Submitter : Ms. Barbara Thiry

Organization : West Penn Hospital

Category : Nurse

Date: 06/02/2006

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-1832-Attach-1.DOC

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:

As a hospital case manager who deals with patient discharge issues on a daily basis, I welcome 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.

In response to a final rule promulgated under the Benefits, Improvements, and Protection Act (BIPA) for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospices, HAP submitted a comment letter that outlined the burden and operational requirements associated with home health agencies providing advance written notice to Medicare Advantage enrollees and Medicare beneficiaries and detailed notices to Medicare beneficiaries when an expedited review is filed with the state's QIO. It is evident in both this rule and those already promulgated for other service settings that there is a fundamental lack of understanding on how care is delivered in these settings. I recommend that CMS consider implementing the same provisions currently used in hospitals in these other settings—namely to provide a notice at the time of admission for services similar to the "Important Message from Medicare" and to provide information regarding the right for an expedited

review/determination to those Medicare beneficiaries who disagree with discharge from or termination of health care services.

I, again, believe CMS has proposed an unworkable solution in its attempts to improve the hospital discharge planning process and that the proposed rule fundamentally ignores how care is delivered in hospitals. Hospitals do not differentiate care provided to patients based on financial class. To require a 24-hour notice only for Medicare patients requires these patients to be treated differently during the course of rendering care to all patients on a unit. This is in opposition to other existing federal regulations.

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 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.

Detailed operational, financial and other concerns are included as an attachment to this letter. Based on these identified concerns, I recommend the following:

- CMS should maintain its current requirements for hospitals and use a consistent approach for oversight and enforcement of these already existing requirements, including penalties for those facilities that fail to consistently comply with current law and regulation.

- 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, I offer the following modifications to the proposed rule for consideration by CMS:

- For Medicare Advantage patients, I strongly recommend that it be the Medicare Advantage plans' responsibility for communicating information regarding non-coverage. Specifically, I think 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, I urge CMS to build flexibility into the requirements for Medicare notification procedures for hospital discharges. I recommend that CMS allow hospitals to deliver the generic notice during the course of care as opposed to 24-hours in advance.

- I 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, I 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.

I 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.

I 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. I strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Should you have any questions or seek clarification, please feel free to contact me at The Western Pennsylvania at 412-578-4696

Sincerely,

Barbara Thiry, RN
Case Management
Western Pennsylvania Hospital

Submitter :

Date: 06/02/2006

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

REGULATORY IMPACT The addition of this ruling to the health care delivery system will have a total negative impact for patients, hospitals, and health care providers. The cost and time of implementing this program is purely a duplication of services already in existence, and therefore would create a burden on an already overwhelmed health care delivery system.

Regulatory Impact

Regulatory Impact

There is already in existence several regulations that if applied appropriately would already address this part of the health delivery system.

Submitter : Ms. Dianna Graham **Date:** 06/02/2006

Organization : OSF Healthcare System

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment for CMS - 4105 - P

CMS-4105-P-1852-Attach-1.PDF

#185

OSF HealthCare System
800 N.E. Glen Oak Ave
Peoria, Illinois 61603

Department of Health and Human Services
Centers for Medicare and Medicaid Services
RE: Proposed Rule Related to Notification Procedures for Hospital Discharges
File Code: CMS - 4105 – P

To Whom It May Concern:

OSF HealthCare System is providing comment on proposed rule CMS – 4105-P and specific identifier "Provision of the Proposed Rule". We oppose adoption of this rule based on the following concerns:

- Discharges from the hospital are based on the conclusion of medically necessary acute care services. Often, this is not known the day prior to discharge.
- Due to short length of stays – we could be providing the patient with the discharge notice and the Important Message from Medicare at the same encounter which has similar information. Patients have a lot of paper work to sign upon admission already, adding more will not improve patient safety, patient satisfaction or quality of care.
- Patients' condition can change suddenly. CMS did not address what happens if we deliver the notice and the patients' conditions change. This can cause undue and unnecessary stress and confusion on the patient. Patients would then be concerned they would be responsible for bills when discharge dates are delayed for medical reasons.
- If the notice is not delivered the day prior to discharge, we could see an increase in length of stays.
- Delivering the notice has timing and problematic issues such as: patient not in the room, patient incompetent and unable to reach the legal guardian, or the doctor writes the order for the same day discharge. Hospitals don't discharge patients – physicians do.
- Doctor makes late evening rounds and Utilization Management/Case Management is not available to deliver, have the patient sign, and provide an explanation of the notice. This would require hospital to train already overburdened nursing staff or increase staff to meet this regulation.
- The amount of time and dollars estimated by CMS for providers to implement this rule in our opinion are greatly underestimated. Trained hospital staff must be available seven days a week to deliver this document and to assist in the appeal process as requested by the beneficiary. Unfunded mandates stretch healthcare resources. In this case, it would add burden to duplicate a current process.
- This rule will require Physician education and training to write an "anticipate discharge on ____" so this notice can be provided to the patient. How are hospitals supposed to document that the physician concurred with the discharge

date of the notice if he doesn't write the anticipated discharge date in his progress notes?

- Medicare patients receive the Important Message from Medicare at admission. This outlines for the Medicare patient the steps necessary to appeal a decision if they think they are being asked to leave the hospital too soon. At the time of discharge, if the patient refuses or disputes the plans to discharge, information regarding the process to appeal that decision while remaining in the hospital is provided per the current Medicare mandates.

Respectfully submitted,

Dianna Graham, RN
Compliance and Privacy Coordinator
OSF HealthCare System
800 N E Glen Oak Avenue
Peoria, Illinois 61603

Submitter : **Ms. Tina Treish**

Date: **06/02/2006**

Organization : **LifeCare Hospitals of NC**

Category : **Nurse**

Issue Areas/Comments

Background

Background

CMS-4105P

GENERAL

GENERAL

CMS-4105P

Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS-4105P

Regulatory Impact

Regulatory Impact

CMS-4105P

CMS-4105-P-1862-Attach-1.WPD

Attach # 186

LifeCare Hospitals of NC
1051 Noell Lane
Rocky Mount, NC 27804

6/2/06

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

Re: CMS-4105-P

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am the Senior Director of Case Management at LifeCare Hospitals of NC, a 50 bed, Specialty Acute Care Hospital located in Rocky Mount, NC 27804.

As a Case Manager, I have been directly involved with discharge planning for acutely ill patients in rural north Carolina for the past 8 years. Our current discharge planning process begins at the time of admission when patients are provided with the Important Message from Medicare during registration. Next, the admission nurse screens the patient's current living situation and available resources. In addition, case managers assess all patients who may need post-acute services or who may be at risk for discharge delays. Patients and their families are involved in discharge planning activities and given a choice of providers for post acute services. Our process also includes ample opportunity for patients and families to consider all options, and if in disagreement with the discharge decision, to appeal the decision to the Carolinas Center for Medical Excellence, the Quality Improvement Organization (QIO) for North Carolina.

In the current environment of shortened lengths of stay for medically complex patients, it is often difficult to accurately predict discharge 24 hours in advance. Patients who may have been unstable can respond to treatment and be ready for discharge the same day. Once diagnostic reports are available to the physician, discharge plans can be finalized quickly. And, bed availability in extended care facilities is totally unpredictable.

The CMS proposed change places administrative burdens on the hospital that greatly outweigh the benefit. CMS estimates it will take only five minutes to deliver the generic notice and have it signed. This is a grossly underestimated time allotment given the fact that most patients and family members will not sign a document without carefully reading it and asking questions. Experience has shown that the delivery of any official governmental notice defining a discharge date and the details of patient financial responsibility consumes a tremendous amount of time. It is more realistic to assume an average of thirty minutes for the delivery of each generic notice. In cases where the

patient is not the decision-maker, it will take much more time to locate and wait for the responsible party to arrive to sign the Notice.

CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal. This is an underestimation because patients will become more aware how easy it is to continue their hospitalization. It is difficult to predict how many patients will request an expedited appeal, but for all patients who make this request, an additional two to three days minimally will be required to prepare the Detailed Notice, file the Notice and wait for a response from the QIO. The patient assumes no financial liability until the QIO responds.

Many patients are discharged from the hospital in one to two days, very soon after the patient has received the Important Message from Medicare during the admission process. Several regulations already exist, that if applied appropriately, address this very important part of the delivery of care to patients in the acute care setting. With the combination of the Hospital Issued Notice of Non-Coverage found in the Beneficiary Notice Initiative, the Discharge Planning regulations, the Utilization Review and Patient's Rights Conditions of Participation, there is adequate regulation about notifying a patient of his/her discharge status. There is no need for an additional regulatory requirement.

In fact, the proposed rule appears to be in conflict with an existing condition of participation for discharge planning. Sec. 482.43 Condition of participation: Discharge planning (b) Standard (5) states "*The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to* ***avoid unnecessary delays in discharge***." The proposed rule will create unnecessary delays in discharge!

In summary, the proposed rule would place a tremendous burden on hospitals. Many hospitals are challenged by space and personnel shortages. The potential back log of patients in emergency departments and surgical recovery areas in hospitals operating at or near capacity can only have a detrimental effect on patient flow and ultimately, patient care. This is contrary to Joint Commission on Accreditation of Healthcare Organizations, 2006 Hospital Accreditation Standard LD.3.15, which requires leaders to develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.

I appreciate the role of CMS in safeguarding patient rights. I believe we must protect patient rights, but we must also be good stewards of limited resources as we strive to insure timely discharge plans for our hospitalized patients.

Sincerely,

Tina Treish RN, MSN, CCM

Submitter : Ms. Mary Herrera **Date:** 06/02/2006

Organization : The Western Pennsylvania Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1872-Attach-1.DOC

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:

As a hospital case manager who deals with patient discharge issues on a daily basis, I welcome 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.

In response to a final rule promulgated under the Benefits, Improvements, and Protection Act (BIPA) for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospices, HAP submitted a comment letter that outlined the burden and operational requirements associated with home health agencies providing advance written notice to Medicare Advantage enrollees and Medicare beneficiaries and detailed notices to Medicare beneficiaries when an expedited review is filed with the state's QIO. It is evident in both this rule and those already promulgated for other service settings that there is a fundamental lack of understanding on how care is delivered in these settings. I recommend that CMS consider implementing the same provisions currently used in hospitals in these other settings—namely to provide a notice at the time of admission for services similar to the "Important Message from Medicare" and to provide information regarding the right for an expedited

review/determination to those Medicare beneficiaries who disagree with discharge from or termination of health care services.

I, again, believe CMS has proposed an unworkable solution in its attempts to improve the hospital discharge planning process and that the proposed rule fundamentally ignores how care is delivered in hospitals. Hospitals do not differentiate care provided to patients based on financial class. To require a 24-hour notice only for Medicare patients requires these patients to be treated differently during the course of rendering care to all patients on a unit. This is in opposition to other existing federal regulations.

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 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.

Detailed operational, financial and other concerns are included as an attachment to this letter. Based on these identified concerns, I recommend the following:

- CMS should maintain its current requirements for hospitals and use a consistent approach for oversight and enforcement of these already existing requirements, including penalties for those facilities that fail to consistently comply with current law and regulation.

- 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, I offer the following modifications to the proposed rule for consideration by CMS:

- For Medicare Advantage patients, I strongly recommend that it be the Medicare Advantage plans' responsibility for communicating information regarding non-coverage. Specifically, I think 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, I urge CMS to build flexibility into the requirements for Medicare notification procedures for hospital discharges. I recommend that CMS allow hospitals to deliver the generic notice during the course of care as opposed to 24-hours in advance.

- I 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, I 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.

I 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.

I 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. I strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Should you have any questions or seek clarification, please feel free to contact me at The Western Pennsylvania at 412-578-4696

Sincerely,

Mary L. Herrera, RN
Case Manager, The Western Pennsylvania Hospital

Submitter : Ms. Ann Kunkel

Organization : Wellspan Health

Category : Hospital

Date: 06/02/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1882-Attach-1.DOC

June 5, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
http: www.cms.hhs.gov/eRulemaking.

Dear Sir/ Madame:

On behalf of Wellspan Health System, I welcome the opportunity to comment on the proposed rule in the **"Medicare Program: Notification Procedures for Hospital Discharges,"** as published in the April 5, 2006, *Federal Register.*

Attached is a analysis of the concerns Wellspan staff have identified with initiating the rule as proposed in the April 5, 2006 *Federal Register.*

To summarize:

1. Requiring a 24 hour notice is not feasible in 38% of the Medicare cases based on the quick progression of care.
2. Wellspan transfers 249 patients a month to other hospital or other institution type care which too would make compliance with the 24 hour advance notice difficult if not impossible.
3. The implications of this proposed rule will affect access to hospital services and longer length of stays.
4. Access to dispute resolution needs to mirror health care delivery.
5. The administrative burden is not just in executing the notice in advance but also requires a level of administrative infrastructure not present today.
6. An unintended consequence of this ruling is that the Medicare beneficiary would needed to be differentiated during the course of rendering care in order to comply with the advance notice.
7. Clarification of how to handle unexpected discharges, emergent transfers and other situations needs to occur.
8. The estimated cost of this ruling for Wellspan facilities is between $497,000 and 1.500,000.
9. Protecting and ensuring beneficiary access to expedited determinations when the beneficiary disagrees with a hospital discharge, termination of services or Medicare Advantage plan's decision to no longer cover a hospital stay is important.

Wellspan appreciates the interest CMS has in receiving comments on this proposed rule and recognize CMS interest in protecting and ensuring beneficiaries' rights to have access to an expedited determination process when they disagree with hospital discharge or termination of services, or when a Medicare Advantage plan determines that they will not cover the hospital stay. However, the proposed rule would create operational problems for hospitals and result in increase length of stays that will negatively impact

the community's access to care. Additionally the financial implications need further consideration and request the consideration of convening a stakeholder group to determine how best to address concerns about discharge planning, preparation and beneficiary protection with a pilot demonstration prior to full implementation.

Should you have any questions regarding the comments submitted, you may contact me as listed below.

Sincerely,

Ann Kunkel, RN
Director Care Management
Wellspan Health
Akunkel@wellspan.org
(717) 851-2178

Summary of Wellspan Health Review of the Proposed Discharge Notice Requirement and Implications
CMS -4105-P

Summary

The Center for Medicare and Medicaid services has proposed requiring hospitals to issue a discharge notice to all Medicare Beneficiaries, CMS-4105-P as posted in the April 5, 2006, *Federal Register.* The change described in the proposed rule is to requires a beneficiary discharge notification with the purpose of aligning the hospital level of care process with the skilled nursing, home health, and outpatient processes.
CMS has invited comment on the ruling.

Currently hospitals are required to give patients information upon admission ("Important Message from Medicare Notice") and upon discharge when the patient is not in agreement with discharge and has verbalized such (Hospital Issuance of a Notice of Non Coverage, HINN). Hospitals have not been ***formally*** required to notify all Medicare patients prior to discharge of their discharge date nor of the beneficiary rights/appeals. In addition, there has been a lack of clarity between the responsibilities of the Medicare Advantage plans and hospital providers over the issuance and format of notices to the beneficiaries.

The proposed changes would require that hospitals give a pending discharge notice to patients **twenty four hours in advance of discharge** in a standard format that gives beneficiaries information about and the steps to execute their rights as a member of Medicare. If a member disputes the discharge notice then the hospitals (and Medicare Advantage plans) are required to give a detailed notice which specifically describes the process for resolution. The dispute resolution involves contacting the Quality Improvement Organization (QIO) for a review and determination of the dispute.

Implications

Hospitals and health systems have been asked to publicly comment on the implications of these proposed changes as they relate to the acute care environment.

Acuity of care and the rapid response to treatment

In Wellspan facilities, the average length of stay for Medicare beneficiaries is 5.58 days. Approximately half of the Medicare patients are discharged in under 3 days which creates a logistical issue in when the delivery of such a notice would be appropriate. See attachment.
In these cases the change and recognition that patients have stabilized is typically within hours and not days. To require a 24 hour notice be given to patients prior to discharge will unnecessarily increase the length of stay further crippling the access to acute care services.

Home health agencies as well as skilled health facilities and their associations have commented that they too struggle with the timing of the notice, predicting discharge, and therefore compliance with the notice issuance. It should be noted that length of stay is typically longer and patient acuity is more stable/predictable in these levels of care that in acute care.

At Wellspan, between York Hospital (293 patients/ month) and Gettysburg Hospital (56 patients/ month), we transfer **249** patients per month to other institutions. This includes emergent transfers for care that can not be provided at our hospitals; as well as, transfers to other facilities for further care. In emergent circumstances the ability to give 24 hour notice does not exist due to the nature of care. For discharges requiring further care at other facilities, often times the discharge to these facilities is dependent on bed availability and 24 hour notice of the bed availability is not available particularly if the patient is stable awaiting the bed.

If a Physician does not give a 24 hour advance notice and discharges the patient what are the legal ramifications for the hospital's compliance with this rule? Can hospitals keep the patient if the physician refuses to write orders? Clarification of how hospitals should handle these situations is recommended.

Administrative burden

CMS indicates that the task associated with delivering the generic notice is an average of 5 minutes. However this does not account for the logistics in determining at what point the letter should be given nor does it account for the time frame for communication between the care providers. Additionally, in our pilot test of this, we determined that the time to deliver the notices was greater than 5 minutes on average.

Hospital staff that render care do not differentiate patients based on financial class. To require a 24 hour notice for Medicare patients *only* requires that these patients be differentiated during the course of rendering care. This is in antithesis of other federal regulations.

Additionally, administrative staff, who are charged with helping patients coordinate care within their benefit plans, have not been required to be available on off hours- specifically evenings and nights. The burden for hospitals is not necessarily in the amount of minutes that it would require completing the task but the administrative burden of off hour coverage.

Again, based on our review of Wellspan cases 30 to 40 % of our Medicare cases have less than a 3 day stay and the ability to comply with the regulation would not exist.

The detailed notice issuance requires the citing of specific regulations. CMS estimates that this will take 90 minutes. There is concern that this will take longer than 90 minutes to research, create the letter, coordinate the content with the care providers, deliver it, and explain it to the beneficiary.

Financial Cost

The financial burden of this proposed rule has both operational cost, adding hospital days, as well as staffing cost. In the proposed rule it is estimated that it will take an average of 5 minutes to complete giving the generic notice to the patient, if disputed, an average of 90 minutes for the detailed notice to be given, and the staffing wage is $30 per hour. However, it is not clear that these estimated times include process changes that would be required to implement the execution of the notice. This equates to a cost of $365,040 in staffing.

It is estimated in the ruling that 2% of patients will dispute the discharge requiring the detailed notice and will affect the length of stay from 1 to 3 days to allow for a QIO review. **The operational cost of longer hospital stays is $ 131,986 for a total CMS projected cost of $497,026.**

We believe the calculations as to the amount of time it will take to execute the Notice and the number of disputed accounts is underestimated. Additionally this proposed change would require the development and cost of an administrative infrastructure that is an unnecessary burden. Eliminating the 24 hour time limit would reduce the administrative burden of this proposed rule. See Attached.

Based on our review, we estimate the total cost of both the staffing and longer length of stay of this rule is $1,599,285.

Additionally there is the loss of access to care which has not been captured in this financial assessment.

Acute Care Access and Capacity challenges

Unlike the other levels of care, skilled care and home care, the course of care in acute care is more unpredictable and need for services is emergent and urgent at a higher frequency. Additionally, hospitals are already struggling with maintaining access to care.

Like many hospitals York Hospital is currently working on managing the capacity and patient flow challenges. Below demonstrates the current

capacity challenges. Moving forward this proposed rule, in its current format, would create even greater access issues.

Month	Divert hours
July '05	27
Aug '05	53
Sep. 05	43
Oct '05	32
Nov'05	66
Dec'05	34
Jan'06	113
Feb'06	32
Mar'06	91
Apr'06	51

Access to care and the ramifications of potentially delaying discharges by requiring 24 hour notice needs to be carefully considered prior to implementing this change.

Patient Involvement

CMS has a responsibility to protect and ensure beneficiary access to expedited determinations when the beneficiary disagrees with a hospital discharge, termination of services or Medicare Advantage plan's decision to no longer cover a hospital stay. Modifications to the proposed rule need to be considered and ensuring access to the QIO is an important element of the infrastructure to be considered.

The need for patient participation in discharge preparation is vital to all safe discharges and the prevention of unnecessary problems in care. While there has not been a formal requirement of hospitals to demonstrate this participation and this proposed notice does attempt to address the formal requirement of hospitals to demonstrate participation, the manner with which this is to be executed is troublesome and administratively burdensome. Elimination the 24 hour advance notice would allow the hospital to determine when to give the patient notice.

Availability of Dispute Resolution

Hospital care, including the discharge process, does not occur only within the window of Monday through Friday 8 AM to 4 PM. The rule describes that access to the Quality Improvement Organization (QIO) needs to be with 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 in further hospitalization impacts the community's access to health care as well as potentates patient safety issues.

Recommendations:

1. Given the implications and potential ramifications, a pilot / demonstration project of these changes, in cooperation with a QIO and hospital provider, should occur prior to full implementation
2. Eliminate the 24 hour requirement for patients who have a length of stay of 3 or less days and revise the, "Important Message from Medicare" to make this information more visible.
3. Medicare Advantage (MA) plans are required and responsible for issuance of the detailed letter. Additionally MA plans are required to give the hospital notice of a pending coverage termination **at least 24 hours** prior to the termination of payment.
4. Allow hospitals to deliver the generic notice **during the course of care** in oppose to 24 hours in advance of discharge.
5. If the determination is that the visibility of the beneficiary rights at the point of discharge is pertinent; then, require the generic notice be given at the time of discharge which would require the patient to make a dispute decision with in hours of discharge not days.
6. Require the access to QIO dispute resolution to mirror health care delivery of services which are twenty four hours a day, 365 days a year.
7. Clarification of how hospitals should handle when a discharge is canceled and rescheduled; does a second notice need given? Will it require an additional 24 hour timeframe?
8. Clarification of how this rule applies to emergent and urgent transfer as well as transfers to other health care facilities needs to occur.
9. Clarification of legal ramifications when a physician discharges a patient without the hospital giving 24 hour notice needs addressed.

Attachment A

Medicare Cases
York Hospital
July 2005 through January 2006

Month	Total Cases	Cases< 3 days	**Percent of Volume**
July	1058	506	48%
August	978	467	48%
September	1027	508	49%
October	1024	494	48%
November	1006	477	47%
December	1016	490	48%
January	1104	528	48%

Medicare Cases
Gettysburg Hospital
July 2005 through January 2006

Month	Total Cases	Cases< 3 days	**Percent of Volume**
July	163	59	36%
August	185	64	35%
September	181	76	42%
October	181	68	37%
November	165	59	36%
December	198	79	40%
January	195	72	37%

Financial Implications

Based on the above Medicare volume for each hospital

* Cost of care per day based on cost report for each Hospital

Hospital	7 Month volume	Annualized Cases	2% disputed 5% disputed	3 Days for QIO Review	Estimated Cost
York Hospital	6263	10,736	215	645	$457,950
			537	1611	$1,143,810
Gettysburg Hospital	1268	2174	44	132	$86,196
			109	327	$213,531

Total estimated Operations cost based on CMS Estimated time to complete $ 131,986

Total estimated Operations cost based on Wellspan's Estimated time to complete $1,357,341

Estimated Staffing Cost

Hospital	Annualized Cases	CMS estimate time: generic (5 minute average)	CMS estim. Detailed 2% at 90 minute	Total FTE	CMS Estimated wage cost (30.00/hr does not including benefits) These calculation include benefits	If 24 hour coverage needed FTE	Total FTE	Total Estimated Cost including 24 hr coverage t
		Wellspan estimated time 15 minute average *2080 hr= 1 FTE	**Wellspan estimated detailed (5% at 150 minutes)** *2080 hr= 1 FTE					
York Hospital	10,736	53680 min. 894 hrs/2080 hrs 0.43 FTE	215 (90)= 19350 min 322.5 hrs/2080 0.15 FTE	0.58				
		161040 min. 2684 hrs/2080 1.29 FTE	537 (150)= 80550 min. 1342.5 hr/2080 0.65 FTE	2.20				
Gettysburg Hospital	2174	10870 min 181.2 hrs/2080 0.09 FTE	44 (90)= 3960 min 66hr/2080 0.03 FTE	0.12				
		32610 min 543.5 hrs 0.26 FTE	109 (150)=16350 min 272.5 hrs/2080 0.13 FTE	0.39				
Combined	12910	Combined CMS estimated resource utilization		0.7	$65,520	3.2	3.9	$365,040
		Combined Wellspan estimated resource utilization		2.59	$242,424	3.2	5.79	$541,944

Total estimated cost of staffing cost based on CMS Resource Utilization $365,040

Total estimated cost of staffing cost based on Wellspan's Resource Utilization $541,944

CMS estimated costs: Staff and Operations: **$497, 026**

Wellspan's estimated costs: Staff and Operations: **$ 1,599,285**

Submitter : **Rebecca Eklund** **Date: 06/02/2006**

Organization : **Bronson Methodist Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1892-Attach-1.DOC

BRONSON
Methodist Hospital

Attachment #
189

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:

After careful review and consideration of proposed rule CMS-4105–P, we have the following concerns. As a 343-bed acute care hospital, implementation of this rule poses significant barriers in three main areas including; effective patient discharge, inefficient financial impact, and significant administrative time associated with rule implementation. Implementation of Proposed Rule Code CMS-4105-P would create a quagmire of bureaucracy.

In the practice of medicine and the art of discharging a patient, providers observe clinical nuances as a patient progresses from illness to wellness. Subtleties in antibiotic response, observation of lab values, and individual patient response to medications and treatments demand close monitoring to ensure the right patient is discharged at the right time to the right level of care. Clinicians operating on principles of best practice often decide to the discharge the patient after morning rounds, or they may round twice in a day and discharge the patient in the afternoon. Compliance with delivering a letter, prior to completing care for the patient and observing the nuances and effects of treatment would mandate letter delivery at the time of that decision, with discharge occurring 24 hours later to maintain rule compliance. Hence, length of stay would be unnecessarily increased. An additional impact on LOS is found in the required lag time on the expedited appeals process.

Financial impact related to oversight of Rule implementation and increased lengths of stay are significant. Personnel oversight of this process, potential for error and setting up systems to prevent error as well as mailing and courier costs represents increased healthcare overhead costs. Future cost increases related to a growing Medicare population in our community must also be recognized.

The time involved in implementation of such a rule, including letter creation, copying, delivery, monitoring and evaluation requires far more than proposed in this Rule. At our organization, several HINN letters are served per year; this Rule requires a multitude of

601 John Street
Kalamazoo, MI 49007

BRONSON
Methodist Hospital

letters be served to each and every patient. Effective implementation of this rule also requires monitoring of letter delivery, evaluation of timeliness of letter delivery as well as personnel time to write, copy and deliver these letters. Staff training, physician education as well as business office training represents not only a demand on time but additional costs as well.

We urge CMS to reconsider adoption of Rule CMS-4105-P, in the interest of the patients we serve, the fiduciary partners in our healthcare system, and the rising costs of healthcare. The impact and burden on length of stay, healthcare costs and resources would place a burden in the practice of patient care delivery.

Thank you for consideration of our comments.

Sincerely,

Rebecca Eklund, Director Compliance and Reimbursement
Phone: 269.341.7007

Jacqueline R. F. Wahl, Executive Director, Support Services
Phone: 269.341.6287

601 John Street
Kalamazoo, MI 49007

Deleted: Centers for Medicare and Medicaid¶
Department of Health and Human Services¶
Attention CMS-4104-P¶
P.O. Box 8010¶
Baltimore, MD 21244-1850¶
¶
¶
To Whom it May concern.¶
¶
After careful review and consideration of all aspects of proposed rule CMS-4105 –P, numerous concerns emerged. As 343-bed Acute Care Hospital, implementation of this rule poses significant barriers in three main areas; effective patient discharge, heavy and unanticipated financial impact, and impact on time consumption associated with rule implementation. Implementation of Proposed Rule Code CMS-4105-P would create a quagmire of bureaucracy. ¶
¶
In the practice of medicine and the art of discharging a patient, providers observe clinical nuances as a patient progresses from illness to wellness. Subtleties in antibiotic response, observation of lab values, and individual patient response to medications and treatments demand close monitoring to ensure the right patient is discharged at the right time to the right level of care. Clinicians operating on principles of best practice often decide to the discharge the patient after morning rounds, or they may round twice in a day and discharge the patient in the afternoon. Compliance with delivering a letter, prior to completing care for the patient and observing the nuances and effects of treatment would mandate letter delivery at the time of that decision, with discharge occurring 24 hours later to maintain rule compliance. Hence, the increase in length of stay. An additional impact on LOS is found in the required lag time on the expedited appeals process. ¶
¶
Financial impact related to oversight of Rule implementation costs as well as reduced ability to do business related to and increased lengths of stay are significant. Personnel oversight of this process, potential for error and setting up systems to prevent error as well as mailing and courier costs represents institutional costs. Future cost increases related to a growing Medicare population in our community must also be recognized.¶
¶
¶
The time involved in implementation of such a rule, including letter creation, copying, delivery, monitoring and evaluation requires far more than proposed in this Rule. At our organization, a few HINN letters are served per year; this Rule requires a multitude of letters be served to each [1]

Centers for Medicare and Medicaid
Department of Health and Human Services
Attention CMS-4104-P
P.O. Box 8010
Baltimore, MD 21244-1850

To Whom it May concern.

After careful review and consideration of all aspects of proposed rule CMS-4105 –P, numerous concerns emerged. As 343-bed Acute Care Hospital, implementation of this rule poses significant barriers in three main areas; effective patient discharge, heavy and unanticipated financial impact, and impact on time consumption associated with rule implementation. Implementation of Proposed Rule Code CMS-4105-P would create a quagmire of bureaucracy.

In the practice of medicine and the art of discharging a patient, providers observe clinical nuances as a patient progresses from illness to wellness. Subtleties in antibiotic response, observation of lab values, and individual patient response to medications and treatments demand close monitoring to ensure the right patient is discharged at the right time to the right level of care. Clinicians operating on principles of best practice often decide to the discharge the patient after morning rounds, or they may round twice in a day and discharge the patient in the afternoon. Compliance with delivering a letter, prior to completing care for the patient and observing the nuances and effects of treatment would mandate letter delivery at the time of that decision, with discharge occurring 24 hours later to maintain rule compliance. Hence, the increase in length of stay. An additional impact on LOS is found in the required lag time on the expedited appeals process.

Financial impact related to oversight of Rule implementation costs as well as reduced ability to do business related to and increased lengths of stay are significant. Personnel oversight of this process, potential for error and setting up systems to prevent error as well as mailing and courier costs represents institutional costs. Future cost increases related to a growing Medicare population in our community must also be recognized.

The time involved in implementation of such a rule, including letter creation, copying, delivery, monitoring and evaluation requires far more than proposed in this Rule. At our organization, a few HINN letters are served per year; this Rule requires a multitude of letters be served to each and every patient. Effective implementation of this rule also requires monitoring of letter delivery, evaluation of timeliness of letter delivery as well as personnel time to write, copy and deliver these letters. Staff training, physician education as well as business office training represents not only a demand on time but costs as well.

We urge CMS to reconsider adoption of Rule CMS-4105-P, in the interest of the patients we serve and the fiduciary partners in our healthcare system. The impact and burden on Length of Stay, healthcare dollars and time resources would place a burden in the practice of patient care delivery.

Submitter : **Mrs. Suzanne Suppers** **Date:** **06/02/2006**

Organization : **West Penn Hospital**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-4105-P-1902-Attach-1.DOC

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:

As a hospital case manager who deals with patient discharge issues on a daily basis, I welcome 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.

In response to a final rule promulgated under the Benefits, Improvements, and Protection Act (BIPA) for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospices, HAP submitted a comment letter that outlined the burden and operational requirements associated with home health agencies providing advance written notice to Medicare Advantage enrollees and Medicare beneficiaries and detailed notices to Medicare beneficiaries when an expedited review is filed with the state's QIO. It is evident in both this rule and those already promulgated for other service settings that there is a fundamental lack of understanding on how care is delivered in these settings. I recommend that CMS consider implementing the same provisions currently used in hospitals in these other settings—namely to provide a notice at the time of admission for services similar to the "Important Message from Medicare" and to provide information regarding the right for an expedited

review/determination to those Medicare beneficiaries who disagree with discharge from or termination of health care services.

I, again, believe CMS has proposed an unworkable solution in its attempts to improve the hospital discharge planning process and that the proposed rule fundamentally ignores how care is delivered in hospitals. Hospitals do not differentiate care provided to patients based on financial class. To require a 24-hour notice only for Medicare patients requires these patients to be treated differently during the course of rendering care to all patients on a unit. This is in opposition to other existing federal regulations.

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 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.

Detailed operational, financial and other concerns are included as an attachment to this letter. Based on these identified concerns, I recommend the following:

- CMS should maintain its current requirements for hospitals and use a consistent approach for oversight and enforcement of these already existing requirements, including penalties for those facilities that fail to consistently comply with current law and regulation.

- 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, I offer the following modifications to the proposed rule for consideration by CMS:

- For Medicare Advantage patients, I strongly recommend that it be the Medicare Advantage plans' responsibility for communicating information regarding non-coverage. Specifically, I think 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, I urge CMS to build flexibility into the requirements for Medicare notification procedures for hospital discharges. I recommend that CMS allow hospitals to deliver the generic notice during the course of care as opposed to 24-hours in advance.

- I 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, I 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.

I 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.

I 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. I strongly recommend that CMS retain the current requirements pending further discussion with key stakeholders.

Should you have any questions or seek clarification, please feel free to contact me at The Western Pennsylvania at 412-578-4696

Sincerely,

Suzanne Suppers, BSN, RN
Case Management Coordinator
Western Pennsylvania Hospital

Submitter : **Mrs. Bonita Boehlke** **Date:** **06/02/2006**

Organization : **Conway Medical Center**

Category : **Nurse**

Issue Areas/Comments

Background

Background

See attached

GENERAL

GENERAL

See Attached

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attached

Regulatory Impact

Regulatory Impact

See Attached

CMS-4105-P-1912-Attach-1.DOC

CMS-4105-P-1912-Attach-2.DOC

June 2, 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: Comments on Proposed Rule on the Medicare Program: Notification Procedures for Hospital Discharges (CMS-4105-P)

Conway Medical Center appreciates the opportunity to comment concerning this proposed rule that will negatively impact our member hospitals and the beneficiaries we serve.

Conway Medical Center supports proper notification of our seniors related to their healthcare services. Proper notification also relates to the timing of the notices beneficiaries receive and to the process for health care providers of these services. The proposed rule will not serve our seniors or hospitals without burden through repetitious notices and delay in proper discharge that is determined by the patient's attending physician. Not all beneficiaries have valid concerns with hospital discharge.

Unlike home health and skilled nursing facilities, hospitals have always had a process in place to notify patients of the appeals process and a discharge planning condition of participation that begins at the point of admission to the facility. The discharge planners and physicians work together to ensure the patient and their family will be prepared for a safe discharge at the right time. The hospitals do not make the final determination on the date discharge will actually occur; this is the sole responsibility of the patient's attending physician. The proposed rule will adversely impact utilization of inpatient services since the hospital does not have the authority to discharge patients. This means the hospital won't have the ability to always provide the generic notice of discharge on the day prior to discharge without adding another day of utilization since the staff must wait for the physician to order discharge. CMS has always deferred to physician judgment, including the UR or peer review by the QIO. The proposed rule will thus adversely impact the Medicare Trust Fund by adding a required inpatient day for each hospital discharge required through redundant beneficiary notices.

The proposed rule creates a 3-step process for hospitals, not a 2-step process as proposed:

1. the Important Message is a generic notice at the time of admission
2. the new generic notice of discharge on the day before discharge
3. the HINN

The purpose of providing notice at discharge needs to be clarified. If the purpose is to notify the beneficiary of appeal rights, the current process with the Important Message at admission serves that purpose. If the purpose is to ensure that beneficiaries have advance notice of their expected discharge so they and their families can be ready, that is accomplished by the discharge planning process, already required by Medicare. If the purpose is to notify beneficiaries of financial liability when they stay beyond the point that they need acute inpatient care, the current HINN process serves the purpose.

Other Concerns Identified:
The proposed negatively impacts the current push for an electronic medical record by requiring a paper document, complete with beneficiary signature.

The proposed rule does not offer a plan for short stays or transfers.

The proposed rule does not appropriately address the current Medicare Advantage organizations views on utilization and notices. We have MA plans that state they don't have utilization in their plans and our QIO has not had MA plan contact concerning MA enrollee discharges from our hospitals.

The proposed rule does not address the actual availability of the QIOs for weekend or after 5 p.m. discharge disputes by beneficiaries.

The proposed generic notice contains language that could cause unwarranted concern for beneficiaries on the appropriateness of their physician's decision to discharge.

CMS also 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.

Beneficiaries have a difficult time understanding the difference in activities of daily living and clinical, skilled services when it comes to health care concerns. The notice process does nothing to educate our seniors on these matters. This process could promote opportunities for beneficiaries to remain hospitalized for social reasons versus true clinical concerns.

Summary Suggestions:
Conway Medical Center would like to work with CMS on developing a sound notification process that will benefit all concerned. We have highly qualified social workers/discharge planners that work with our seniors on a daily basis that are willing to work with the agency to refine the notification process. CMS could begin by further refining the Important Message from Medicare that is given at the point of admission.

Conway Medical Center encourages CMS to reconsider this proposed rule that will not positively impact the information our beneficiaries will receive and will negatively impact hospital staff and the Medicare Trust Fund. Please contact me at 843-347-5896 or bboehlke@cmc-sc.com should you have questions concerning these comments or would like to form a workgroup to develop a sound notification process.

Sincerely,
Bonnie Boehlke, RN,ACM

Attachment #191

Director of Case Management
Conway Medical Center
Conway, South Carolina

Submitter : Ms. Lucy McKibbin

Organization : Salem Hospital

Category : Nurse

Date: 06/02/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1922-Attach-1.DOC

Attachment#192

SALEM HOSPITAL
REGIONAL HEALTH SERVICES

665 Winter St. SE
Post Office Box 14001
Salem, Oregon 97309-5014

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

June 2, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am an Assistant Manager in the Care Management Department at Salem Hospital, a 455 bed community Hospital located in Salem, Oregon.

As a RN Assistant Manager in Case Management, I have been directly involved with discharge planning for adult and pediatric patients for the past eight years. Our current discharge planning processe begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, case managers interview all patients meeting the hospital's screening criteria: patients over age 80, Medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

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

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients are discharged from the hospital in 1 – 2 days, very soon after the patient has received their Medicare rights information during the admission process. My final recommendation is for the generic notice to be required for patients in the hospital for 3 days or more.

I have read that CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1 – 2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expect results, and indeed, the increased costs (administrative and LOS) do not justify the means.

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

Sincerely,

Lucy J. McKibbin, RN CPUM
Assistant Manager, Care Management Department
Salem Hospital

Submitter : Robert Buzzell **Date:** 06/02/2006

Organization : DuBois Regional Medical Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-1932-Attach-1.DOC

Comments concerning CMS – 4105 – P2, Proposed Rule on Notification Procedures for Hospital Discharges.

As Social Work Manager of DuBois Regional Medical Center, I have serious concerns about the Proposed Rule on Notification Procedures for Hospital Discharges. Our hospital does an excellent job informing Medicare Beneficiaries of their rights to appeal a discharge determination, as do the large majority of hospitals. The proposed rule imposes a very heavy operational and financial burden on all hospitals, when proper enforcement of current rules concerning notification (including provision of the "Important Message from Medicare" on admission and informing beneficiaries of their rights and procedures to appeal a discharge decision) would assure that all beneficiaries' rights are appropriately protected.

My specific concerns about the Proposed Rule on Notification Procedures for Hospital Discharges include the following:

- Medicare Advantage plans should be required to issue and deliver notices about coverage and discharge decisions. It is inappropriate for hospitals, which may disagree with the Medicare Advantage plan's determination, to provide a notice and to have to interpret or explain the decision. It is impossible to know all that entered into the Medicare Advantage plan's decision making process, and explaining it may confuse the patient, or the hospital may innocently misinform the patient, leading to further problems, and potential undermining of the patient's rights.
- In today's hospital environment the health care team works diligently to assure that only appropriate care is provided, so that when a patient is ready for discharge, the discharge usually happens quickly. Because the date and time of the discharge is often not known in advance, hospitals will have to provide multiple notices of discharge to the patient, in an attempt to comply with the requirement that notices be provided a day in advance. This greatly increases the costs of complying with the Proposed Rule on Notification Procedures for Hospital Discharges, and will lead to confusion and frustration of the patient, the patient's family and the staff of the hospital.
- The Proposed Rule on Notification Procedures for Hospital Discharges requires notification the day prior to discharge. Because discharges occur 7 days a week, 365 days a year, usually from early morning until early evening, hospitals will be required to have additional staff trained in the notification process, preparing the second notice, and available most of the time, in order to assure that proper notification and explanation is given. This will lead to significant increase in staffing, resulting in increased costs at a time when hospitals are under significant financial pressures to reduce costs and focus on care of patients.
- Because the Proposed Rule on Notification Procedures for Hospital Discharges requires notice the day prior to discharge, I am concerned about the availability of the QIO to receive and respond appropriately and timely to a beneficiary's request for an expedited review. The QIO must be available 24 hours a day, 7 days a week, 365 days a year to respond, or hospitals will be required to absorb additional costs and patients may receive unnecessary and costly services.

- The Proposed Rule on Notification Procedures for Hospital Discharges is unclear about what a discharge is, and this may lead to delays in transferring patients to appropriate levels of service. Examples of problem delays in discharges include delays in transfer to another acute hospital which provides medical services not available at the original hospital, delays in transferring from psychiatric hospitals to other levels of care or to a non-psychiatric acute care facility, and most dangerously delays in transferring emergent cases that cannot be taken care of in the originating hospital.
- The Proposed Rule on Notification Procedures for Hospital Discharges may create problems in timely transfers to nursing homes, especially when there is a scarcity of beds. Currently our hospital can discharge patients within a few hours, when medically appropriate and the only cause for delay is lack of an appropriate nursing home bed, upon notification of an available bed. If required to give notice the day prior to discharge, patients will remain in a more costly and inappropriate care environment, and in fact the bed may not be available for that patient if the admission cannot take place immediately. This makes no sense in the very common situation when the physician, patient and family all agree with the discharge plan; the Proposed Rule would interfere with appropriate care.
- Many hospital patients are in the hospital for very brief stays, often 1, 2 or 3 days. To comply with the Proposed Rule on Notification Procedures for Hospital Discharges, hospitals will need to give the notice upon admission, then give another notice every day thereafter. This is an inappropriate expense and use of staff time and efforts, as well as confusing to patients and their families.
- I believe the Center for Medicare and Medicaid Services significantly underestimated the expense of complying with the Proposed Rule on Notification Procedures for Hospital Discharges. Developing and printing the forms, completing the forms appropriately, training multiple staff members in the process and procedures, and actually presenting and explaining the Notices are extremely time consuming and expensive, adding administrative and financial stress to a heavily burdened hospital industry.

In summary, I believe that the Proposed Rule on Notification Procedures for Hospital Discharges is unnecessary and should not be implemented at all, as it is addressing a problem which should be addressed directly, rather than burdening hospitals, their staff and physicians. There are numerous issues with the Proposed Rule on Notification Procedures for Hospital Discharges that must be addressed and corrected, if any change in the current process of notification of discharge rights must be undertaken.

Submitter : Miss. Shannon Webb **Date:** 06/02/2006

Organization : Southeast Georgia Health System

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

This new requirment will be very burdensome on the Case Management staff and confusing to the patients. The current process of Level 1 & 2's is currently consumes a great deal of time and explanation. The language in the proposed document gives the patient the impression that the discharge is not appropriate.

Thank you for allowing the providers to comment on this process.

Submitter : PATRICIA ANDERSEN **Date:** 06/02/2006

Organization : OKLAHOMA HOSPITAL ASSOCIATION

Category : Health Care Professional or Association

Issue Areas/Comments

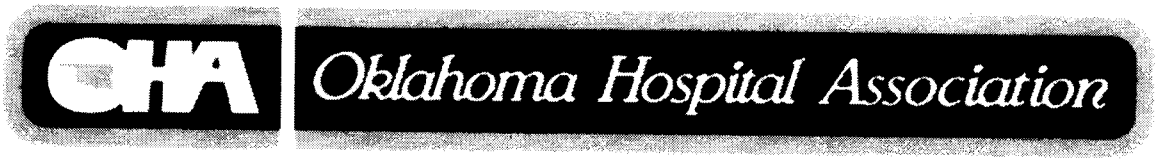
GENERAL

GENERAL

SEE ATTACHED LETTER

CMS-4105-P-1952-Attach-1.DOC

#195



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:

The Oklahoma Hospital Association (OHA), on behalf of our 120 member hospitals 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:

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

The OHA 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. In addition, there has been no compelling case asserted as a reason for the implementing this change. Therefore, the OHA does not believe CMS should proceed with these changes without a more thorough and realistic examination and understanding of the existing processes.

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

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

2. 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.

3. 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 proposed rule 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 proposed rule 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 Medicare patients when hospitalized.** The average Medicare length of stay nationwide is six days—very different from average length of stays for patients receiving home health care or enrolled in hospice or for patients admitted to SNFs or CORFs. A three-step process is unreasonable for an environment with an average length of stay of six days. 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 OHA 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 plans 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 for appropriate discharge to the patient's home or another setting, when appropriate.

- *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 with the only purposed being consistency with requirements designed for other, very different, patient care 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 OHA 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 OHA 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 (405) 427-9537 or pandersen@okoha.com.

Sincerely,

Oklahoma Hospital Association

Patricia Andersen

Patricia Andersen, VP-Finance & Information Services & CFO

Submitter : Mr. Mike Scherneck, EVP **Date:** 06/02/2006

Organization : Southeast Georgia Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

This proposal adds additional procedures to the Medicare beneficiary discharge planning process. The proposal is very labor intensive to administrate and will confuse the Medicare patient.

Thank you for thoughtfully considering these comments with regard to the aforementioned propsal.

Submitter :

Date: 06/02/2006

Organization :

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

Please refer to Comment # 82345 submitted yesterday 6/1/2006. I am unable to find my submission today???

Submitter : **Ms. Holly Snow** **Date: 06/02/2006**

Organization : **Piedmont Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

See Attachment

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

Regulatory Impact

Regulatory Impact

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Jill Johnson** **Date: 06/02/2006**

Organization : **Corry Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-1992-Attach-1.DOC

Corry Memorial Hospital

June 2, 2006

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

Comments on Notification Procedures for Hospital Discharges (CMS-4015-P)

Dear Sir/Madame:

Corry Memorial Hospital has reviewed the proposed ruling and disagrees that this will resolve a discharge notification issue that was experienced, as the result in a recent lawsuit or other similar situations. In an acute hospitalization, the patient needs inpatient hospital care during the acute phase. This phase is often very short and thus the reason for the current notice at time of admission, "Important Message from Medicare". To impose this proposed rule, of notification 24-hours prior to discharge, will have detrimental results rather than its' intended positive results in an already burdened, complicated health care delivery system. It will cause delays in discharges that currently are already agreed upon between physician and patient as satisfactory resolutions in the acute hospitalizations. It will impact patient flow, hospital capacity, emergency room diversion and additional frustration and dissatisfaction to the nurses attempting to give proper patient care to deal with increased paperwork.

Implications to the Operation of the Hospital

The current implication of this ruling in the Swing Bed program has already been taxing at times at best. The fact is that for the majority of Medicare patients receiving hospital care, it is difficult to predict with certainty whether or not the patient will be cleared for discharge. For the acute inpatient, many of these patients have co-morbidities and chronic diseases that can flare up due to the stress of the condition that brought the patient to the hospital. These conditions should be under control at the time of discharge, but to predict all the factors in advance of the day of discharge makes it almost impossible to comply with the 24-hour requirement notice. In addition, there are often final test results pending

prior to discharge, and other parameters that must be met in order to medically find a patient safe for discharge.

To comply with the proposed ruling, hospitals would frequently be giving the notice at the time the physician writes the order to discharge. Then the patient would stay an additional day when it is not medically necessary, and result in holding up admissions when the patient census is full and unnecessarily cause emergency department diversions. Ultimately, this is not good patient care for all the patients involved.

We believe the current process with the required "Important Message from Medicare" is sufficient. We have not experienced any problems with the current system. If there are hospitals that fail to adhere to it, then they should be held accountable rather mandate more steps to all the hospitals.

At Corry Memorial Hospital, we are a small rural hospital, and we do not have the staff for 7 day per week case management or discharge planning, so already our nurses must take care of these issues on evenings and weekends. To add this extra paperwork and all the work involved to comply with this ruling, would add even more stress and discontent, to an already complex nursing job which is to care for patients. Even the most diligent nurse will end up failing to give the advance written notice to the patient or family in many instances due to the multitude of tasks that (s)he is currently given to comply with all the rules and regulations of this complex health care system. And if a patient did request a review, that it would involve even more burden to the staff awaiting a response from the QIO. The physician dissatisfaction would also increase, as it has with the current ruling for our Swing Bed patients.

Another issue to consider is, if the physician has deemed the patient medically stable to be discharged, but the notice has not been given, and the patient must wait another 24 hours, there will be no orders to cover the patient while waiting for the 24 hours. This will provoke even more frustration, because the physician may soon need that bed for an acutely ill patient, but the bed is now unavailable due to this ruling. Patient care for the acutely ill patient will now be compromised again while an alternate plan is attempted to be made.

This ruling is not quite clear, but if it is implied for all discharges, does it include transfers? If a psychiatric patient develops an acute medical problem and needs transferred to acute care, how is this to be issued? For patient safety, this patient cannot wait 24 hours, or for any patient that that needs transferred. Or if a patient is stable to be transferred to a skilled nursing facility, and bed suddenly opens a day before it was anticipated, now the patient must wait an extra day and other acutely ill patients must diverted to an alternate hospital? Patient care must be a priority in all instances.

Implications for the Financial Operation of the Hospital

Previously, it was noted that this 24- hour notification, will extend the stay for most Medicare patients. Translated financially, this will result in more finances used by Medicare and the hospital alike, to unnecessarily keep a patient that the physician has deemed medically stable for discharge.

The cost to the health care delivery system to comply with an expedited review, in the majority of cases, is questionable if it will truly benefit the patient. We believe that the rule fails to accurately estimate the time it will take to deliver the notice to the patient or appropriate party. As noted previously, in the everyday operations of the hospital, it will take much more time to deliver this advance notice, and will cause more overtime to accomplish this task for the staff involved.

Other costs not considered by CMS are costs and time associated with printing and copying the forms once the patient has signed it. Other considerations are: the time required to coordinate with physician and other care professionals to establish when the notice can be delivered, the actual time to explain the form to Medicare beneficiary and/ his/her family or POA and get the form signed; the time to assist the patient or family to request an expedited review by the QIO; the costs associated in copying the medical records sent for review to the QIO; the cost associated with researching and providing the specific language required in the detailed notice of explanation; the costs of hiring and having more staff to deliver the notices or overtime involved to complete this task according to the timeframe as mandated. And all this is another unfunded mandate to hospitals; many of these hospitals are struggling to survive in this day in age.

Corry Memorial Hospital utilization management staff does not have ready access to the Medicare policies that they would need to cite to be in compliance with the proposed rule. The research for each of these detailed explanations for each specific beneficiary as required is not feasible or realistic. And the rule that the hospital must give the detailed notice to the beneficiary by the close of the business day that the hospital is informed by the QIO of the receipt of request, is yet another step that will be time consuming and thus more costly.

Discharge Notification Language

The hospital disagrees with the expectation that "Generic Notice of Non-coverage" and the "Detailed Explanation of Non-coverage" need to have a hospital logo added to the notices. Since the hospital is not the decision making body for the non-coverage; we believe the notice should not indicate that it comes from the hospital. On the Generic Notice, the statement, "Your hospital and/or Medicare Advantage plan have determined that Medicare probably will not pay" is not an accurate statement, since we as a hospital do not make the determination regarding Medicare coverage. It is also untrue that the patient would not incur any additional financial liability for the services being rendered before being notified of the independent reviewer's decision other than regular cost-

sharing for which the patient would be liable. On the form, it states, "If you request an immediate review, you will not have to pay for any services."

Recommendations:

We strongly recommend that CMS maintain its current requirements and enforce the existing requirement for hospitals that consistently do not comply with the current regulation. An additional proposal such as this, will not add to patient safety. We already provide safe discharge plans for our patients in a timely and agreeable manner to the patient and the physician administrating the care.

If CMS wants to explore other avenues, we suggest they convene with national hospital associations, professional groups and other pertinent groups to investigate the current provisions in discharge planning to address concerns.

Thank you for your consideration to these comments.

Sincerely,
Jill Johnson, RN
Utilization Review Coordinator for
Corry Memorial Hospital

Submitter : **Mr. Michael Grisdela** **Date: 06/02/2006**

Organization : **Memorial Healthcare**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-2002-Attach-1.DOC

June 2, 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:

Memorial Healthcare appreciates this 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. Memorial Healthcare includes a 148 bed short term acute care hospital located in Owosso, Michigan. 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 inpatient discharge decision is made by the physician, frequently during morning rounds, Memorial Healthcare believes this proposal would be unnecessarily burdensome for both patients and hospitals and that it is atypical of 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.

Memorial Healthcare 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 clear. 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 Memorial Healthcare hospitals 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. At Memorial Healthcare there are 2,500 Medicare inpatient discharges annually.

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 while resulting in bed shortages for hospitals with high occupancy levels. 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, Memorial Healthcare believes it is inappropriate in for the CMS to require an acute care discharge notice 24 hours prior to discharge. 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

Memorial Healthcare 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, the hospital would be required to deliver both the IMM and the standardized discharge at admission. Memorial Healthcare believes this would 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 Memorial Healthcare, a hospital with 2,500 Medicare cases, kept 10 percent of patients an additional day and 2 percent of Medicare patients an additional 3 days due to appeals, the hospital would experience an increase in length of stay of 400 days, with no

additional Medicare payment. The estimated annual incremental cost to Memorial Healthcare is $244,500. 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 hospitals 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, Memorial Healthcare strongly opposes this policy due to its significant impact on hospitals and Medicare beneficiaries. As indicated above, **Memorial Healthcare 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 with high occupancy levels
- 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, **Memorial Healthcare suggests 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.

In addition, **Memorial Healthcare believes it would be helpful if the CMS formed a workgroup, including beneficiaries, to provide input regarding the proposed discharge notice.**

Again, Memorial Healthcare 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 (989) 729 - 4824 or mgrisdela@memorialhealthcare.org

Sincerely,

Michael F. Grisdela
VP Administration, CFO

Submitter : Mrs. Joye Bailey **Date:** 06/02/2006

Organization : Lexington Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-2012-Attach-1.TXT

June __, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
via www.cms.hhs.gov/eRulemaking

Ref: CMS-4105-P

Dear Ladies or Gentlemen:

We appreciate the opportunity to submit our comments on your recent Proposed Rule regarding notification procedures for hospital discharges. We have given consideration to the information in your proposal, and would like to share our views as follows.

We are concerned that throughout the proposal reference is made to "the hospital's discharge decision". We would remind you that physicians write the order to admit and discharge patients. Hospitals do not independently decide which patients should enter or leave their care.

Provisions of the Proposed Rule

We believe the proposed two-step notice process would be confusing and upsetting to most beneficiaries, not helpful. When physicians and patients discuss leaving the hospital, the focus is typically on the patient's improvement, further testing to be done in the outpatient setting, and other clinical aspects of the patient's care. The proposal would place the hospital in a more adversarial position by requiring us to provide a written notice to the patient stating the date that coverage of inpatient hospital services will end. Regardless of the patient's perception of their care up until that point, the patient then holds, essentially, an eviction notice. By forcing the hospital to interject financial concerns into the discussion, instead of following the physician's advice that the patient is well enough to leave, the hospital is set up to be the bad guy – caring only about the money. We believe that providing the "Important Message from Medicare" to Medicare patients during admission is the optimal time to inform patients of their rights. If individualized information is needed on the form, we believe modifying the form is a much better solution than requiring a second form to be provided at a different time.

Regarding the potential to provide a more consistent approach to communicating appeal rights to beneficiaries across provider settings, we believe that we already have a two-step process in the hospital setting. The first step is providing a generic notice during the admission process, known as the Important Message from Medicare. The second is the hospital-issued notice of non-coverage if the patient' stay is determined to be no longer medically necessary. Either notice may be modified to include or exclude specific content. Because the nature of inpatient hospital care is continuous and acute, we believe that a different schedule for providing the two notices is appropriate. Outpatient settings, such as home health, involve care in more sporadic episodes. Requiring a one or two day delay between providing the first notice and ending the coverage of their services does not necessitate a home health agency to providing additional care in the interim. Inpatients are in our hospitals receiving services while the "waiting day" passes. Even if they are not receiving ancillary tests, they are receiving expensive nursing care, food, medications, and any necessary medical supplies with no additional reimbursement.

In response to your request for comments on whether there are exceptional circumstances under which a hospital should be able to deliver the standardized notice on the day of discharge, we are concerned that exceptions would greatly complicate an already cumbersome

proposal. Incorporating the generic notice into the information provided to the patient during admission would eliminate the need to track the normal versus exceptional cases, as well as the entire dilemma of locating the patient or representative. We do not believe providing this information during admission would diminish its effectiveness because most acute hospitals have a relatively short length of stay. Our average length of stay for Medicare inpatients was 6.6 days last year.

The proposed requirement to provide the generic notice on the day before discharge would be extremely difficult to administer. Approximately 25% of our Medicare inpatients had 1 or 2 day stays last year. Under the proposal, these patients would receive the Important Message during the admission process, and the same day or next day receive the generic notice. We believe that would bombard the patient with paperwork that reiterates the same basic information. Because the length of any patient's hospitalization is not known in advance, we believe that the generic notice should be incorporated with the Important Message information and provided during the admission process. By requiring the generic notice to be delivered at the beginning of the hospitalization, a patient would have the maximum time possible to focus and comprehend the information provided about their options if they rights.

Under the proposal, a patient may be ready for discharge earlier than expected, but have to wait for the mandatory day before discharge. We have seen many patients' discharge expedited because a procedure was cancelled, a nursing home bed becomes available before expected, or even the improvement of the patient's condition. Likewise, the deterioration of a patient's condition can prompt a previously unanticipated transfer to a more specialized facility. We do not believe the proposal intends to delay a needed transfer, but we found no statement to that effect. Discharge planning has taught us that elderly bodies can be quite unpredictable. We believe the notice requirements need to be flexible enough to accommodate the physician's medical determination of the patient's readiness for discharge.

We believe the proposal for the detailed notice is reasonable. We envision that process would be very similar to the existing process for issuing hospital-issued notices of non-coverage (HINNs). Our primary concern is that patients or family members may request QIO review to prolong their stay by a few days.

Regulatory Impact

The choice of wording in the proposal is quite interesting. "We also believe that the new approach we are proposing would not be overly burdensome for providers or MA organizations." Recognition is given to the fact that the proposal would be burdensome, but, based on some interesting assumptions, determined to not be overly so.

We strongly disagree with the estimate of 5 minutes for deliver each notice. While this may reflect the time to physically deliver the notice, it does not consider any time or expense for tracking our Medicare inpatients to determine which are or are not expected to be discharged the following day, preparing the notice, discuss the notice with the patient, obtain the patient's signature, document the notice in our records, or a variety of tasks that must be performed in addition to simply taking a piece of paper to a patient. If the patient is not able to comprehend the notice, the time required to contact, discuss, and obtain the signature of their representative is even greater than simply walking to the patient's room. These costs are real, and we believe will push the true cost of implementing the proposal much higher than this estimate.

Conclusion

While we agree with CMS' intent of protecting the patients' rights, we believe the proposal should be modified to better meet this intent. In our opinion, the Important Notice could be modified and provided during admission to advise the patient of their rights if they disagree with their physician's decision to discharge them from an acute level of care. A separate notice provided at a separate point in time would not provide information that is currently not shared with the patient. Requiring that the notice be provided to the patient one day prior to discharge would be extremely difficult to accomplish, as opposed to the current provision during admission.

Again we thank you for the opportunity to share our views on this important matter.

Sincerely,

Joye Bailey
Director of Corporate Compliance

Submitter : Ms. Mary Lou Cunningham **Date:** 06/02/2006

Organization : Emerson Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-2022-Attach-1.DOC

CMS-4105-P-2022-Attach-2.DOC

June 5, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human 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 American Hospital Association (AHA), on behalf of our 4,800 member hospitals and health care systems, and 35,000 individual members, 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 AHA 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 AHA 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 AHA 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 AHA 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.**

June 2, 2006

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

Comment to proposed rule change for discharge process: CMS-41050-P, published in the Federal Register, April 5, 2006 (71 FR 17052 – 17062)

The purpose of this letter is to add to concerns expressed by the American Hospital Association. As a patient advocate, having practiced the vocation of nursing for more than 30 years in many different settings, I can see nothing positive in the proposed rule change, and in fact can see extreme hardship both to the providers of care, but more importantly to Medicare beneficiaries.

The stated purpose of this change is standardization of the discharge process, making discharge from the acute hospital setting the same as discharge from the skilled nursing facility or from home care services. However, care delivered in the acute hospital setting varies widely from the other two areas mentioned. Hospitals have been under great pressure to provide continued access to care in light of a great loss of hospital beds over the past 10 years, and increased pressure from consumer driven health care initiatives that have greatly reduced operating margins therefore also reducing available resources. Identifying the appropriate level of care and appropriate utilization of resource management for patients comprises a large commitment by hospitals and on-going, daily challenges to balance the varying needs of very sick patients.

Hospitals are committed to having patients and families participate in their acute care plan and assist in the plan for post discharge needs. These needs may be acute rehabilitation level of care, short term rehabilitation in a skilled nursing facility, on-going acute care delivered in a long-term acute facility, or home with services from a home care agency and/or community services that may be available. Discharge to hospice care is also an important component of discharge planning for appropriate patients.

All of these decisions and choices relate to safe discharge planning as well as facilitating timely and appropriate care during the acute phase of illness in a hospital setting. This requires an enormous amount of patience and skill by physicians, nurses, rehabilitation specialists and social workers, and staff serving in the role of discharge planning or care coordination. This is a population already burdened with forms and paperwork, which they can not understand. Medicare Part D is a perfect example. Now to add to that burden by introducing another form that will need to be explained in detail and add to an already complex process is neither advantageous for the beneficiary or in any way helpful to the hospitals attempting to provide the best quality care available.

Estimating the time of 5 minutes per form is totally unrealistic. Many patients do not have family members available to act as Health Care Proxies and many of these same patients are not able to make decisions on their own. The added burden and time of using faxes and/or return receipt mail to obtain needed signatures is horrifying at best.

The added Length of Stay that hospitals will experience will result in both hospitals unable to provide adequate access for patient care, and those with minimal margins no doubt will be forced to close, again negatively impacting much needed access to care for the ever growing Medicare population. There will no doubt be an increase in Emergency Department overcrowding and need to be on diversion. Most importantly, this new proposal will force Medicare beneficiaries to utilize their benefit for administrative purposes rather than the medical necessity for which it was originally designed.

I fully support the AHA recommendations that the current notices and procedures be retained until need for revisions are clearly established and more workable, and less burdensome approaches are developed.

Mary Lou Cunningham, RN, MS, CCM
Director, Social Work and Care Coordination
Emerson Hospital/Emerson PHO
133 ORNAC
Concord, MA 01742

Submitter : Jane Hounsell **Date:** 06/02/2006

Organization : Columbia St. Mary's Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment.

CMS-4105-P-2032-Attach-1.DOC

Attachment #203

June 1, 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: NOTIFICATION PROCEDURES FOR HOSPITAL DISCHARGES
"PROVISIONS OF THE PROPOSED RULE"

FROM: Columbia St. Mary's Hospitals
Milwaukee, Wisconsin
Jane Hounsell, MSW, LCSW, Lead Medical Social Worker

To Whom It May Concern:

Columbia St. Mary's 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.

In addition, regulations already exist that address the issue of notification of pending discharge to patients and individuals acting on their behalf. These existing standards include:

1) The Conditions of Participation for Discharge Planning (§482.43) which requires timely initiation of discharge planning,

2) The hospital-issued notice of noncoverage (HINN) which must be provided to any Medicare beneficiary that expresses dissatisfaction with an impending hospital discharge,

3) Condition of Participation: Utilization Review (§482.30) which requires hospitals to establish procedures for review of medical necessity of admissions and appropriateness of setting, and

4) The Patient's Rights regulation which addresses planning for care after discharge.

Based on the number of regulations already dealing with the topic of notice of discharge, this additional regulation is not needed.

As a Medical Social Worker in a hospital, I have been directly involved with discharge planning for 20 years. Our current discharge planning practice begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, RN Case Managers and Medical Social Workers screen all patients during daily Care Coordination Rounds and interview all patients at risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

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 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. Columbia St. Mary's Hospitals are committed to providing high quality, low cost 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.

Submitter : **Dana Griffin** **Date: 06/02/2006**

Organization : **Northport Medical Center-DCH**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-2042-Attach-1.DOC

Attachment #204

NORTHPORT MEDICAL CENTER-DCH
2700 Hospital Dr
Northport AL 35476
205-333-4500

June 2, 2006

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

Re: CMS – 4105-P, Medicare Program; Notification Procedures for Hospital Discharges

To Whom It May Concern:

On behalf of Northport Medical Center in Northport Alabama, I welcome this opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with our comments, concerns, and suggestions on the proposed new rule regarding discharge notification procedures.

Northport Medical Center supports CMS' efforts to ensure that Medicare beneficiaries are kept informed of their care planning, including planned discharge date. Currently, every patient begins the process of discharge planning at the time of admission; more intense discharge planning services are coordinated by a case manager based on need as determined through a medical-social screening. Our process involves the patient and their decision-maker giving them choices for providers of post acute care services. Patients are given ample opportunity to change their minds, revise discharge plans, disagree with planned discharges and request appeals through our QIO.

The proposed rule will place an administrative burden on the hospital that outweighs any benefit and is likely to become a patient dissatisfier. Our assessment is based on specific concerns discussed below.

Many times the patient's decision-maker is not available which could easily cause a one day delay in issuing the generic notice.

Ensuring that patients and/or their representatives understand their appeal rights is a very complicated process. It is difficult to predict how many patients will request an expedited appeal, but for all patients that make this request an additional 2-3 days will be required to prepare the detailed notice, file the notice and await a response from the QIO. The patient assumes no financial responsibility until the QIO responds.

Reflecting back to the "Important Message About Medicare Rights" of September 2000, HCFA revised its estimate of the costs borne by hospitals to issue the notice for inpatient stay. The new cost estimate totaled more than $170 million - a seven-fold increase from HCFA's original estimate of $24 million, cited in the April 12 *Federal Register* notice. Similar costs will be associated with this proposed rule and the burden and expense of compliance must be borne solely by hospitals, not the health plans. Responsibility will be shifted to hospitals, but resources for this activity will have to be diverted from already stretched resources for patient care. Further, the current environment in which paperwork and documentation demands continue to increase contributes greatly to clinical staff dissatisfaction with working in the health care field.

While this new requirement to administer the written notification of discharge may appear minor to CMS, to hospitals, it is yet another requirement that takes time and resources away from direct patient care. We maintain that any perceived benefit from administering this notice during the course of an inpatient stay is not justified by the very real increase in costs. We propose that the Medicare program share appeal rights information with beneficiaries through the Medicare handbook, and hospitals reinforce knowledge and understanding of those rights when a discharge is in dispute. Otherwise, hospitals should be required to continue to distribute the "Hospital Issued Notice of Non Coverage", as they have done for years, when continued stay is inappropriate and unnecessary.

CMS also fails to include a cost estimate for storing the forms. Whether stored on paper, microfiche or by computer, significant administrative costs are associated with storage.

Northport Medical Center is supportive of CMS's role in safeguarding patient rights. It is understandable that CMS wishes to ensure these rights are upheld. But, as Medicare shifts much more of these administrative functions to providers compared to the private payers, CMS has an obligation to energetically pursue efficient administrative approaches. Hospitals cannot afford to continue diverting so many resources to paperwork, rather than patient care. We must be responsible stewards of the very limited resources we have while ensuring that patients do not take advantage of a new opportunity to unnecessarily extend a hospital length of stay.

Northport Medical Center appreciates the opportunity to submit these comments. If you have any questions regarding our comments, please contact me, Dana Griffin-Director, Quality Management.

Sincerely,

Dana Griffin, R.N.
Director-Quality Management
Northport Medical Center
2700 Hospital Dr
Northport AL 35476
205-333-4869

Submitter : Mrs. Jo Anne ` Bryant **Date:** 06/02/2006

Organization : Newnan Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

June 2, 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:

Newnan Hospital 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.

We believe 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, Newnan Hospital 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.

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.

Once again, hospitals will end up being penalized because of decision-making on the part of the physician. It is not possible to anticipate all discharge dates even one day in advance. This proposal will likely end up increasing length of stay for beneificiaries...which is in no one's best interest...particularly, the beneficiary. Adding a redundant administrative burden to an already complex process will take away more time from direct patient care planning which, I believe, must be the intent of the proposal. Hospitals already bear the burden of most Medicare regulations. Every hospital I am aware of already spends a tremendous amount of their own resources trying to create safe discharges for patients. Please do not add this burden to hospitals or beneficiaries.
Respectfully submitted, J Bryant, RN, BSN, CCM

Provisions of the Proposed Rule

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.

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.

Submitter : Mary McClintock RN **Date:** 06/02/2006

Organization : Caritas Christi Health Care System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Increasing Length of Stay - There is not an oportunity to give the "discharge Notice" to the patient the day before discharge if: The patient is admitted overnight after surgery (inpatient only list) and is discharged the next day; or the patient is admitted through the ED that has had aggressive/appropriate treatment and is discharged the day after admission. It is not appropriate to give the patient a discharge notice before surgery has been performed or the workup completed and treatment started.

Anxiety to the patient and family caused by document- To present a form to the patient and family indicating not only the discharge date, but indicating a financial responsibility will be very stressful and anxiety provoking to the elderly population. This will unnecessarily create an adverse relationship between the patient/family and the hospital staff. We feel the situation should not be compared to the skilled nursing facilities nor home health agencies as in those instances there is a plan from the day of admit how long the services will be needed. This is not the case in the hospital setting where stabilization of the patient's acute care issue is often variable.

Staff time/Financial Impact- The Federal Register cites that in 2002 there were approximately 10.9 million fee-for-service Medicare inpatient hospital discharges. The total annual breakdown associated with this proposed requirement is 908,333 hours. It further notes that it is estimated that it would take hospitals 5 minutes to deliver each notice. This raises several points. There is a potential on a short stay unit to have 10 to 20 discharges in 24 hours, depending on the size of the hospital. This 5 minutes now has suddenly become 50 minutes to 3 hours. It is mentioned that the first notice would be individualized for the patient with name, date services would end, and the date financial liability would begin. The second notice would be more detailed similar to the current notices of non-coverage. The cost of printing these forms, and the inference that the first form would encourage the patient to at least receive and review the second form, would have a significant impact on human resource time to process.

Patients unable to understand the form - Due to the aging process there are a number of elderly patients who would not be able to understand the form and what it means. In these instances the family is contacted. Due to our current society's busy schedule it is not always feasible to connect with a family in a timely manner. Also at a disadvantage would be the non-english speaking population. These patients or families would require the use of costly interpreter services. Although interpreter services are available 24/7 they are not always readily available.

Monday discharges after a weekend - In the community hospitals the community physician will frequently have coverage for at least one of the weekend days. The Case management staff is usually limited on weekends. An attending will frequently identify on Monday a patient that was not identified on Saturday or Sunday for discharge. This decision would impact the discharge notice from getting completed within the designed parameters.

Return to same nursing facility - the patient who is returning to a skilled nursing facility will frequently have a higher level of care than a patient going home. There will have been a discussion with the patient and family regarding a tentative discharge date but a final decision may not be made until certain tests or treatment outcomes are known. This discharge determination may be made when a physician makes evening or early morning rounds.

Medicare Advantage - It is unclear as to who would bear the burden of providing these enrollees with the notice. Would the hospital then have to notify not only the patient but also the insurer. Current practice is that the insurer generates a notice when benefits are to be terminated.

Regulatory Impact

Regulatory Impact

Charitas Christi Health Care System (CCHCS)appreciates the oportunity to comment on the proposed rules for Medicare Programs:Notification Procedures for Hospital Discharges. CCHCS is a network of 6 hospitals located in Massachusetts and we have a number of concerns regarding this proposal. These comments submitted by the Directors of Case Management Mary McClintock RN, Betty O'Brien RN, Judith Pelleteir RN, Cathy Beaupre RN, Geraldine McEachern RN

Submitter : **Mrs. Kim Rankin** **Date: 06/02/2006**

Organization : **Waccamaw Community Hospital**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

see attached

CMS-4105-P-2072-Attach-1.TXT

CMS-4105-P-2072-Attach-2.RTF

CMS-4105-P-2072-Attach-3.DOC

CMS-4105-P-2072-Attach-4.DOC

CMS-4105-P-2072-Attach-5.TXT

CMS-4105-P-2072-Attach-6.TXT

Waccamaw Community Hospital
4070 Hwy 17 bypass
P.O. Drawer 3350
Murrells Inlet, SC 29576

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

06/01/2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am a registered nurse case manager at Waccamaw Community Hospital a 129 bed, community, Hospital System located in Murrells Inlet, SC.

As a Registered Nurse case manager I have been directly involved with discharge planning for acute care patients for the past four years. Our current discharge planning practices begins at the time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, case managers interview all patients meeting the hospital's screening criteria: patients over age 70, Medicare beneficiaries under age 65 and patients at high risk for needing post acute services. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to the QIO.

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

In addition, a "day's notice" also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 4 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance. My recommendation would be for the hospital to notify the patient by 12noon

on the day of expected discharge and allow the patient to appeal the discharge by 5:00PM that evening. I believe this provides the patient ample time to consider the discharge and notify the QIO if they would like an expedited appeal.

Many patients are discharged from the hospital in 1 – 2 days, very soon after the patient has received their Medicare rights information during the admission process. My final recommendation is for the generic notice to be required for patients in the hospital for 3 days or more.

I have read that CMS estimates only 1 – 2% of beneficiaries will request an expedited appeal, if this is true, it would not be overly burdensome for hospitals to complete the detailed explanation of Hospital Non-Coverage. I am concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay. My recommendation would be for CMS to institute this rule on a temporary basis to judge the actual impact on hospitals. If only 1 – 2% of patients request the expedited appeal and a significant percentage of the appeals are upheld then it is apparent that CMS has acted in the best interests of the public. If the percentage is significantly higher and nearly all appeals are overturned, then it becomes apparent that this proposal did not yield the expect results, and indeed, the increased costs (administrative and LOS) do not justify the means.

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

Sincerely,

Kim Rankin RN

Submitter : Mrs. Luretha Russell **Date:** 06/02/2006

Organization : Spalding Regional Medical Center

Category : Hospital

Issue Areas/Comments

Background

Background

The proposal would require all inpatient Medicare beneficiaries to sign an additional form explaining that they have exhausted their benefits during their current stay. This additional form confuses patients by describing an appeals process that causes the patient to question the necessity of the discharge. The new notice is duplicative because it would be in addition to the Important Message from Medicare (IMM) given at admission which already provides an explanation of Medicare discharge appeal rights.

GENERAL

GENERAL

The proposed discharge notice process is unnecessarily burdensome and out of sync with standard discharge planning and physician discharge order patterns. The procedure is counter to hospitals movement toward electronic medical records since it is not clear whether provisions will be made for electronic alternatives.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

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. Physicians do not write discharge orders until their patients actually achieve the clinical status that determines hospital care is no longer needed. At that point, the patient is discharged so you do not have a day between determination for discharge and the actual discharge process to obtain additional duplicative paperwork. 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. I recommend that CMS withdraw the proposal and retain the current requirements.

Submitter : **Ms. Janice Doeringer** **Date: 06/02/2006**

Organization : **Emory University Hospital**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

I'm quite concerned about the impact of this proposal relating to notification procedures for hospital discharges. The process places undue burden on hospital systems intent on transitioning patients to the appropriate level of care in a timely manner. As Assistant Director for the Social Services Department at Emory University Hospital in Atlanta, Georgia, and as a professional who has been involved in discharge planning for hospitalized patients for 30 years, I would like to add my support to the number who have voiced their concern. Please consider adding language to the letter that patients receive upon admission to the hospital rather than proposing that the patients be notified of discharge 24 hours in advance. Thank you for your attention to this comment. Janice Doeringer, LCSW

Submitter : **Dr. Lee Sacks** **Date: 06/02/2006**

Organization : **Advocate Health Care**

Category : **Hospital**

Issue Areas/Comments

Background

Background

See attached

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached

Regulatory Impact

Regulatory Impact

See attached

CMS-4105-P-2102-Attach-1.DOC

#210

June 5, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Proposed Rule CMS-4105-P Notification Procedures for Hospital Discharges

Dear Dr. McClellan:

On behalf of Advocate Health Care, I 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 (MA) programs. Oak Brook-based Advocate Health Care, the largest health care provider in Illinois, has ranked among the nation's top 10 health care systems for five straight years. Advocate's 200+ sites of care in metropolitan Chicago include eight acute care hospitals and two children's hospitals, a home health care company, Chicago's largest contracting and care management organization, and three of Chicago's largest medical groups.

We have a number of significant concerns about the proposed rule, chiefly among them, the significant administrative and financial burdens this would place on hospitals and the potential for unintended consequences that could adversely impact patients. We believe that this proposed rule would increase the length of stay for Medicare patients. We also believe that the rule would restrict patient access to care by challenging hospitals' capacity limitations.

The Metropolitan Chicago Health Care Council (MCHC) estimates that 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.

Moreover, these cost estimates do not include the most significant negative effect of this proposed rule—the cost to patients who may need inpatient hospital care and may not be able to access such care in a timely manner due to increased lengths of stay and capacity limitations. They also do not account for the costs of keeping Medicare beneficiaries in the hospital when such patients are well enough to be discharged, including costs stemming from exposing patients to complications such as hospital-acquired infections.

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 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.

We respectfully recommend that these issues be taken into consideration before the Centers for Medicare and Medicaid Services (CMS) issues a final rule modifying the current hospital discharge notice procedures. In addition, we suggest that CMS consider forming a national multi-disciplinary workgroup to assist the Agency on this matter.

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 hospital-issued notice of non-coverage (HINN). Congress specifically required the "Important Message from Medicare" to ensure that Medicare beneficiaries know their discharge rights. 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. In the case of MA 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. The HINN, as it currently exists, is truly an exception process. Individual Advocate Health Care hospitals estimate that they prepare and deliver only one to six HINNs annually to their Medicare patients.

There is no evidence that the current process is inadequate, nor is any such evidence offered in the proposed rule. Therefore, there appears to be no compelling reason to change the discharge process. CMS has offered little in the way of rationale as to 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. We do not believe that it is necessary to require the same discharge notice procedure in an acute care setting as in the home health setting, for example.

The proposed discharge notice process is inconsistent with the timing of physician decision-making and with hospital operations. Discharge decisions are made by physicians, not hospitals. The physician may document an anticipated discharge plan, but generally a final discharge decision is not made until the day of discharge, when the discharge order is entered into the patient's record. The physician's decision to discharge a patient takes into account the diagnostic work-up and clinical condition of the individual patient. Occasionally, the physician may give a discharge approval pending the outcome of certain clinical criteria, e.g. test results being negative or within specified limits, or absence of a fever. The proposed rule requires that the notice be given to the beneficiary at least one day in advance of discharge. Because the notice cannot be delivered until after a discharge decision is made, the proposed discharge notice process will add at least one additional day to every Medicare beneficiary's stay. This is because even though 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.

The proposed generic discharge notice language could invite inappropriate appeals extending lengths of stay even more. The language of the generic discharge notice, particularly the repeated references to "an immediate review," may raise doubt in the beneficiary's mind with respect to whether the discharge is appropriate. The beneficiary may view the notice as an invitation to appeal the discharge decision. Moreover, providing a patient-specific discharge notice to every Medicare beneficiary will lead to unnecessary and longer hospital stays while discharge decisions are being appealed.

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 also would 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 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.

The cost estimates for delivering generic and detailed hospital discharge notices are grossly understated. CMS estimates overall annual costs of complying with the proposed requirements of $7,075 per hospital. Unfortunately, CMS failed to account for a number of significant costs related to the delivery of the proposed discharge notices.

MCHC has estimated that it would take hospital staff 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. Additional costs also would be incurred for patients who do not speak English; patients who are mentally incompetent and for whom a guardian must be identified; and patients who choose to appeal the discharge. Accounting for these factors, MCHC estimates that the average Chicago-area hospital could incur costs of $205,000-$410,000 annually. Moreover, according to MCHC, the additional annual cost per hospital as a result of increased length of stay would range from $9.9 million to $13 million. This is of great

concern because Medicare payments are generally not adequate to cover the cost of care under the current system.

Recommendation

Considering all of the challenges associated with the proposed rule, we respectfully request that CMS take these concerns into account before issuing the final rule modifying the current hospital discharge notice procedures. In addition, we recommend that CMS consider convening a national multi-disciplinary workgroup to assist the Agency on this matter.

Further Information

Thank you again for the opportunity to review CMS's proposal and to offer comments. If you have any questions about the issues raised above or need any additional information, please feel free to contact Sharon Otten at 708-684-5266.

Sincerely,

Lee B. Sacks, MD
Executive Vice President and Chief Medical Officer

Submitter : Mr. Tim Size

Date: 06/02/2006

Organization : Rural Wisconsin Health Cooperative

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

We strongly agree with the Wisconsin Hospital Association s Comments previously submitted. 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. 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.

Submitter : **Ms. Stephanie McDonald** **Date: 06/02/2006**

Organization : **Fairview Health Services**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-2132-Attach-1.DOC

#213

FAIRVIEW
Fairview Health Services
Patient Financial Services
P.O. Box 147
Minneapolis MN 55440-0147
(612) 672-6724 Fax: (612)-672-6727

May 26, 2006

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

Re: Federal Register Notice (71 FR 17052-17062) April 5, 2006; Medicare Program Proposed Rulemaking for Notification Procedures for Hospital Discharges.

Dear Sir or Madam:

Fairview Health Services, which has seven hospitals in Minnesota, wishes to thank you for the opportunity to comment on the proposed Standard Discharge Notification Procedure. Our comments are as follows:

Time to deliver the standard notice:
This will take more than 5 minutes to do. From experience dealing with these patients, this will generate a lot of questions that will take time for a nurse to answer. While it may take 5 minutes to prepare, deliver, and have a signature done, there will be a lot of questions between delivery and signature. Patients with no available family will take extra time to track down a family member or representative. This is often the case for patients coming in from a nursing home. In addition, the language in the proposed notice is almost threatening, which will lead people to ask more questions to find out if the discharge is appropriate, and may actually cause people to appeal, just to get a second opinion form the QIO. Conservative estimate: 15 minutes.

Patients going to a nursing facility:
Patients on their way to a nursing facility who do not meet the 3-day qualifying stay will want to appeal the discharge in order to get that extra day. Another concern is then that Medicare will come back and say that the extra day was not necessary and the patient does not meet the 3-day qualifying stay after the fact. One hospital identified a case where this had happened when a HINN had been issued.

Delivery of notice 24 hours prior to discharge:
This will be a moving target. It is difficult to predict when a patient will be discharged, and hospitals do not make the discharge decision. While hospitals have staff handling utilization, case management, discharge planning and teaching, physicians make the discharge decision, and that decision is based on medical criteria. When the patient meets those criteria, the patient may be discharged. Some individuals respond to

treatment sooner than others, making the discharge time impossible to predict. A person who meets the criteria sooner may be able to go home before the 24 hour notice period expires, someone who meets it later may miss the proposed discharge dates, and someone who develops other problems may not meet the proposed date(s) at all. A patient who had already received the standard discharge notice would require a lot of reassuring that Medicare or the MA Plan isn't going to terminate coverage because the patient didn't meet the date.

Examples:
Physicians will often write an order equivalent to: patient may go home Tuesday or Wednesday, when (list of criteria are met). In this instance, there could be at least 24 hour notice of discharge. However, the actual discharge decision is not made until the results of the tests (or other criteria) are in.
The notice requires more flexibility to cover this in order to avoid

- confusing the patient (when am I really going home?)
- causing the patient to worry that s/he might have to pay the last day because s/he didn't meet the earlier "deadline"
- causing unnecessary appeals to QIO in an attempt to avoid the earlier discharge date.

Physicians often make the discharge decision at morning rounds and write the order for discharge for the afternoon of the same day.

- We cannot keep the patient an extra day just so we can do a 24 hour notice as this would be an unnecessary day for which a hospital would expend effort but not be able to be paid.
- CMS wants comments on issuing this the day of discharge, but
    - we have concerns that CMS will consider this undue pressure on the patient to make a decision to appeal.
    - the patient may feel pressured, considering the language on the proposed notice, and file an appeal
    - We do not know that the QIO will be able to comment in a timely manner
    - There will be extra effort to get the information together for the detailed notice
    - There may be no actual Medicare regulations that can be quoted on the detailed notice for the reason Medicare will no longer pay. The patient is being discharged because s/he is medically stable.

Physicians can only estimate actual discharge for short stays, so giving the notice on admit is not reasonable.

- It is possible to give only the estimated day of discharge to the patient at the time of admit, since it's not always possible to anticipate problems
- The notice could be given by an admit clerk, but the clerk would not be able to answer any medical questions
- The concerns are
    - the patient on arrival is sick and probably somewhat scared and will focus on "your coverage will end" language in the notice and worry what will happen if s/he exceeds the planned discharge date/time.

- Patients do not always have a family member or representative with them on arrival who can receive this information
- For inpatient-only procedures, the date of discharge may well be the same day as the day of admit. All of the concerns are then compressed into a very short time frame and at what point will the patient be able to receive the information and not be under undue stress?
- It is duplicative of the information in "an important Message from Medicare"

Transfers between distinct part units or other transfers;
If a patient is being transferred from a med/surg unit to a less intensive unit such as rehab, the patient is likely to be in better state of mind to take the information. However, patients who are going from a psych unit to a med/surg unit or vice versa are often being transferred because of a crisis.

- there is no time to do a 24-hour notice and maybe not even a four-hour notice
- there is often no family member or representative available
- care cannot wait to locate a family member or representative
- the most that will be able to happen in this instance is that the hospital representative will have to note on the standard notice
  - there were no family members available
  - the patient was in no condition to read or sign the form
  - initial the form

Moving a patient from one part of the hospital to another part of the same hospital (distinct part unit) should be relatively seamless for the patient. It is not a termination of services in their mind and will cause concerns and more questions about why Medicare won't pay for their services in the other unit. The patient may decide to appeal the discharge out of fear that further services won't be paid, which could delay necessary treatment available in the other unit.
There should be a different notice for moving a patient to a hospital's own distinct part unit.

- The wording does not accommodate the idea of starting a new episode of care
- The wording sounds as if the patient's care in the distinct part unit will not be covered
- This will generate worry on the patient's part and cause more questions and explanations.

There should be a different form for transferring a patient to care elsewhere

- The wording does not accommodate the idea of starting a new episode of care
- The wording sounds as if the patient's care in the receiving facility will not be covered
- This will generate worry on the patient's part and cause more questions and explanations.

Comments to CMS
Standard Discharge Notice Proposal

Effort:
This will require additional weekend/evening staff.
This will also mean that other patients' discharge needs may have to be switched around in order to accommodate the extra requirements for Medicare and Medicare Advantage patients.
This is an extra storage requirement at a time when we are being encouraged to use electronic medical records.

Patient refusal to sign:
We appreciate CMS' allowing a notation and initials by the staff when a patient refuses to sign.

Relation to "An Important Message from Medicare"

- This message only refers to appeal rights when given a notice of non-coverage (HINN)
- The message should be altered to include appeal rights when notified of discharge date (regular discharge).
- This is much less threatening, requires less preparation, and delivers the same message

In summary, given the above information, we feel that the notice is duplicative of the information given in "An Important Message from Medicare", will cause a great deal of effort, will have a negative financial impact on hospitals, and will cause patients unnecessary concerns.

Thank you for the opportunity to comment.

Sincerely,

Stephanie McDonald
Compliance Specialist
Fairview Health Services
Corporate Office
400 Stinson Blvd NE
Minneapolis, MN 55413

University of Minnesota Medical Center, Fairview
Fairview Southdale Hospital
Fairview Ridges Hospital
Fairview Northland Regional Hospital
Fairview Lakes Regional Medical Center
Fairview Red Wing Hospital
University Medical Center, Mesabi

Submitter : Ms. Alice Polley **Date:** 06/02/2006

Organization : Sturdy Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

The current Important Message from Medicare that is given upon admission covers patient rights and appeal rights just fine. This proposed Rule is workable in the long-term care setting, but is entirely inappropriate and burdersome and counter-productive in the acute care setting. The AHA is correct in supposing that this proposal is based on a basic misunderstanding of how patient care decisions are made in a hospital setting. We would not be able to give this proposed notice until the doctor wrote the discharge order, usually done on the day of discharge and often at the urging of a case manager who informs the doctor that the patient no longer meets inpatient criteria. This is a terrible Rule that will have multiple unintended consequences.

Thank you for the opportunity to comment. Alice Polley, Vice President for Clinical Services, 508-236-7157

Provisions of the Proposed Rule

Provisions of the Proposed Rule

The American Hospital Association has submitted a lengthy letter covering all the important issues. However, they have actually UNDERSTATED the burden this Rule would impose on hospital staff. CMS has estimated that it would take five (5) minutes to prepare and deliver the generic discharge notice. That is conservative in the absurd. Moreover, if a patient responded negatively to the alarmist language in the mandated letter, the subsequent letter that we would be required to write to the MassPRO (QIO) would require a physician or nurse to spend up to an hour pulling together the detailed and specific reasons why services are no longer reasonable or no longer covered by Medicare. While this letter is being composed, someone in Medical Records would have to copy the entire chart to send to the CIO. Finally, a Nurse Case Manager would need to give that letter to the patient, but only IF the patient is competent and able to understand it. Otherwise, the designated family member would need to be tracked down. There would also be the overnight FedEx expense to get the record to the QIO. If there is an appeal by the patient, it would add two (2) days to the stay unnecessarily while the CIO made its determination. Even if there is no appeal, one unnecessary day would be added to nearly every Medicare stay because of the way the discharge process actually works. Unfortunately, hospitals in Massachusetts cannot afford to do this. There are not enough beds here to allow the luxury of keeping patients in them when they could and should be treated at another level of care or discharged home. More patients are always waiting in the Emergency Department for an inpatient bed.

Submitter : Mrs. Crista Meadows

Date: 06/02/2006

Organization : Satilla Regional Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Recommend that CMS withdraw the proposal and retain the current requirements. If there specific discharge planning issues that need to be addressed, we recommend that CMS convene with a national workgroup comprised of hospital, physician, beneficiary, CMS, & QIO representatives to ensure the full understanding of how current and proposed revised procedures truly balance the hospital and program administrative costs with beneficiary rights. Recommend tht the current notices and procedures be retained until the need for revisions are clearly established and more workable, and less burdensome approaches are developed.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

the prosposed rule is unnecessarily burdensome because it is out of sync with standard discharge planning and physician discharge order patterns. Physicians not hospitals make discharge decisions. It is virtually impossible to know with certainty the discharge date on a day in advance. Requiring a notice the day before discharge would be increasing the length of stay of a patient in the hospital unnecessarily. The notice would likely encourage appeals and extended stays that are a matter of convenience for the patient and family, rather than on medical necessity

CMS-4105-P-2152-Attach-1.DOC

CMS-4105-P-2152-Attach-2.DOC

Satilla Regional Medical Center

June 2, 2006

To Whom It May Concern:

I am writing in response to the proposed rule CMS-4105-P, Medicare Program; Notification Procedures for Hospital Discharges. I am Department Manager of Case Management at Satilla Regional Medical Center in Waycross, Georgia.

As a Case Manager, I have been directly involved with discharge planning for our patients at Satilla Regional Medical Center for the past six years. Our current discharge planning practices begins at time of admission when patients are provided with the Important Notice from Medicare during patient registration. Next, the admission nurses assess the patient's current living situation and needed resources. In addition, case managers interview all patients meeting the hospital's high risk screening criteria: 70 & older and living alone, New CVA, new amputee, etc. Patients and their families are involved in discharge planning activities and are provided with choices of agencies for post acute services. Our process also includes ample opportunity for patients to change their minds, or disagree with the discharge process and request appeals to QIO.

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

In addition, a 'day's notice' also poses an unnecessary financial burden on the hospital. In our hospital the average LOS is 5 days. Since lengths of stay are short and patient's conditions can stabilize quickly, it becomes difficult to predict a discharge one day in advance.

I have read that CMS estimates only 1-2% of patients will request an expedited appeal. I'm concerned that this may be a gross underestimate as patients become more aware of how easy it is to continue their hospital stay.

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

Sincerely,

Crista Meadows, RN,BSN
Dept. Manager
Case Management/Satilla Regional Medical Center

Submitter :

Date: 06/02/2006

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-4105-P-2162-Attach-1.DOC

Attachment #216

Formatted: Right

St Luke's HOSPITAL & Health Network

801 Ostrum Street
Bethlehem, PA 18015

June 2, 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:

Thank you for the 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.

In response to a final rule promulgated under the Benefits, Improvements, and Protection Act (BIPA) for home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and hospices, HAP submitted a comment letter that outlined the burden and operational requirements associated with home health agencies providing advance written notice to Medicare Advantage enrollees and Medicare beneficiaries and detailed notices to Medicare beneficiaries when an expedited review is filed with the state's QIO. St. Luke's Hospital & Health Network is in complete agreement with these comments. It is evident in both this rule and those already promulgated for other service settings that there is a fundamental lack of understanding on how care is delivered in these settings. HAP's recommendation to CMS in correspondence was that CMS should consider implementing the same provisions currently used in hospitals in these other settings—namely to provide a notice at the time of admission for services similar to the "Important Message from Medicare" and to provide information regarding the right for an expedited review/determination to those Medicare beneficiaries who disagree with discharge from or termination of health care services.

We believe CMS has proposed an unworkable solution in its attempts to improve the hospital discharge planning process and that the proposed rule fundamentally ignores how care is delivered in hospitals. Hospitals do not differentiate care provided to patients based on financial class. To require a 24-hour notice only for Medicare patients requires these patients to be treated differently during the course of rendering care to all patients on a unit. This is in opposition to other existing federal regulations.

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 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.

Our greatest concern is that during times of high censuses and peak admission periods hospitals will be forced to be placed on divert status. Consequently there may not be enough acute care beds for patients who need them and patients may be harmed.

Based on these concerns we recommend the following:

- CMS should maintain its current requirements for hospitals and use a consistent approach for oversight and enforcement of these already existing requirements, including penalties for those facilities that fail to consistently comply with current law and regulation.

- 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, we further offer the following modifications to the proposed rule for consideration by CMS:

- For Medicare Advantage patients, we strongly recommend that it be the Medicare Advantage plans' responsibility for communicating information regarding non-coverage. Specifically, we think 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, we 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.

- We support HAP and DVHC's recommendation to eliminate 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, we 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.

We 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.

We 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. We fully support HAP and DVHC's strong recommendation that CMS retain the current requirements pending further discussion with key stakeholders.

Thank you for the opportunity to offer comments on this proposed rule, and for your consideration of our recommendations.

Sincerely,

Robert L. Wax, Esq.
Associate General Counsel

Submitter : Dougas L. Strong **Date:** 06/02/2006

Organization : University of Michigan Hospital & Health Centers

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-2172-Attach-1.DOC

Attachment #217

University of Michigan Health System

Douglas L. Strong
Interim Director & Chief Executive Officer
University of Michigan Hospitals & Health Centers
300 N. Ingalls
Ann Arbor, MI 48109-0474
(734) 764-1505
(734) 763-5311 fax
dougs@umich.edu

June 2, 2006

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

Comments on Notification Procedure for Hospital Discharges, Proposed Rule
File Code: **CMS-4105-P**

The University of Michigan Health System (UMHS) appreciates the opportunity to provide comments on the aforementioned proposed rule.

UMHS is deeply concerned about this proposal. We firmly believe that the proposal will reduce patient access, generate unnecessary inpatient days, produce burdensome compliance issues, increase hospital costs, and create losses in revenue. We also believe that the potential benefits to Medicare beneficiaries are relatively small and do not justify even a fraction of the very large costs to providers.

We strongly urge withdrawal of the proposed rule.

As requested by CMS, our comments are organized by the Proposed Rule sections – Background, Provisions of the Proposed Rule, and Regulatory Impact.

I. Background

CMS's 2003 decision to not require the two-step notification process for hospitals was the correct decision. It continues to be correct today.

In 2001, CMS proposed a rule establishing a two-step termination/discharge notice procedure for all Medicare beneficiaries in SNF, HHA, CORF, hospice and hospital facilities. In its 2003 Final Rule, CMS elected to exclude hospitals from the requirement. The reasons CMS gave for excluding hospitals remain true and valid today:

- Delivering information about appeal rights twice is an unnecessarily burdensome requirement on hospitals. (68 Fed. Reg. 16659)

Formatted: Right
Formatted Table
Formatted: Font: 8 pt
Formatted: Space Before: 3 pt
Formatted: Font: Arial, 7 pt
Formatted: Space Before: 3 pt
Formatted: Space Before: 3 pt
Formatted: Indent: Left: 3.13"
Deleted: June 2, 2006¶
Deleted:
Deleted:
Deleted:
Deleted:

Formatted: Right

- The current practice of delivering detailed notices of non-coverage to beneficiaries only when they express dissatisfaction with the termination is effective, as evidenced by similar rates of appeal between patients receiving one notice and those receiving two. (68 Fed. Reg. 16660)

The current CMS proposal does not eliminate the "unnecessarily burdensome" nature of the requirement, and CMS has provided no evidence to suggest the rates of dissatisfaction and appeal would differ today from its previous findings.

Deleted: ——Page Break——

II. Provisions of the Proposed Rule

The proposed rule will not be helpful to most hospital patients because most hospital stays are short.

Deleted:

It is important to recall that the current one-step notice procedure does not leave patients in hospitals without adequate appeal rights, or fewer rights than their counterparts in non-acute facilities. CMS regulations currently require hospitals to provide every Medicare inpatient with notice of their right to appeal upon admission, as part of the "Important Message from Medicare" document. Further, if a physician determines that discharge is appropriate and a patient objects to that decision, hospitals are required to provide them with a detailed notice (a HINN). This HINN provides full details on how to appeal the discharge, and notifies the patient that during the three days during which an expedited appeal is processed, s/he will have her/his hospital stay covered by Medicare. Essentially, the only potential benefits of the proposed pre-discharge notice are to remind patients of the appeal rights that they are already informed of at admission, and to allow one night to think about the physician decision to discharge.

Deleted:

Deleted:

Deleted:

Unlike patients in SNFs, CORFs, HHAs, and hospices, the vast majority of hospital patients do not enter the hospital with the prospect of receiving long-term care. The average length of a hospital stay is approximately five days. By contrast, the average length of stay in long-term care facilities is close to 50 days. Over the course of 50 days, beneficiaries may have forgotten, misplaced or lost the notice of appeal rights provided at the time of admission. A reminder of these rights in the form of a pre-termination notice is appropriate. This is not the case for most acute care hospital patients. We believe that notice provided to a patient less than a week, on average, before the decision to discharge is sufficient.

Deleted:

Deleted:

Deleted:

Deleted:

Deleted:

Deleted:

CMS has provided no data to suggest that beneficiaries do not adequately understand their rights, as enumerated in the "Important Message from Medicare," or that the lapse of time from admission to discharge is a factor in the patient's ability to understand these rights. However, if this is true for a segment of the Medicare inpatient population, consideration should be given to making the "Important Message from Medicare" clearer, and possibly requiring that it be reissued to patients again at discharge only if they have been in the hospital for longer than two weeks, or some other reasonable period. A modification to existing practice, such as this, could meet the CMS objective at a reasonable cost.

Deleted:

Deleted:

The proposed rule will be extremely burdensome and costly for hospitals.

We believe that CMS's estimates of the costs of implementing the proposed rule are significantly underestimated for several reasons.

Formatted: Right

- **Many patients will need to be kept in the hospital an additional day in order to comply.** Discharge decisions are made on a case-by-case basis, and for many patients these decisions are made on the day of discharge. Physicians' reliance on conditional logic in determining a patient's readiness for discharge prevents them from being able to identify many discharges in advance. The discharge decision is frequently dependent on lab test results, evaluation during morning rounds, or resolution of symptoms such as fever, pain or bleeding. Although some discharges can be predicted with reasonable accuracy (such as scheduled surgery), other patients have considerably less predictable outcomes (such as infectious disease). *Compliance with this rule will likely result in hospitals retaining patients for an extra day, beyond that medically necessary, so that 24 hours can elapse between providing notice of discharge and actual discharge.* We estimate that the discharge decision cannot be made by the physician until the date of discharge for 20% to 30% of our patients.

  Deleted:
  Deleted:
  Deleted:
  Deleted:

  In addition, the provision for expedited review (appeals) will result in many patients staying for 3 days longer than the physician believes is necessary. CMS estimates that 2% of the patients who receive the proposed notice will appeal. UMHS believes this to be an underestimate but, even if accurate, it means a significant increase in patient days to accommodate appeals.

  A rough estimate of the cost of extending inpatient stays is as follows: Assuming 60 million Medicare inpatient days per year, a 3% increase in average length of stay, and an average cost of $500 per day, the proposal will cost hospitals ***over $900 million annually.*** Based on our assessment, this is a conservative estimate.

  Deleted:
  Deleted:

- **If beds are occupied by Medicare patients who no longer need them, access to those beds will be denied to other patients who do need them.** This is clearly a significant burden on our mission of providing excellent tertiary medical care. Because we typically operate at or near full capacity, we calculate turning away approximately ***300 new admissions per year*** under the proposed rule. This is likely to cost UMHS alone as much as ***$3.5 million a year in lost revenue.*** In contrast, Medicare will make no additional payment for the extra days that beneficiaries are kept in the hospital.

  Deleted:

- **Actual notice will take more than the five minutes CMS estimates**. To comply with the proposal, someone at the hospital must prepare a notice, determine the patient's competency to understand it, arrange for a competent person to be present in case of patient incompetence, deliver the notice, explain why the notice is being delivered, explain the patient's right of appeal, explain the financial implications, obtain a signature from the patient, and store all the documentation. We believe that this will regularly exceed 20 minutes, far more than the five minutes CMS estimates. This increases the expected administrative cost from $31.2 million to ***over $120 million annually***.

- **The cost of developing a process to comply with the proposal will be enormous.** The amount of time needed to identify the population of patients planned for discharge the following day is significant. Physicians round at various times of day, receive results for labs and tests throughout the day and decision making can occur at any time. This rule anticipates there to be a simple way to collect this information. CMS has completely ignored the cost to develop and maintain a system that will allow hospitals to comply with the pre-discharge notice. We believe that the cost of designing the data collection process, developing a method of using the data to make the pre-discharge determinations,

  Deleted:
  Deleted:

Formatted: Right

affecting the necessary changes in physician and nursing behavior to comply with the proposal, and training our thousands of affected caregivers, is a tremendous undertaking and expense.

- **Staffing changes will need to be made which CMS failed to address**. It is not clear which staff level is best suited for such a diverse range of tasks (from filing papers to determining competency), and with the nursing shortage around the country, pushing such a burden to nurses is likely to compromise the quality of care.

Deleted:

- **Some patients will lose the opportunity to be transferred to an extended-care facility.** Last year, UMHS discharged over 1,400 Medicare patients to extended-care facilities. These beds are often in short supply and high demand. Inability to respond immediately to an opening risks the loss of the bed for our patient. If all patients must receive a notice one day in advance of discharge, we will be unable to immediately respond to these openings as they occur, further delaying discharge and increasing length of stay.

There is no value in having a "consistent approach" to communicating appeal rights across provider settings.

Although consistency is desirable *within* provider settings, there is no value in forcing a one-size-fits-all solution on diverse settings. Hospitals are fundamentally different than hospices, skilled nursing facilities, home health agencies, and outpatient rehabilitation facilities. Medicare beneficiaries are typically brought to hospitals for *acute medical concerns*, not long-term care; the services they receive are typically *advanced interventional care*, not health maintenance or rehabilitation. Patients expect, and need, different treatment in hospitals.

Consistency for the sake of consistency adds no value to the patient experience, and as explained above, has significant adverse effects on the quality of care provided, the opportunity to receive hospital care at all, and the cost of that care.

III. Regulatory Impact

The proposed rule will cost far in excess of CMS's estimates and will exceed the Unfunded Mandates Reform Act's threshold of $120 million annually. Thus a Regulatory Impact Analysis is required for the proposed rule.

A regulatory impact analysis (RIA) must be prepared for major rules. CMS believes this rule will not reach the economic threshold of $120 million or more per year and is thus exempt from this requirement. Unfortunately, CMS underestimated the costs associated with the delivery of the notices, and completely failed to consider the costs associated with a) increasing hospital length of stay, b) developing a program to comply with the proposal.

We believe that costs related to length of stay changes are the most significant. As noted above, UMHS believes that Medicare patient days could increase by at least 3% as a result of this provision, and a conservative estimate of the additional cost is over $900 million per year. Given the other considerations – process change, the additional time to deliver the notices and manage appeals, the indirect costs of less efficient patient care – we believe the ***true cost of this proposal will easily exceed $1 Billion per year.*** Not included in the figure is the intangible cost of reduced

Deleted:

Deleted:

Deleted:

Formatted: Right

access - as Medicare beneficiaries use valuable bed capacity for unnecessary care, other citizens in critical need of care will be denied or delayed.

A realistic calculation of the total costs associated with the proposed rule including length of stay impact, program development, compliance monitoring etc, would easily reach the economic threshold for a major rule requiring a regulatory impact analysis.

Formatted: Keep with next

Deleted: ¶
¶
¶

Summary

The proposed rule will cause significant increases in cost, reduced access to care, and burdensome compliance issues, with relatively little benefit to Medicare beneficiaries. We believe patient's rights are sufficiently protected with the delivery of the "Important Message from Medicare" provided at the time of admission and question the need and usefulness of another notice. If there are shortcomings with the existing admission notice, the best course is to correct the deficiencies and not add another layer of administrative burden, especially when the new layer has the potential for such an enormous negative impact on access, quality and efficiency.

We trust that after serious consideration of the ramifications of this change the appropriate conclusion will be reached and the proposal will be withdrawn.

We appreciate your attention to these comments and would be pleased to provide any additional clarifications or information at your request.

Sincerely,

QuickTime™ and a
TIFF (LZW) decompressor
are needed to see this picture.

Deleted: ¶
¶
Douglas L. Strong¶

Interim Director & Chief Executive Officer
University of Michigan Hospitals & Health Centers

Associate Vice President for Health System Finance & Strategy
University of Michigan Health System

Submitter : **Mrs. Lorrie Jones-Hartley** **Date: 06/02/2006**

Organization : **Durham Regional Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-4105-P-2182-Attach-1.DOC

DUKE UNIVERSITY HOSPITAL
DUKE UNIVERSITY HEALTH SYSTEM

Attachment #218

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:

Durham Regional Hospital 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.

Durham Regional Hospital 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, Durham Regional Hospital 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. 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. 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.

Durham Regional Hospital 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. **Durham 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.**

Durham Regional Hospital appreciates the opportunity to comment on this proposed rule. To discuss any questions or reactions to our comments, please contact Lorrie Jones Hartley, Director of Care Management at 919-470-8494 or lorrie.jones-hartley@duke.edu.

Sincerely,

Lorrie Jones-Hartley, MSN, CRRN-A
Director, Care Management
Durham Regional Hospital
Duke University Health Systems

cc: 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

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

Submitter : Mrs. Linda Van Allen **Date:** 06/02/2006

Organization : Sutter Health Sacramento Sierra Region

Category : Hospital

Issue Areas/Comments

Background

Background

C. Notifying Beneficiaries and Enrollees of Discharge From Inpatient Hospital Level of Care (405.1205 and 422.620)

Comments on the economical impact estimated at $5200 per provider:
This is new work. Per above comments, letter preparation and delivery will take at best 15 minutes per discharge. Using the calculations given, each notice would cost $7.50. That is a total of $225,000 ($45,000 per hospital) per year for the CMS patients served by Sutter hospitals in the Sacramento Sierra Region. At 15 minutes per notice, the national impact is still under the $100 million threshold, while providing a more accurate assessment of the cost to providers.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Comments on the requirement that the notice be given the day before discharge:
This assumes that the hospital knows the day the patient will go home. Home health and skilled nursing care runs a longer more defined course. Hospital stays are much shorter and dynamic. While there is a plan of care in place, many factors can disrupt the plan of care including changes in the patient condition and availability of the next level of care. The reality is that many of these patients are discharged to home health or skilled nursing facilities and there are many factors involved in the timing of patient acceptance and transfer. Additionally the patient s health condition can improve or worsen unexpectedly.

Comments on whether there are exceptional circumstances under which a hospital should be able to deliver the standardized notice on the day of discharge:
' Length of stay at or below four days
' Elective hospitalizations because the anticipated length of stay is communicated to patients prior to admission
Section 405.1205 Notifying Beneficiaries of Discharge From Inpatient Hospital Level of Care

Comments on the estimation that it would take hospitals 5 minutes to deliver each notice:
The 5-minute time frame is based on the standardized format and that the notice would be disseminated during the normal course of related business activities. The factors that may have been overlooked include:
' The standardized format requires the hospital to enter patient specific information for each notice including appropriate patient demographic information, the date coverage ends, and the date the patient s financial liability begins. The document preparation and print out alone will take 5 minutes.
' The standardized format requires patient signature. This is not a 5-minute process for this patient population. I recommend you test this assumption with time studies. The signature process alone will require 10 15 minutes per patient to explain the form, explain they are not losing their coverage and allow them time to read, ask questions and sign.
' The normal course of business activities does not include a visit from business services the day prior to discharge. And case management does not see all patients the day prior to discharge because not all patients have discharge planning needs. Who is delivering this notice in the normal course of business? The unit nursing staff? Staff nurses provide patient care, they do not deny care or apply benefits.

Regulatory Impact

Regulatory Impact

C. Notifying Beneficiaries and Enrollees of Discharge From Inpatient Hospital Level of Care (405.1205 and 422.620)

Comments on the economical impact estimated at $5200 per provider:
This is new work. Per comments below, letter preparation and delivery will take at best 15 minutes per discharge. Using the calculations given, each notice would cost $7.50. That is a total of $225,000 ($45,000 per hospital) per year for the CMS patients served by Sutter hospitals in the Sacramento Sierra Region. At 15 minutes per notice, the national impact is still under the $100 million threshold, while providing a more accurate assessment of the cost to providers.

Submitter : **Ms. Jennifer Warren** **Date: 06/02/2006**

Organization : **Purcell Municipal Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED LETTER

CMS-4105-P-2202-Attach-1.DOC

June 2, 2006

Purcell Municipal Hospital
P.O. Box 511
Purcell, OK 73080

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 Purcell Municipal Hospital in Purcell, 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 860 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 $860,000.*
    - *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 860 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 $860,000 per year.

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

Purcell Municipal 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.

Purcell Municipal 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 (405)527-6524 x228 or jdwarren@purcellhospital.com.

Sincerely,

Jennifer Warren

Purcell Municipal Hospital
Jennifer Warren, CFO

Submitter : Sue Englert **Date:** 06/02/2006

Organization : Community Medical Center

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

As the Manager of the Care Management Services Department at Community Medical Center in Missoula Montana, I strongly oppose the proposed procedures for hospital discharges as described in the April 2006 Federal Register notification.

The proposed unfunded Medicare rule requiring healthcare providers to give patients written notice of their impending discharge at least a day ahead of time will result in an increased length of stay for patients and add additional tasks to an already an overburdened system of care.
CMS is grossly underestimating the time and effort which translates into money required for hospitals to comply with the rule as written.

This proposed rule is adding more bureaucracy to an already complicated and confusing discharge process for a population, generally over age 65, who need our assistance and guidance. Many Medicare patients will be confused by the extra paperwork handed to them at discharge. Confusion will necessitate that additional staff time will be required to explain the paperwork.

Community Medical Center involves patients in the discharge planning process. There are many factors that could disrupt the discharge plan, including changes in the patient's condition and the availability of services at the next level of care. Predicting the exact time of discharge in order to issue a discharge notice will be problematic. Adding the additional 24 hours for notification when the patients do not need it will extend the length of stay past the DRG and the hospital will not get paid.

In summary, the proposed rule has missed the mark. While patients need to be informed of their rights to appeal discharge decisions, notices should be given upon admission or printed in the Medicare Handbook for reference. Hospitals are focused on providing patient centered care and make decisions based on the patients conditions, and wishes. Adding an additional layer of bureaucracy and paperwork will compromise the complex discharge planning process, extend length of stay, and become very costly for medical care that is already operating on slim margins.

Submitter : Amy Heydlauff **Date:** 06/02/2006

Organization : Chelsea Community Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached document.

CMS-4105-P-2222-Attach-1.DOC

CMS-4105-P-2222-Attach-2.DOC

RE: Notification Procedures for Hospital Discharges
[Federal Register: April 5, 2006 (Volume 71, Number 665)]
[Proposed Rules]
[Pages 17052-17062]

Attachment #222

CMS-4105-P
"PROVISION OF THE PROPOSED RULE"

Page 17054 the proposed rule states:

> *"Our proposal to require a two-step notice process is **intended only to** provide hospital inpatients with the same two-step notice of appeal rights afforded to beneficiaries in other settings."*

The intent of this proposal, as stated, is not sound.

- This proposal provides no evidence Medicare HHA, SNF, COFR and hospice patients, CMS or providers benefited from a two-step notice process.
- This proposal provides no evidence the proposed two-step process will benefit hospital inpatients, CMS or hospitals. This is a concern because of the negative impact it will have on patients and hospitals.

We would argue, based on our experience discussing like matters with Medicare patients, the Medicare population is generally confused by issuance of multiple documents describing the same rights. This confusion adds to the stress many feel because of their illness and the upcoming transition to a lower level of care, including home. Instead of benefiting your beneficiaries (our patients), this proposal is likely to cause consternation. At a time when patients and families need reassurance and support the issuance of the 'standard notice' may lead to an undermining of the patient's belief in the physician's concern for the patient.

RE: Notification Procedures for Hospital Discharges
[Federal Register: April 5, 2006 (Volume 71, Number 665)]
[Proposed Rules]
[Pages 17052-17062]

On page 17054 the proposed rule states:

> *"Given the greater volatility of hospital discharge patterns, we propose..."*

We appreciate CMS's recognition that inpatient discharge patterns are volatile.

In the Medicare population discharge patterns are especially unpredictable because:

- Discharge is often dependent on specific outcomes that can't be precisely predicted, especially in the elderly (resolution of an ileus, response to an antibiotic or diuresis, improvement of an abnormal lab value...)
- Older adults often have multiple co-morbidities. Resolution may depend on stabilizing a secondary diagnosis as well as the primary diagnosis
- Additional or new clinical concerns often surface after a discharge plan is in place. Will this revision require re-issuance of the standardized notice when the patient's condition changes and discharge is delayed?
- Safe discharge may depend on family and community resources with shifting availability. Frequently a bed in an ECF or SNF is unavailable, than suddenly a bed becomes available. This proposed change would legally require a hospital to pass on an ECF or SNF bed, available right now, because the hospital hadn't issued a 'largely generic', standardized notice that mimics information provided on the day of admission.

We are concerned about the redundancy of the two-step process in an inpatient level of care with a generally shorter length of stay than home health, skilled nursing, or hospice. Hospitalization occurs over days, not weeks or months.

Although this proposal estimates the cost of the two-step process ($2.50 per notice according to "REGULATORY IMPACT") the proposal does not consider the cost of extending a length of stay by one or more days each time a hospital is unable to accurately predict the discharge date. Realistically, hospitals will not predict 100% of discharges the day before they occur due to the range of human responses to illness and treatment. Many extra days of care is a more significant cost than $2.50 per notice.

Predictably longer median lengths of stay without increased reimbursement will impact financial wellbeing. Quality outcome reporting, public reporting, and perhaps pay-for-performance reimbursement will also be impacted.

RE: Notification Procedures for Hospital Discharges
[Federal Register: April 5, 2006 (Volume 71, Number 665)]
[Proposed Rules]
[Pages 17052-17062]

Chelsea Community Hospital's recommendations for CMS-4105-P:

We suggest the *Important Notice from Medicare* be revised to assist patients to obtain a clear understanding of their rights. The revision might include a highlighted, bolded section explaining discharge appeal rights. This highlighted section would include a line for the patient or the patient's representative to initial signifying an understanding of their rights. CMS may require a hospital representative to verbally review the information with the patient or the patient's representative before the patient or representative initials the Notice.

Other possible approaches may include:

- **An additional line in the Important Notice from Medicare providing a patient or the patient's representative with the name and contact information for a patient advocate within the hospital with whom the patient could discuss his or her rights**
- **A statement on the written discharge instructions stating the patient understands his or her appeal rights. The statement may be followed by a signature line.**

Respectfully Submitted
Chelsea Community Hospital

CC: Michigan Peer Review Organization
Michigan Hospital Association

Submitter : Mr. David Buckley **Date:** 06/02/2006

Organization : St. John Health

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. David Buckley **Date:** 06/02/2006

Organization : St. John Health

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-4105-P-2242-Attach-1.DOC

Attachment #224

June 2, 2006

COMMENTS SENT VIA Rulemaking

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:

On behalf of its eight member hospitals located in Southeast Michigan, St. John Health (SJH) appreciates this 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 also made with the patient's physician, frequently during morning rounds, SJH 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, SJH 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. SJH 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, SJH 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.

SJH 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 clear. 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 hospitals 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. For SJH, there are almost 48,000 Medicare inpatient discharges annually.

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 SJH 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 while resulting in bed shortages for hospitals with high occupancy levels. 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, SJH believes it is inappropriate in for the CMS to require a discharge notice 24 hours prior to discharge. 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

SJH 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 differ 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, the hospital would be required to deliver both the IMM and the standardized discharge at admission. SJH believes this would 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 SJH hospital's kept 10 percent of our 48,000 Medicare cases patients an additional day and 2 percent of Medicare patients an additional 3 days due to appeals, the hospital would experience an increase in length of stay of 7,680 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.

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

- impact of increasing hospital length of stay which will have a negative financial impact for hospitals and will result in bed shortage issues for SJH hospitals. This is especially true for SJH's three largest hospitals. St. John Hospital & Medical Center located in Detroit, Michigan, St. John Macomb Hospital located in Warren, Michigan, and Providence Hospital located in Southfield, Michigan.
- 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
- confusion it will cause for Medicare beneficiaries, which will lead to decreased patient satisfaction
- proposal is inconsistent with the CMS' desired movement to electronic health records

If the CMS is concerned about providing patients with a discharge notice, **SJH suggests 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.

In addition, SJH **believes it would be helpful if the CMS formed a workgroup, including beneficiaries, to provide input regarding the proposed discharge notice.**

Again, the SJH 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 via e-mail at david.buckley@stjohn.org.

Sincerely,

David R. Buckley

David R. Buckley
Corporate Director of Reimbursement
St. John Health

Submitter : **Ms. Kathy Poling** **Date: 06/02/2006**

Organization : **William Beaumont Hospital- Troy**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.