MAY, 1986

CONTROL #P09-86-00051

MEDICARE

PATIENT DENIAL NOTICES

HOW PATIENTS ARE NOTIFIED ABOUT TERMINATION OF A HOSPITAL STAY

June 12, 1985

Mr. Bert Smith
3 Payne Boulevard
Evanston, Proland 00001

Dear Mr. Smith:

The Nowhere General Hospital has reviewed the medical services you have received for the treatment of the ulcerations of your left leg from June 1, 1985 through June 11, 1985. Your attending physician has been advised that beginning June 13, 1985 further treatment of the ulcerations of your left leg could be safely rendered in another setting. You should discuss with your attending physician other arrangements for any further health care you may require.

You will not be responsible for payment of the services which are rendered by this hospital from June 13, 1985 through June 14, 1985 except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. If you decide to stay in the hospital, you will be responsible for payment...

Office of the Inspector General

The mission of the Office of the Inspector General (OIG) is to promote the efficiency, effectiveness and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent fraud, waste and abuse. Created by statute in 1976, the Inspector General keeps both the Secretary and the Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations and inspections with approximately 1,200 staff strategically located around the country.

Office of Analysis and Inspections

This report is produced by the Office of Analysis and Inspections (OAI), one of the three major offices within the OIG. The other two are the Office of Audit and the Office of Investigations. OAI conducts inspections which are typically, short-term studies designed to determine program effectiveness, efficiency and vulnerability to fraud or abuse.

This Report

Entitled "Medicare Patient Denial Notices" this report was prepared to determine the extent to which inappropriate denial notices were being issued to hospitalized patients, to analyze impact of this problem and to identify corrective actions.

The study was prepared by the Regional Inspector General, Office of Analysis and Inspections, Region IX. Participating in this project were the following people:

San Francisco Region

Thomas A. Purvis (Project Leader)
Rita M. Lutticken

Headquarters Office

Penni St. Hilaire

TABLE OF CONTENTS

MAJOR FINDINGS

° BENEFICIARIES ARE ADVERSELY AFFECTED BY CURRENT DENIAL NOTICE PROCEDURES

- They are frequently confused and upset by receipt of denial notices.
- Informal discussion, not formal denial notice, is the usual prelude to premature discharge.
- Many complaints concern inadequate discharge planning and follow-up care.
- They do not challenge "authority figure" decisions made by physicians or hospital officials; they are not aware they have the right to do so.

° PRO REVIEW IS NOT COMPLETE

- PROs conduct reviews which are not adequately targeted on patient discharge or discharge planning.
- PROs feel that the newly-issued HCFA instructions concerning review of notices are adequate for content, but do not help them identify premature discharge cases.

° CONSUMER ORGANIZATIONS URGE STRONGER ROLE, MORE EDUCATION

- There is a major lack of quality educational materials about PPS coverage. Beneficiaries and sophisticated providers alike indicate a high level of misconception.
- Consumer representatives have the potential for more active roles on Peer Review Organizations boards.

° HOSPITAL NOTICES LACK ADEQUATE SAFEGUARDS

- Hospitals are taking corrective action to reduce the incidence of inappropriate written denial notices but
  - -- Until recently, frequently issued notices that contained incorrect or misleading information and
  - -- Are still routinely discharging patients without informing them of their rights.

INTRODUCTION

BACKGROUND

Most Medicare patients are routinely discharged from the hospital when their physician decides that they no longer need acute care. The physician conveys this decision verbally to the patient and the patient leaves, usually the next day. For such routine discharges, no formal written notification is given. Sometimes, however, a patient or a patient's family indicates a desire to stay in the hospital beyond the time that acute care is deemed necessary. In such cases the hospital itself, acting though its utilization review (UR) committee, can decide to terminate an acute care stay. When the hospital decides to discharge the patient, the hospital is required to issue a written notice to the patient. This is called a "denial notice." The attending physician may or may not concur in the hospital's decision to issue a denial notice. Only a small percentage of patients, however, receive formal, written denial notices.

The provisions for issuing denial notices are outlined in the PPS regulations. These regulations contain a number of procedural safeguards and appeals. The content of the notice must spell out these safeguards by specifically informing the beneficiary that

1) It is the hospital's determination with the concurrence of the attending physician or the Peer Review Organization (PRO) that the beneficiary no longer requires inpatient hospital care;

2) The patient will be liable for the hospital's customary charges for continued stay, beginning with the third day after receipt of the notice;

3) If the patient remains in the hospital after he/she becomes liable, the PRO will make a formal determination of the medical necessity and appropriateness of the hospitalization;

4) This formal determination is subject to a reconsideration by the PRO at the request of the patient, hospital or attending physician; and

5) Any monies for continued stay collected by the hospital will be refunded by the hospital, if a finding is subsequently made that the patient did require continued inpatient hospital care.

In cases where the attending physician concurs with the hospital that continued acute care is not necessary, the hospital may issue the notice directly. If the attending physician disagrees with the hospital's discharge decision, the hospital must obtain the approval of its decision from the PRO. The notice therefore must indicate that the PRO has reviewed the case and agrees with the decision of the hospital. In the case where the patient actually stays in the hospital after receipt of the notice, PRO review is mandatory. The PRO reviews at least a 10 percent sample of cases where the patient had received the notice and left before incurring charges. Corrective action must be initiated for all

cases where a PRO determines that notices have been issued inappropriately. These actions include education, intensified review, and sanctions.

In addition to the medical review of a hospital's decision to issue a denial notice, the PROs also must review the content of this notice. Under the requirements of HCFA Transmittal IM 85-3 issued in May 1985, PROs must insure that the notice is (1) in conformity with PPS regulatory requirements and (2) does not contain statements which allege that the decision to discharge the patient was made by a party other than the hospital or that the number of days "allowed" by Medicare for a certain DRG category is fixed. The PROs secure samples of model denial notices from all hospitals in their area and review them for conformity to the requirements. The PROs not only provide detailed comments to the hospitals concerning irregularities in the notices, but also monitor them to insure that correction of the notices is implemented. After the initial review of all notices issued by all hospitals, the PROs must initiate an ongoing process for reviewing a monthly random sample of notices. These reviews are currently underway.

PURPOSE AND APPROACH

The purpose of this inspection is to determine (1) the extent of the problem related to hospitals issuing inappropriate or improper denial of coverage notices to Medicare beneficiaries; (2) the impact of improper denials on beneficiaries and the extent to which they contribute to premature patient discharge; (3) the role played by hospitals and by physicians in issuing formal or informal denial notices; (4) whether recent HCFA instructions and subsequent PRO reviews of notices are bringing about adequate corrective action; and (5) the role of consumer groups and senior citizen organizations in beneficiary education and advocacy.

Representatives of 48 PROs were contacted, either in person or by telephone. In addition, a number of interviews were conducted with hospital staffs and associations, beneficiary advocate groups, providers of services to senior citizens as well as with individual beneficiaries. Field work for this inspection was done during the period of August to October 1985.

This inspection is closely tied into the inspection of premature patient discharge now being carried out by the Office of Analysis and Inspections, Region V.

FINDINGS

1. Until Recently Inappropriate Patient Denial Notices Were Common

The PROs reported that prior to the May 1985 issuance of HCFA review and corrective action instructions, hospitals did not use a common format for issuing patient denial notices. Failure to conform to the PPS regulatory requirements was widespread. Some of the more common deficiencies were:

a) Indicating that Medicare restricts the number of days a patient can stay in the hospital;

b) Indicating that Medicare or the PRO, rather than the hospital itself, determines when a patient can be discharged from acute care;

c) Failing to properly notify patients of their appeal rights or to furnish the patient with the name and phone number of the PRO so that an appeal could be made if necessary;

d) Failing to include the actual date the patient becomes liable for inpatient charges (starting the third day after patient receipt of the notice); and

e) Failing to include a statement that any monies collected by the hospital will be refunded if a finding is subsequently made that the patient required continued inpatient care.

Neither HCFA nor the PROs, however, conducted a systematic survey to actually measure the extent of the problem or provide a breakdown of the specific kinds of deficiencies that existed prior to May 1985. However the majority of PROs contacted during this inspection were aware that problems relating to the issuance of formal patient denial letters did indeed exist. Seven of the PROs, in fact, described it as a major problem, while only nine stated that it was not a problem at all.

2. Hospitals are Taking Corrective Action

In May 1985 HCFA issued instruction IM 85-3 "PRO Monitoring of Hospital Notices for Denial of Continued Stay." This instruction set out steps for PROs to follow to review all notices issued by hospitals, provide comments to the hospitals to correct those that are not appropriate, and set up a monitoring system to insure that these deficiencies are corrected.

Nearly all of the PROs contacted felt that the recent HCFA instructions have resulted in appropriate action to correct problems identified with formal, written patient notices. As one PRO noted, "we caught a lot of problems with the notices when we did the review of all of our hospitals. We are sending these back and telling the hospitals to do the notices correctly, in conformity with the HCFA regulations. We anticipate no trouble in getting the corrections made."

As the following chart shows, of the 41 PROs who responded to this question most now report an improvement in the written notification process:

Comment	Number of Sample PRO Responding
Notices were a major problem, now corrected	7
Notices were a minor problem, now corrected	10
Some improvement noted, but still a minor problem	15
Notices were never a problem at all	9
Total Responding	41

3. Receipt of Denial Notices Upsets and Confuses Patients

Hospital UR coordinators and PRO staff, as well as senior advocate organizations, report that patients are frequently upset and often confused by receipt of denial notices. References to "responsibility for payment of services" and "formal determination of medical necessity and appropriateness" can be disturbing to patients, especially those believing they should be allowed to remain in the hospital. Moreover, respondents feel that the notices do little to clarify what is now a patient's responsibility under PPS. Further confusion results from patients receiving notices after they have been discharged, or in some cases notices going to family members after the patient has died. HCFA has tried to word the notice clearly and simply, but respondents in this inspection say improvements can be made.

4. PROs Report No Problem Implementing HCFA Instruction IM 85-3

None of the PROs contacted reported any difficulties in implementing the HCFA instructions. The PROs feel that the action steps required by IM 85-3 do deal adequately with the problems of written notices. "The instructions required a lot more work from us, but we had no problem in implementing them" was a typical response. A few PROs reported some minor difficulties in getting hospitals to understand the role of the PRO; namely, that the PRO is only involved in the initial denial notification process when the hospital and physician disagree.

The American Medical Peer Review Association (AMPRA) in a letter to HCFA dated July 29, 1985 raised several concerns about the HCFA procedures. The most important of these dealt with the need for clarification of the authority of hospitals to issue, and PROs to review, pre-admission denials.

As of late October, HCFA had not responded to this concern. Pre-admission denials are made by the hospital either on the basis of its own utilization review criteria or in anticipation of prior authorization review by the PRO. Usually, there is not a formal written notice to the patient. PRO review under such circumstances could be quite difficult. It is anticipated that HCFA will issue clarifying instructions dealing with review of pre-admission denials.

5. Informal Discussion, Not Formal Denial Notices, is the Usual Prelude to Premature Discharge

Most of the time, discharge from the hospital follows an informal conversation between the patient and the physician during which the physician states that continued acute care is not necessary. Patients or their families usually accept this decision and make arrangements for any needed post-acute care. Formal denial notices are issued only when the hospital anticipates a problem because a patient might stay beyond the time that acute care is necessary.

PROs and other respondents feel that when premature hospital discharge does occur, it is more likely to follow informal patient-physician discussion rather than when a written notice has been issued. Before a notice can be issued both the hospital utilization review committee and the attending physician have to agree that the patient is ready for discharge. If the attending physician does not agree, then the PRO has to review the case and concur or not concur with the hospital's decision. The checks and balances involved in these steps provide a degree of protection to the patient that is not present in the more informal patient-physician dialogue that precedes most discharges. PRO staff and some other respondents feel that patients usually leave the hospital when they are asked to, without protest and without appeal. The formal notice, on the other hand, spells out the patient's right to reconsideration of the decision. In most cases, a patient's protest will trigger the issuance of a written denial.

Moreover, improper and inappropriate reasons for discharge are more likely to be conveyed as a part of informal discussion than through a formal notice. The physician may say, "Mrs. Jones, we are going to discharge you tomorrow because Medicare won't pay for your care any longer," but no such statement appears in the patient record. Occasionally, PROs find statements to the effect that "patient was discharged because DRG days were used up" in medical records, but this is not common. When such statements are found they should trigger a review by the PRO.

Because of these factors, some respondents feel that formal, written notice should be given to all patients at least 24 hours before their discharge. Such notices would inform patients of the reason for discharge, discuss arrangements for discharge planning and follow-up care, and set forth their appeal rights and procedures.

Other respondents, however, point out that issuing such a notice just prior to discharge could "stir up" patients who properly should be discharged. Patients might try to use the appeals mechanism to buy time - extra days in the hospital-while their appeal is pending. Giving information on appeals to patients at the time of admission rather than discharge might alleviate this potential problem. HCFA has, in fact, restated the responsibility process in an October 25, 1985 transmittal. Even so, respondents feel that more beneficiary education should be carried out.

6. <u>There is a High Level of Misconception About PPS and Medicare Coverage; There is a Major Lack of Quality Educational Materials</u>

Beneficiaries and sophisticated providers alike indicate that there is a high level of misinformation about Medicare coverage in general and specifically about PPS. Efforts have been made by many organizations, including senior citizens and patient advocacy groups, to provide information about hospitalization under PPS, but more needs to be done. The PROs and other informants indicate that the biggest need is to have information on patients rights, benefits and responsibilities, including the appeals process, set out in a simplified format that could be given to all Medicare beneficiaries or their families upon admission or before admission for an elective procedure. Material for general distribution is less effective, since people often do not read it until there is urgent need.

Physicians also have many misconceptions about PPS. Physicians themselves, as well as PRO staff and others, stated this. The most significant misconception is a lack of understanding that physicians are solely responsible for decisions concerning admission and discharge of patients, and should not abrogate that responsibility to the hospital or to any other entity. As the medical director of one of the PROs put it, "the PROs are the advocates for patients. Physicians need to know that if they feel they are being pressured, they should let us know. Information about PPS responsibilities needs to go into the medical professional media."

A number of senior citizen groups, such as congregate and home delivered meal sites, senior citizen centers and adult day treatment centers, are also anxious to provide educational programs on Medicare as a part of their services. Many respondents commented that more should be done to encourage cooperation and communication between HCFA and programs funded by the Administration on Aging.

Some efforts are being made by HCFA and other organizations to provide consumer information on PPS.

The HCFA Office of Beneficiary Services issues on a monthly basis "Medicare/Medicaid Notes." These notes contain factual information about the program thought to be useful to beneficiaries. They are distributed to news media and various organizations for use in publications distributed to beneficiaries. The May 1985 issue, entitled "Medicare's Prospective Payment System - What it Means and What it Does Not Mean" had the largest distribution of any of the "Notes." In addition to regular channels, this issue was sent to the Administration on Aging for distribution to the Area Agency on Aging network. This issue tried to dispel such myths as "Medicare is ordering patients out of hospitals"; "Medicare hospital reimbursement has been cut back"; and "that quality of care to Medicare patients is declining."

The American Association of Retired People (AARP) has just issued (October 1985) a booklet on PPS called "Knowing Your Rights." This material provides a basic description of PPS from the consumer's viewpoint. There is detailed

coverage on the role of the PRO and a section on the appeals process entitled "How to protect your right to the care you need." A list of the 50 PROs and their phone numbers is given and beneficiaries are told to contact PROs if they have received a denial notice and feel that they have been denied coverage prematurely or that they require further treatment. The AARP is planning to distribute this booklet to each of its members and make it available to hospitals and other agencies on request.

HCFA also publishes a pamphlet entitled "Your Right to Appeal Decisions on Hospital Insurance Claims." This pamphlet deals with retrospective denials on the grounds of coverage. It does not cover problems of patients who are still in the hospital. The HCFA "Medicare Handbook" is still the standard explanation of benefits. Recent editions cover changes resulting from PPS. But revised handbooks go only to a small percent of Medicare beneficiaries (about 3.5 million of the 35 million total).

The California PRO has written to each member of the California Congressional and State legislative delegation urging their support to insure that Medicare beneficiaries and the general public understand that "Medicare's efforts to curb unnecessary hospitalizations should not result in a hospital's failing to provide medically necessary care." The PRO enclosed an article about PPS and quality of care concerns for the legislators to disseminate to their constituents.

The AARP booklet, several Congressional hearings and other sources have begun to publicize the role of the PRO as a possible source for beneficiaries to take their appeals. This development has raised concern on the part of some PROs and HCFA staff. Although PROs could be viewed by beneficiaries as the entity which would resolve any complaint about Medicare, they are obviously not staffed or funded to play such a role. For this reason, HCFA deliberately did very little until recently to educate beneficiaries or the general public on the role of PROs. PROs were seen as a contractor to HCFA to carry out specific review functions. This initial view has been changing, however, and the PROs have recently been getting increased visibility.

Respondents in this inspection supported publications such as those of HCFA and the AARP. Their further dissemination is to be encouraged. However, respondents also feel that general distribution publications do not substitute for information given to the patient "on the spot," either at admission or at the time of discharge from a hospital.

In the past, hospitals had an incentive to help patients appeal denial notices. Under PPS, the burden of submitting appeals has shifted to patients and their families. This change makes it far more important that clear, detailed information on appeals be readily available.

7. Consumer Representatives Have the Potential for More Active Roles on Boards of Peer Review Organizations

Several PROs have added consumer representative to their boards in the past

several months. Most of these consumers are active in the American Association of Retired Persons or one of its state affiliates. Currently, the consumer representatives are collecting information and orienting themselves to PRO functions and activities. Active programs of assistance and education for beneficiaries are being planned but have not yet been implemented. Board members are surveying beneficiaries and looking into specific complaints that have been submitted. Based on this research, they will formulate programs for developing beneficiary education and appeal rights, participating in PRO review of quality of care, and providing more explicit assistance to beneficiaries following their hospital discharge.

Consumer participation in PRO activities is currently limited both in numbers of PROs participating and in scope of activities. PRO directors, however, feel that consumer board members offer high potential for helping to alleviate quality of care problems.

HCFA has been informally working with AARP to develop a national training program for PRO board members. This training program would stress the role of board members in helping to insure quality of care.

There is no HCFA or Congressional mandate for PROs to have consumer members on their boards. Some PROs will not allow such representation or any kind of "outside" training such as that proposed by AARP.

8. Many Beneficiary Complaints Concern Inadequate Discharge Planning and Follow-up Care

Many beneficiary complaints sent to HCFA, Congress, the PROs and other sources actually concern inadequate discharge planning and sub-acute care following discharge. When inadequate arrangements are made for post hospital care, some patients will end up back in the hospital. In one case referred to HCFA from the mid-West, a patient was readmitted to the hospital four times within 6 weeks because of poor discharge planning by that hospital. The hospital failed to describe the difficult and combative nature of the patient because it knew nursing homes would not accept such a patient. Absent this description, nursing homes accepted him for a short time, then returned him to the hospital. In commenting on this case the HCFA regional office said that "extended ambulance rides and subsequent return to the hospital for readmission were the direct result of poor discharge planning on the part of the hospital -- an accredited facility, the hospital is responsible for discharge planning. In this case, calls were made to the nursing home to reserve beds; however, the patient's behavior and condition were not adequately explained." The PRO followed up the case by taking corrective action with the hospital. Poor discharge planning is felt by many respondents to lead to subsequent readmission or even to the death of patients. Discharge planning is a critical factor affecting the well-being of patients and their overall quality of care.

This particular case, and others like it, come to the attention of HCFA and the PRO because the beneficiary's family documented the problems in writing and enlisted the assistance of a local patients' advocate organization.

The relationship of PPS to discharge planning is now getting attention within the profession. The Society for Hospital Social Work directors of the American Hospital Association is holding a series of conferences around the country on the theme "How Discharge Planning Works - and Can Work for You - Under Prospective Payment." As a part of their statement on discharge planning, this group stated "Social workers must view with alarm the currently rising pressures for hurried, depersonalized transfer of patients out of acute care hospitals as a part of the thrust for cost-effectiveness. Existing criteria for determining levels of care by bodily needs alone are inadequate and often misleading."

9. PRO Review is Not Adequately Targeted on Patient Discharge or Discharge Planning

Quality of care is supposedly reviewed by PROs whenever they review records for admissions, DRG validation or any other purpose. Most cases of premature discharge, however, come to PRO attention only upon review of patients who are readmitted to the same hospital within seven days from the first discharge. A patient who is readmitted after seven days, or is not readmitted at all, may still suffer because of premature discharge or lack of adequate discharge planning. Unless a complaint is filed by a patient or a patient's representative, however, this lapse of care will probably go unnoticed.

Some PRO staff, physicians and others feel that additional reviews should be carried out by the PROs in order to plug this gap in quality of care review. There are several variations of review that potentially could be performed, but are not now. These include (A) targeted patient discharge review; (B) concurrent patient discharge review; (C) day-of-discharge review; and (D) review of discharge planning. A more explicit focus on review of discharge and discharge planning would greatly reduce the incidence of premature discharges and inadequate discharge planning.

Such reviews should not be viewed as adding additional onerous requirements on the PROs or on hospitals. Many hospitals will be putting more resources into discharge planning because it is in their self interest to do so. This is especially so as they move towards horizontal expansion, taking on services such as nursing homes, hospice and home health agencies.

An inquiry was made to the Joint Commission on Accreditation of Hospitals to obtain results of survey findings concerning hospital discharge planning. The results of this are shown in the chart below. This shows that at least four of the survey elements pertaining to discharge planning have negative findings in ten percent or more of the cases:

	1983		1984	
Total Numbers Survey Reports Analyzed	1797		1472	
	"No"	%	"No"	%
Medical Record Services				
Does the clinical resume contain at least the condition of the patient on discharge?	-	-	140*	9
Does the clinical resume contain at least pertinent instructions for further care (e.g., physical activity limitations, medications, diet)?	-	-	357*	24
Do nursing department/service entries in the patient's medical record include a final nursing progress note reflecting the patient's status for transfer within the hospital and/or discharge from the hospital?	42	2	45	3
Do nursing department/service entries in the patient's medical record include an indication of the patient's or family's understanding of instructions given to patients who are discharged from the hospital on nursing care regiment?	40	2	39	3
Social Work Services				
Do the social work services policies and procedures relate to consultation and referral procedures?	66	4	53	4
Do the social work services policies and procedures relate to the role of the social work department/ service in discharge planning.	75	4	50	3
Nursing Services				
Does the written nursing care plan include consideration of patient education and patient/family knowledge of self-care?	247	14	221	15
Does the written nursing care plan include nursing measures that will facilitate the medical care prescribed and that will restore, maintain, or promote the patient's well-being?	429	24	469	32

	"No"	%	"No"	%
Utilization Review				
Does the utilization review plan include a mechanism for provision of discharge planning?	60	3	16	1

Source: JCAH Aggregate Survey Data (ASD)

* Data not accumulated into JCAH system until April 1984.

10. Physician Decisions Are Not Usually Challenged

Senior advocacy groups, some PRO staff and others stressed the reluctance of beneficiaries to challenge the decisions of their physicians or the information given to them by hospital staff or others. In many cases beneficiaries cannot read or understand the information given to them , yet are very reluctant to admit this or to ask questions. As one provider at a neighborhood clinic put it "Elderly patients are reluctant to make demands on the system. It is a matter of pride with them. They do not realize that they are entitled to good health care and that Medicare is not welfare." Another respondent, a senior activist herself, stated "older patients do not understand the process, are intimidated by the physicians and everyone else in the system and simply won't speak up about their rights. Someone needs to speak for them!"

Nearly all of the senior advocate group representatives and many of the PRO staff agreed with these sentiments. At a time when patient assertiveness is essential, the facts are that patients will seldom challenge those in authority.

CONCLUSIONS

Written denial notices allow hospitals to terminate acute care benefits to Medicare beneficiaries. However, only a small number of discharged patients actually receive written notices. Current HCFA procedures for issuing notices and for their review by the PROs appear to provide adequate safeguards to patients. Problems which did exist in the content of notices have been largely eliminated with the issuance of new HCFA procedures in May 1985.

This study indicates that cases of premature hospital discharge usually do not occur when a formal denial notice has been issued. When a case of premature discharge is identified, it more likely follows an informal discussion between the physician and his patients or their families. During this discussion, the physician is likely to give as a reason for the discharge that DRG days have been used up or that Medicare will not pay any longer. Notations to this effect occasionally appear in medical records, resulting in corrective action by the PROs. More often, however, there is no record of verbal communications concerning patient discharge. A written notice is not issued unless the hospital initiates the discharge, or the patient complains.

Unless the patient is readmitted within seven days, cases of premature discharge in the absense of a written notice or other record are difficult to identify. For this reason, some of the PROs and patient advocate groups have urged that written notification be issued for all discharged patients, that the notice spell out an appeals procedure and that it be subject, under some circumstances, to review by the PRO. An expanded review role by the PRO covering discharges and discharge planning has also been advocated.

Lack of knowledge about PPS provisions is widespread. Virtually all respondents urge education campaign covering providers as well as beneficiaries. This campaign would encompass many facets, including articles in the professional media, Congressional education of constituents, and beneficiary information not only in hospitals, but in any other location where senior citizens gather or receive services. Coupled with increased vigilance on quality of care review by the PROs, educational campaigns would help resolve premature discharge and quality of care problems.

Social Security also plays a role in providing information about Medicare as well as in determining eligibility. The SSA District Offices are the focal point for beneficiaries to get an explanation of their Medicare benefits and to get answers to questions they may have, including questions on denial notices. HCFA staff feel that SSA is not giving these responsibilities enough attention. For example, they have not been made a performance element for evaluating the management of a district office. There is need to update and give higher priority to a memorandum of understanding between HCFA and SSA concerning beneficiary services activities.

In the past HCFA has been very careful not to intrude or give the appearance of intruding in the physician-patient relationship. This has certainly been appropriate. But a balance must be struck. Not intruding can also give the appearance of not caring, of condoning lapses in quality of care. HCFA and HHS appear now to be leaning too far on the side of not providing enough information to beneficiaries.

RECOMMENDATIONS

The OIG recommends that HCFA

1. INITIATE REQUIREMENTS to insure that hospitals provide patients, at the time of their admission, with complete information on Medicare requirements for hospital admission and discharge. This material should cover such areas as hospital admittance procedures, covered and non-covered services, discharge decisions, and patient appeal rights. While many hospitals currently furnish such information, there is no uniform set of requirements to date. HCFA should determine how best to implement this new requirement and report results to the OIG no later than March 31, 1986.

HCFA Comments

HCFA agreed with this recommendation and has initiated action (A) requiring that hospitals furnish patient such a statement of appeal rights upon admission to the hospital and (B) to require that PROs monitor hospitals to assure that this is done.

2. DEVELOP MATERIALS that would clearly and explicitly inform physicians of their responsibilities under PPS, including the fact that they have the sole responsibility for decisions about the admission and discharge of patients. Instruct carriers and fiscal intermediaries to issue special reminders of PPS physician responsibility, and request PROs to emphasize it in newsletters distributed to the provider community. Provide similar material to members of hospital boards of trustees.

HCFA Comments

HCFA did not respond to this recommendation, and the OIG would urge that additional steps be taken to inform physicians and other providers of their responsibilities under PPS.

3. COLLABORATE WITH APPROPRIATE OHDS STAFF OFFICES and with the Administration on Aging to develop materials and strategies for increased education and information about hospital stays for Medicare beneficiaries. This should include:

   a) Steps to develop and issue precise, clear, and readable educational literature informing beneficiaries of their coverage, rights, priviledges and responsibilities under PPS. Such materials should be developed in collaboration with groups, such as the American Association of Retired Persons, and build on materials that already exist. A high priority should be given to educational packets provided to patients and their families upon admission to the hospital or prior to admission.

   b) Greater utilization through OHDS of the "Aging Network" as a means to reach Medicare beneficiaries and get information to them.

c) Increased use of volunteers who could serve as advocates for Medicare patients before, during, and after hospitalization. OHDS should take the lead in disseminating information about model volunteer programs already established by some area agencies on aging.

HCFA Comments

HCFA responded by describing a number of colloborative actions which are being initiated or are underway to improve the education of beneficiaries about hospital stays under PPS.

4. WORK WITH SSA to insure that appropriate informational materials are available for distribution to Medicare beneficiaries through Social Security district offices. Steps should be taken to insure that Social Security staff have sufficient training to discuss Medicare issues with beneficiaries. A memorandum of understanding should be developed between HCFA and SSA to insure that these goals are met.

HCFA Comments

HCFA agreed, and described steps being taken to strengthen communication with beneficiaries at the district office (DO) level. HCFA agreed that a HCFA/SSA Memorandum of Understanding would be helpful to promote a dileneation to responsibilities for beneficiary education.

SSA Comments

SSA agrees with the recommendation that HCFA work with SSA to insure that information is available for distribution. SSA listed a number of actions taken over the past two years to achieve this. SSA disagrees that a fomal HCFA/SSA Memorandum of Understanding is needed.

5. INSURE THAT ADEQUATE FOCUS is given to review of patient discharges by the PROs for the 1986-1988 contract period. The draft specifications prepared by HCFA do provide for increased attention to discharge review. The final contracts should include some or all of the following elements as appropriate:

   a) Quality Screens - Apply generic quality screens to all records reviewed, as stated in attachment 3 of draft PRO Scope-of-Work.

   b) Targeted Patient Discharge Review - Identify a sample of patients to be targeted for retrospective review of discharge similar to the five percent sample of patients identified for admission review. The sample could be random or selected from among high-risk patients where premature discharge is more likely to occur.

   c) Concurrent Patient Discharge Review - Undertake a review of a sample of hospitalized patients slated for discharge. Review notification of discharge, as above, or target a select group of patients at risk of premature discharge.

d) Day-of-Discharge Review - Review the services and procedures rendered to an appropriate sample of patients on the day of discharge, in conjunction with use of quality screens, to determine whether inappropriate acute services were provided.

e) Discharge Planning Review - Require a more explicit focus on review of discharge planning done by the hospital to insure that it is adequate.

HCFA Comments

HCFA described a number of steps taken to focus PRO reviews of hospitals which address the OIG recoommendations. HCFA, however, suggested deletion of recommendation 5e that a finding of inadequate discharge planning would call into question the conditions of participation, since this is the PROs responsibility. The OIG agrees with this suggestion, and is deleting that portion of the recommendation.

6. CONSIDER SELECTIVE REVIEW BASED ON DEATH CERTIFICATES. Several PROs have looked into performing a review, on a selective basis, of death certificates issued to recently discharged patients. By examining patient records for these cases the PRO would determine whether premature discharge or poor quality of care may have contributed to the death. The feasibility of requiring such a PRO review activity should be evaluated.

HCFA Comments

HCFA agrees with this suggestion and considering instituting a study to expand PRO review of deaths that occur shortly after discharge.