American Hospital Association

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March 6, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

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

Dear Ms. Norwalk:

The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed revision of the "Important Message from Medicare" (IM) and its related paperwork requirements as submitted to the Office of Management and Budget. This revision seeks to implement the revised regulations on notification of Medicare beneficiaries regarding their hospital discharge appeal rights, which were published on November 27, 2006 in the *Federal Register*.

AHA appreciates the extent to which CMS responded to many of the practical problems identified in our comments on the proposed rule. While the final regulation is much more workable, it still represents a significant increase in burden on hospitals. Our comments on the proposed notice package now focus on how to minimize that burden, where possible, and resolve open questions regarding the notice and appeal process.

MINIMIZING ADMINISTRATIVE BURDEN FOR HOSPITALS

Currently, hospitals provide the IM to beneficiaries when they are admitted to the hospital, generally in the patient's admission package. The IM explains a beneficiary's right to have their discharge decision reviewed by the local Quality Improvement Organization (QIO) if they believe they are being discharged too soon. The notice provides all the information needed by a beneficiary to request such an appeal and explains that they will not be held financially liable for continued hospital care while the QIO reviews their case. A more detailed notice with specific reasons why hospital care is no longer required is provided when beneficiaries indicate that they are not comfortable with the planned discharge date.

Under the new regulations, which take effect on July 1, the IM will be provided to beneficiaries no later than two days following admission, but hospital staff must ensure that the beneficiary understands the notice and signs a copy of it documenting when he or she received it and that they understand it. A copy of the signed notice will be given to him or her at that time. The hospital must then provide another copy of the signed notice no more than two days prior to discharge. Detailed information about a particular discharge will be required only when a beneficiary requests a QIO review. We believe that focusing the process and beneficiary questions on the front-end of the admission will help form more realistic beneficiary expectations about hospital admissions and improve their understanding of how decisions are made and how the discharge planning process works. However, it comes at a heavy price.

Even with the conservative burden estimate included in the paperwork clearance package, CMS projects that the burden will increase from 208,333 hours to 2,990,000 hours – a more than fourteen-fold increase. And, while the former notice was provided by admissions clerks, the new process requires someone with the ability to explain medical necessity and the discharge planning process – generally a nurse case manager or social worker – to present the paperwork. The national average hourly wage for clerks is about $12.50, while the average hourly wage for nurses and social workers is about $24.00 – $28.00. Conservatively, that takes the cost from about $2.6 million to between $71.8 and $83.7 million.

Even though it might require some minor adjustments to the final rule, ***AHA urges CMS to take the following actions to minimize the administrative burden of this new notice and process:***

- ***Eliminate the requirement that the repeat notice at discharge be a copy of the notice signed at admission.*** Since beneficiaries would receive a copy of the signed notice when they sign it, it would be simpler and less burdensome to allow hospitals to provide just the generic notice language at discharge. We have heard from some hospitals that it would be significantly more efficient to simply print the notice as part of their discharge instruction package.

- ***After the first year of implementing this new process, perform an evaluation of whether the new process has yielded sufficient benefit to warrant this significant increase in administrative costs.*** Too often, administrative requirements are adopted to address anticipated or perceived problems. That has already happened once with this requirement. It was adopted by statute when the inpatient prospective payment system was enacted and there were widespread fears of "quicker, sicker" discharges. Those fears were not realized. There also was an earlier requirement for beneficiaries to sign for receipt of the notice; that too was found to be unnecessary and subsequently eliminated.

- ***Provide significant latitude to hospitals in how they provide the notice to beneficiary representatives if the beneficiary is unable to receive or understand the notice.*** This issue was raised during comment on the proposed rule, and the preamble discussion of the final rule indicated that CMS planned to provide guidance regarding how hospitals and health plans may deliver the appropriate notice in cases where a beneficiary's representative may not be immediately available. Such guidance was not included in the instructions for the notice. We urge CMS to allow hospitals to use any means of communication (telephone, fax, email, etc.) necessary to conduct the notice process with beneficiary representatives and allow record notations when these alternatives to in-person notice are used.

- ***Provide on CMS' Web site the text of the notice translated into the top 15 languages hospitals frequently encounter.*** Almost one-fifth of the U.S. population speaks a language other than English at home. Hospitals are required to provide language services for such individuals, but they do not receive compensation for the cost of those services. The size of this population and the vast number of languages now being encountered make it very difficult for individual hospitals to provide translated documents. Since the text of this notice cannot be altered by the hospital, CMS should obtain and provide translations of the key beneficiary notices. The Social Security Administration has a list of 15 languages that it uses for such purposes. Last year, the AHA's research affiliate, the Health Research and Educational Trust, conducted a survey of hospital language services which found 15 languages that at least 20 percent of hospitals encounter frequently. They are: Spanish; Chinese; Vietnamese; Japanese; Korean; Russian; German; French; Arabic; Italian; Laotian; Hindi; Polish; Tagalog; and Thai.

NEEDED CLARIFICATIONS

There are several clarifications that would be helpful in the notice and instructions.

- ***Clarify on the first page of the notice that beneficiaries have the right to receive "medically necessary" hospital services covered by Medicare.*** Beneficiaries need to understand that the standard is medical necessity, not what they think is needed.

- ***Issue instructions to the QIOs regarding their required availability 24/7 to deal with beneficiary appeals.*** The current QIO manual indicates that QIOs are not required to be available 24 hours a day, only during normal business hours. They are required to have an answering machine to take messages, but they are not required to pick up or return messages until the next business day. Page 2 of the notice is inconsistent with the QIO manual.

- ***Reconcile the notice form and the instructions for completing the notice for Medicare Advantage plan enrollees.*** Hospitals are told to fill in the name and telephone number of the Medicare Advantage plan for enrolled beneficiaries, but there is no place on the form to do so.

If you have questions about our comments, please contact me or Ellen Pryga, AHA director for policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

cc: Bonnie L. Harkless