American Hospital Association

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May 2, 2007

Ms. Carolyn Lovett
OMB Desk Officer
OMB Human Resources and Housing Branch
New Executive Office Building, Room 10235
Washington, DC 20503

Re: CMS-R-193 (OMB#: 0938-0692) Proposed Revision of Important Message from Medicare and Related Paperwork Requirements (Vol. 72, No. 66), April 6, 2007

Dear Ms. Lovett:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the 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, which were submitted to the Office of Management and Budget (OMB). The proposed new IM would implement the revised regulations requiring hospitals to notify Medicare beneficiaries about their hospital discharge appeal rights, which were published in the November 27, 2006 *Federal Register*.

The 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 more workable, it still would pose a significant burden on hospitals that may counter any additional benefit that beneficiaries might accrue. We are concerned that CMS will be unable to provide hospitals with the final notice language and instructions with sufficient time for hospitals to effectively implement the new requirements by the regulation's July 1 implementation date.

ADMINISTRATIVE BURDEN FOR HOSPITALS

Currently, hospitals generally provide the IM to beneficiaries in their admissions package. The IM explains beneficiaries' rights to have their discharge decisions reviewed by the local Quality Improvement Organization (QIO) if they believe they are being discharged too soon. The notice provides all of the information beneficiaries need to request an appeal and explains that they will not be held financially liable for continued hospital care while the QIO reviews their case.

Hospitals provide a more detailed notice with specific reasons explaining why hospital care is no longer required when beneficiaries indicate that they are uncomfortable with their planned discharge date.

Under the new regulations, hospitals must provide the IM to beneficiaries no later than two days following admission. Hospital staff must ensure that beneficiaries understand the notice and sign a copy of it documenting when they received it and that they understand it. Then, hospital staff must give the beneficiaries a copy of the signed notice, as well as another copy of the signed notice no more than two days prior to discharge. Hospital staff will be required to give a detailed notice with information about a particular discharge only when a beneficiary requests a QIO review. We believe that focusing the process and beneficiary questions at the beginning 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 annual burden will increase from 208,333 hours to 3,250,000 hours – a more than fifteen-fold increase. And, while admissions clerks provided the former notice to beneficiaries, the new process requires someone with the expertise to explain medical necessity and the discharge planning process – generally a nurse case manager or social worker. The national average hourly wage for clerks is about $12.50, while the average hourly wage for nurses and social workers ranges from $24.00-$28.00. Conservatively, that takes the personnel cost from about $2.6 million to between $78 and $91 million. In addition, hospitals will need to print three-part automatic copy forms for about 13 million admissions per year and train staff in the new requirements, resulting in total costs that will easily surpass $100 million per year. Furthermore, it is unclear whether this new requirement is going to yield sufficient benefit to Medicare beneficiaries to warrant the significant cost and burden increase to hospitals. **Therefore, the AHA recommends that OMB conditionally approve the new form and process and require that CMS perform an evaluation *after* the first year to determine whether the new process has yielded sufficient benefit to warrant this significant increase in administrative costs.**

Far too often, administrative requirements are adopted to address anticipated or perceived problems. For example, Congress enacted discharge rights requirements when the inpatient prospective payment system (PPS) was enacted in response to widespread fears that hospitals would discharge patients prematurely due to the incentives of the PPS to shorten lengths of stay. Those fears of "quicker, sicker" discharges were not realized. Also, an earlier requirement for beneficiaries to sign for receipt of the notice was found to be unnecessary and subsequently eliminated. In short, too many health care dollars are being devoted to administrative and paperwork requirements. Escalating health care costs and the rapid expansion of the Medicare beneficiary population underscore that our country needs more of its health care dollars devoted to bed-side care – not paperwork.

TIMING OF IMPLEMENTATION

It is our understanding from CMS staff that under the best-case scenario, the OMB-approved

notice and instructions would not be available to hospitals until late May or early June. With the July 1 effective date of the regulations approaching, we are concerned that hospitals will have insufficient time to print the new notices, prepare written internal policies and instructions and train staff prior to July 1. If even less time is available, we believe they will be unable to meet the July 1 date. And, if the approved notice and instructions are not available by July 1, we do not know what instructions to give our members, since they cannot use a notice that OMB has not approved. **Consequently, the AHA urges OMB to give hospitals a minimum of 60 days before they are required to implement the new requirements.**

ISSUES REQUIRING CLARIFICATION PRIOR TO IMPLEMENTATION

As the AHA and state hospital associations have worked with hospitals on pre-implementation planning, we realized that the list of issues needing clarification has grown from those identified in our March 6 letter to CMS. **The AHA recommends that OMB require CMS to address the following issues and clarifications in its instructions prior to releasing and implementing the new notice:**

- **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.** The AHA and others raised this issue during the comment period 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 notice in cases where a beneficiary's representative may not be immediately available. However, CMS failed to include such guidance in the instructions for the first draft revised notice offered for comment on January 5 or in the second revised instructions submitted to OMB. In March, we urged CMS to allow hospitals any means of communication necessary to conduct the notice process with beneficiary representatives (telephone, fax, email, etc.) and allow record notations when using these alternatives to in-person notice. Conversations with CMS staff suggest that hospitals that follow their usual protocols in dealing with patient representatives on official documents and forms that must be signed will be in compliance as long as they document their methods. We urge OMB to ensure that CMS clarifies this issue in the final instructions.

- **Provide some flexibility on the timing of the first notice to accommodate late Friday and Saturday admissions.** Hospitals participating in a recent teleconference on implementation issues expressed concern that they would be unable to provide notices to patients admitted on weekends when hospital case managers and discharge planners do not work. Although they are on call for immediate problems, it would be impractical to call them in to explain the initial notice. In discussing ways to address the problem, two options emerged. One is to allow scripted registration staff to provide the initial notice and answer typical questions. In cases where the questions require discussion with a case manager or discharge planner, CMS could allow for follow up in the early part of the next work week. Another option is to simply provide an extra day to provide the initial notice. For example, two days is insufficient for a Friday afternoon or evening admission because the second day after admission is Sunday. In the case of Saturday admissions, the second day after admission would be Monday, making workflow nearly impossible as workers are catching up with weekend activity and new admissions.

- **Provide some flexibility for designating the attending physician for emergency admissions.** For emergency admissions, many hospitals are planning to provide and discuss the notice when they get beneficiaries' consents for treatment. However, the name of the attending physician is often not known at that time, and the form requires the name of the attending physician to be inserted following the patient's name and ID number. We see two options for solving this problem: 1) allow designation of the attending physician on the form after its receipt and signature for emergency admissions, or 2) omit the designation of the attending physician on the form.

- **Allow provision and explanation of the initial notice during pre-admission testing and registration.** Many of our hospitals would like to incorporate the initial notice into the pre-admission process for elective admissions when beneficiaries are focused on the registration process. This suggestion would clearly help beneficiaries, but it is unclear whether the regulations would allow it.

- **Provide on CMS' Web site the text of the notice translated into the 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 patients with limited English proficiency, but they do not receive compensation for the cost of those services. The size of this population and the vast number of languages that hospital staff encounter 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. 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 that identified 15 languages that at least 20 percent of hospitals encounter frequently: Spanish; Chinese; Vietnamese; Japanese; Korean; Russian; German; French; Arabic; Italian; Laotian; Hindi; Polish; Tagalog; and Thai.

In conclusion, this new process adds significant time and cost for hospitals. The clarifications we have requested are essential for hospitals to be able to effectively implement the new rules and notices.

If you have any questions concerning our comments, please feel free to 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 Harkless (CMS)