American Hospital Association

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Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-4105-P
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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 the Centers for Medicare & Medicaid Services (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 hardcopy 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.**

The AHA appreciates the opportunity to comment on this proposed rule. We look forward to working with CMS. To discuss any questions or reactions to our comments, please contact me or Ellen Pryga, director of policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

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