
- The more detailed notice given when a beneficiary is not satisfied with the planned discharge date.

This letter includes our specific comments on the proposed rule and addresses several issues.

- The proposed discharge notice process is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns.

- The alarmist language of the proposed generic discharge notice could cause beneficiaries to doubt whether the planned discharge is appropriate. Consequently, it likely will stimulate an increase in the number of unwarranted appeals and delayed discharges at the expense of the hospital and other patients awaiting admission.

- The hardcopy signature and recordkeeping requirements are counter to hospitals' movement to electronic medical records and federal efforts that encourage an even faster conversion.

- The additional costs that hospitals will incur as a result of increased lengths of stay that will come about if this proposed rule is implemented.

Provisions of the Proposed Rule
The rule proposes that hospitals deliver a **standard notice of non-coverage** to **every** Medicare beneficiary on the day before the planned discharge date that has been approved by the physician. The notice would not be delivered until the discharge decision is made. It would be delivered to the beneficiary or their representative in hard copy and the beneficiary or their representative would be required to sign a copy of the notice, acknowledging its receipt and their understanding of the notice. If a beneficiary refused to sign the notice, the hospital would be allowed to annotate the notice with that decision, and would be required to maintain a hardcopy of the signed or annotated notice indefinitely.

There are several problems with the proposed approach.

- *Physicians, not hospitals, make discharge decisions.*
- *It is virtually impossible to know with certainty the discharge date a day in advance.*
- *By requiring a notice "on the day before discharge" but after the discharge decision has been made, CMS would be requiring an extra day of inpatient care after the patient no longer needs it, with significant financial, operational and patient care consequences*
- *To comply with this requirement, the hospital would have to keep patients when they no longer need inpatient care.*
    - *Our hospital is paid under the IPPS would not receive any compensation for these days because they are paid a set amount for an admission. We have approximately 2,214 Medicare hospital admissions a year, an extra inpatient day for each admission at an approximate cost of $1,000 per day would increase our cost of care for Medicare patients approximately$2,214,000.*
    - *Many patients would be compelled to stay in the hospital when they want and are medically able to go home.*
    - *For patients awaiting admission, their admission could be delayed because of a lack of beds in general or within a particular specialty. This requirement also could contribute to increased emergency department (ED) diversions because too many patients would be housed in the ED waiting for an open inpatient bed.*

Collection of Information and Recordkeeping Requirements
The notice's language and the process for preparing, delivering and documenting receipt are problematic. Some of the troubling requirements are spelled out in the proposed regulation and others in the paperwork clearance package sent by CMS to the Office of Management and Budget (OMB). Those issues include:

- *At a time when the federal government is urging that hospitals move more quickly to create electronic health records for all patients, the hardcopy notice and receipt documentation requirements are at odds with the movement to go paperless.*

- *The alarmist language of the proposed generic discharge notice (which was included in the paperwork clearance package) could cause a beneficiary to doubt whether the planned discharge is appropriate.*

- *The language and required content of the proposed detailed notice is inappropriate for hospital discharge decisions.*

- *The estimated cost and burden of the proposal is grossly understated.*
  - CMS has not realistically estimated:
    - the time necessary to prepare and deliver the generic discharge notices,
    - time needed to explain the notice or why it must be signed,
    - the additional time required to deliver notices to patient representatives and obtain a signature when the beneficiary is not competent,
    - the manpower and capital costs to maintain hard copy files of the signed copy for our hospital's 2,214 Medicare admissions each year and to retain these hard copies for an indefinite period of time.

  - The most significant cost, however, is the additional length of stay caused by the requirement to provide the notice after the discharge order is written the day before discharge (as explained above). At a conservative estimate of $1,000 per day, we estimate the cost to our hospital at $2,214,000 per year.

  - Finally, we believe the generic notice will stimulate an increased number of unwarranted appeals.

Duncan Regional Hospital recommends that the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.

- If CMS believes that the IMM does not provide enough detail about the beneficiary's appeal rights, then that notice should be revised rather than adding an additional notice.

- If CMS believes that the discharge planning process does not adequately prepare beneficiaries and their families for discharge, then improvements to that process should be considered. More paperwork does nothing to improve care – it simply consumes resources that would be better devoted to direct patient care.

Duncan Regional Hospital appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me at 580-251-8555 or scott.street@duncanregional.com.

Sincerely,

Scott Street
President & CEO
Duncan Regional Hospital

VIA E-MAIL

June 5, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator, Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

Dear Dr. McClellan:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 94,000 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the proposed rule regarding "Medicare Program; Notification Procedures for Hospital Discharges" as published in the *Federal Register* on April 5, 2006. We are concerned that, although aimed at hospitals, this proposed rule may have a significant negative impact on physicians who treat Medicare patients in the hospital.

Currently, hospitals must provide Medicare beneficiaries with a general notice of appeal rights (referred to as the "Important Message from Medicare") at or about the time of the patient's admission. If a Medicare beneficiary expresses dissatisfaction with an impending hospital discharge, hospitals must also provide a hospital-issued notice of non-coverage to the beneficiary.

Under the proposed rule, CMS would establish a two-step notice process for hospital discharges that is similar to the process in effect in other settings, such as skilled nursing facilities. The first step would require hospitals to deliver, as soon as the discharge decision is made, a standardized, largely generic notice of non-coverage to each Medicare beneficiary whose physician concurs with the discharge decision. CMS considers delivery of the notice valid if it is delivered on the day before the planned discharge, contains all the necessary elements, and is signed and dated by the beneficiary (or beneficiary's representative) to indicate the he or she has received the notice and can comprehend its contents. The second step, which would occur only in those situations in which a beneficiary wishes to dispute the discharge, would require hospitals to issue a single, detailed notice of non-coverage. The proposed rule is not clear on whether or not CMS would eliminate the "Important Message from Medicare," and CMS invites comments on this and other aspects of its proposal.

Our concerns with this proposal relate to the first step in the proposed two-step process. First, it presumes that hospitals and physicians will always know the date of discharge a day in advance. That is not the case. Sometimes, patients are admitted and discharged on the same date. In this situation, it is impossible to provide the standardized notice of non-coverage the day before discharge. In other cases, a patient may be sufficiently well to be discharged earlier than expected. In such instances, the proposal would seem to require that the hospital keep the patient an extra day, just so it could provide the standardized notice a

day in advance of discharge. This makes no sense, either for the hospital or the physician who is responsible for the patient's care.

Another concern is the apparent redundancy between the proposed standardized notice and current "Important Message from Medicare." As noted in the proposed rule, both documents provide much the same information. We are not aware that the use of the "Important Message" has otherwise failed to provide Medicare beneficiaries or their representatives with the information that they need in this regard, and we see no need to provide them with two documents that say much the same thing, especially when the hospital stay is short. For example, as proposed, hospitals would be required to give beneficiaries both the "Import Message" and the standardized notice on the day of admission if the hospital expected the patient to be discharged the next day.

Finally, and most critically, this proposed rule presumes that hospitals will have active case management staff to handle all of this paperwork and that either the beneficiary will be competent to sign the standardized notice or that the personal representative will be readily available to do so. The reality is that in most small and rural community hospitals, active case management staff does not exist. As such, we anticipate that the burden of this paperwork will often fall to the attending physician, which in many cases will be our members. That burden will be exacerbated by the fact that many Medicare beneficiaries are not competent to sign such a document and their personal representatives will often not be readily accessible to the physician (e.g., because they live some distance away or have a schedule that makes them hard to reach).

Accordingly, we anticipate that this proposal may routinely extend the length of stay for many Medicare beneficiaries by at least one day, regardless of the severity of the cases involved. At a time when CMS is increasingly examining both hospital and physician quality, we are afraid such increasing lengths of stay will reflect negatively on our members and the hospitals that they serve.

For these reasons, we ask CMS to rescind its proposal requiring hospitals to provide a standardized notice of non-coverage the day before discharge and, instead, revise the current "Import Message" to include whatever information CMS believes is currently lacking in this regard. By revising the current "Important Message" and maintaining the requirement to provide it at or about the time of admission, CMS will maximize the opportunity beneficiaries have to discuss the eventual discharge with all concerned, including their family, primary physician and, perhaps, consultants. This approach ensures beneficiaries have adequate time to address discharge questions and issues without creating an additional burden for hospitals and physicians.

Thank you for your time and consideration of these comments.

Sincerely,

Mary E Frank, MD

Mary E. Frank, M.D., FAAFP
Board Chair

(27)

Submitter : Mrs. Phyllis Fritsch **Date:** 06/05/2006

Organization : Upland Hills Health, Inc.

Category : Hospital

Issue Areas/Comments

Background

Background

To Whom It May Concern:

Upland Hills Health joins our Wisconsin colleagues in opposing this proposed rule. Wisconsin hospitals are committed to the belief that all patients are entitled to be clearly informed of both their benefit coverage and right to appeal regardless of their payer source. However, the proposed rule related to Notification Procedures for Hospital Discharges are operationally impractical, overly burdensome to hospitals and unsupported from a patient s rights perspective.

CMS notes that the rule is being proposed to create uniformity between acute care hospitals and home health, SNF and hospice care. However, we believe that there is a fundamental difference between acute care settings where a patient s medical condition is subject to rapid changes, and home health, SNF and hospice care which, by its nature, assumes a more stable patient condition.

Hospital staffs, including discharge planners and social workers in more complex cases, begin the discharge process the day the patient arrives at the hospitals to assure that they are discharged to the appropriate setting at the appropriate time in the continuum of their care. Discharge from the hospital depends on patients meeting certain recovery criteria based on their diagnoses, procedure(s) and health status, not a set length of stay or number of visits. Although we can predict what criteria need to be met to safely discharge the patient, we cannot always predict a day ahead of time when a patient will meet these criteria. For example, it is common that the physician determines the day of discharge on that day based on final test results or physical examination. Encouraging patients to stay an additional day to meet this notification requirement will extend length of stay, adding cost to care that yields no real return in value to the patient. At the other end of the spectrum, patients may be planning to leave on a certain day and end up staying longer due to their clinical condition. This scenario will render the notice of discharge inaccurate and require that the hospital rescind and then re-issue the notice.

In addition to the above, more than 50% of inpatient hospitalizations consist of 1, 2 and 3-day stays. The Important Message from Medicare is already provided to patients on admission. A second notice for these patients would be duplicative and confusing, as it would need to be given almost on the heels of the first.

Finally, we believe that CMS has underestimated the amount of time it will take to process and deliver these notices. A provider s discharge estimate (whether documented in the medical record or relayed verbally to the care team and patient) would need to be transmitted to staff who would then process, deliver and explain the notice. We believe that 5 minutes per patient grossly underestimates the amount of time this would take. (As noted above, this also does not take into account rescinding and then re-issuing notices.) In addition, the rule does not specify whether or not the notice would be a part of the permanent record or not. If it is determined to be part of the permanent record there would be additional work related to scanning the documents for storage since most hospitals are moving the patient s records to an electronic form.

In summary, we support the patients need to be well informed of their rights under Medicare, as well as their right to request an expedited review. We request that you reconsider the necessity, timing and burden of providing this written notice in the less predicable inpatient setting, as this is duplicative of the notice already provided to all Medicare acute care patients. Wisconsin hospitals are known to be high quality, low cost providers of health care services. Imposing this proposed rule is unnecessary and will create a burden on hospitals for compliance that will only escalate health care costs. We strongly urge CMS to forgo implementation of this rule.