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July 1, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1609–P
P.O. Box 8010
Baltimore, MD 21244–1850

Sent via email to: http://www.regulations.gov

Re: Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice

Dear Administrator Tavenner:

ANA welcomes the opportunity to provide comments with respect to this Request for Information. As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses, ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of healthcare settings. ANA members also include advanced practice registered nurses (APRNs) such as nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), and certified nurse-midwives (CNMs).

Global Recommendation
In support of innovative healthcare delivery solutions and the ability of all licensed clinicians to work to the full scope of their practice and license, ANA requests inclusion of provider neutral language throughout future palliative and hospice care rules and directives, rather than the predominant use of physician. Eligible provider and qualified clinician are provided as examples of provider neutral terms.

The remaining ANA comments focus on specific sections of the NPRM:

III. Provisions of the Proposed Rule
B. Solicitation of Comments on Definitions of ''Terminal Illness'' and ''Related Conditions''
4. Definition of "Terminal Illness" (Page 26555)

ANA appreciates the presentation of the history of the definition of '…a "terminally ill" individual to mean "that the individual has a medical prognosis that his or her life expectancy is

six months or less if the illness runs its normal course" (§418.3).' Further discussion addresses the critical recognition "…that the total person is to be assessed, including acute and chronic conditions, as well as controlled and uncontrolled conditions, in determining an individual's terminal prognosis. All body systems are interrelated; all conditions, active or not, have the potential to affect the total individual. The presence of comorbidities is recognized as potentially contributing to the overall status of an individual and should be considered when determining the terminal prognosis."

The follow-on definition of palliative care correctly identifies the focus on optimization of quality of life via the anticipation, prevention, and treatment components of practice associated with patient and family suffering.

The proposed CMS definition of terminal illness misses the mark with the convoluted sentence structure and focus on one single illness being labeled terminal. What really should be addressed is the complex and final phase of the life continuum, the "end of life". The diagnosis of a primary illness or injury or the identification of the collection of associated comorbidities do not significantly contribute to the holistic understanding of the patient's and family's care needs and requisite resources necessary during this time. Symptom management that enables a peaceful death is the goal.

ANA offers this term and accompanying definition as a substitute for terminal illness:
End of life: The final phase of life characterized by the progressive decline of physical, emotional, social, and intellectual processes, without reasonable expectation of stabilization or recovery, ending in death, often projected to occur within six months or less.

B. Solicitation of Comments on Definitions of ''Terminal Illness'' and ''Related Conditions''

5. Definition of "Related Conditions" (Page 26555)

The CMS definition of "related conditions" being "Those conditions that result directly from terminal illness; and/or result from the treatment or medication management of terminal illness; and/or which interact or potentially interact with terminal illness; and/or which are contributory to the symptom burden of the terminally ill individual; and/or are conditions which are contributory to the prognosis that the individual has a life expectancy of six months or less" does not provide clarity. Inclusion of the term "condition" being defined within the explicating text of the definition is not at all helpful.

The proposed definition perpetuates the use of the incorrect term "terminal illness" when it identifies terminal illness as the cause of "related conditions" and also as a component of an actual or potential interaction with related conditions. Other concepts identified as related conditions similarly fail to connote meaning.

ANA recommends a simple definition. Related condition: Anything that contributes to the symptom burden of the individual at the end of life.

Such a definition would support and serve "…as a reminder of the expectation of the holistic nature of hospice services that shall be provided under the hospice benefit…" (p. 26555).

C. Guidance on Determining Beneficiaries' Eligibility for Hospice (p. 26555); and
F. Proposed Addition of the Attending Physician to the Hospice Election Form (p. 26560)

These sections need inclusion of provider neutral language to replace the term physician. ANA supports the clear identification of the patient's choice for the designated "attending" clinician, be it MD, DO, or advanced practice registered nurse.

H. Proposed Updates to the Hospice Quality Reporting Program
4. Future Measure Development (p. 26566)

ANA continues to advocate for effective health information exchange, interoperability, e-quality measures, and ubiquitous use of electronic health records, including within all hospice organizations. Each solution supports interprofessional team care and communication, patient-centered healthcare plans, and effective health information sharing.

H. Proposed Updates to the Hospice Quality Reporting Program
6. Proposed Adoption of the CAHPS® Hospice Survey for the FY 2017 Payment Determination (p. 26566-26567)
a. Background and Description of the Survey

It is understandable that CMS would want to retain the branding associated with CAHPS as a family of surveys—the Consumer Assessment of Healthcare Providers and Systems. However, the proposed strategy for collecting information regarding hospice excludes the actual direct consumer. Data reported by the National Hospice and Palliative Care Organization indicates that three in eight patients stay in hospice for more than 30 days and more than half have a stay longer than two weeks. ANA recommends that CMS consider surveying some portion of the hospice patients whose stay exceeds ten days and who are not incapable of participating in a written survey to collect responses of actual patients' perceptions of satisfaction with their care.

The respondents of the proposed hospice surveys were either informal caregivers (family members) or primary care givers (clinicians) of patients who died while receiving hospice care in the prior two to five months. The stated plan to survey caregivers via a mailed survey two to three months after the death of the hospice patient will never accurately capture the actual hospice patient's perceptions, and it may be too prolonged a time period to allow recall of the family members' experience with the patient's contemporary expressions of satisfaction or dissatisfaction. It may also be too prolonged a time to allow clinicians' recall with respect to specific patients, and such clinicians would obviously not be disinterested observers. ANA recommends at a minimum that the description of the surveys be modified to correctly identify the respondents.

ANA looks forward to continuing activities with CMS related to improving the quality of hospice care provided to all in America. We appreciate the opportunity to share our views on this matter. We would be happy to speak with HHS and/or CMS leadership and staff further. Please contact Carol J. Bickford, PhD, RN-BC, CPHIMS, Senior Policy Fellow, ANA Department of Nursing Practice and Work Environment, at carol.bickford@ana.org, or (301) 628-5060.

Sincerely,

Debbie Hatmaker

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer