The Centers for Medicare and Medicaid Services (CMS) recently issued a policy memo for plans and other interested parties to review and comment on whether questions related to appropriate hospice billing have been addressed. CMS continues to be concerned about payments for analgesic medications used for hospice patients that are inappropriately billed to the Medicare Part D program when Part A should be billed based upon current CMS policy. CMS contracted with Abt Associates to examine the extent of Medicare Part D enrollment among hospice beneficiaries. In 2010, 750,590 hospice beneficiaries were enrolled in the Medicare Part D program and received 14.9% of analgesics through the Medicare Part D program for a total of $12.9 million in payments. The analysis found that 350, or 10%, of all hospice settings accounted for 51% of analgesic claims originating from for-profit, new, or rural facilities. Approximately ½ of all analgesic claims were for hospice beneficiaries residing in long-term care facilities. Below you will find information related to an overview of the hospice benefit and CMS’ new and previous guidance.

Overview of Medicare Hospice Benefit
The Medicare hospice benefit requires an individual to be entitled to Medicare Part A and be certified as terminally ill, with 6 months or less to live, by a hospice medical director or physician on the interdisciplinary group. Hospice care is used to provide palliative relief of pain and symptoms and not curative therapy or treatments. Medicare claims for hospice coverage must be reasonable and necessary for palliation and management of terminal illness and related conditions. Medicare coverage outside of hospice is determined by whether or not the services are for treatment of a condition completely unrelated to the beneficiary’s terminal condition. Beneficiaries eligible for hospice care must approve a waiver of all other Medicare services and therefore, CMS interprets this policy to require that hospices require virtually all care and services, but regulations do not specifically define the list of services included and excluded. Medicare fiscal intermediaries and carriers must make determinations regarding whether the services received are covered by the hospice benefit on a case by case basis.

Medication Coverage under the Hospice Benefit
Only drugs and biologics used for pain and symptom relief are covered by the Medicare hospice benefit. Generally, this includes analgesics, but may also include palliative chemotherapy, radiation, and treatments for heart failure or other related conditions. Medicare Part A covers all medications used for palliative therapy based on a per diem payment arrangement.
Individual hospices generally use a formulary of medications used for palliation and management of terminal illness, but must ensure that medications meet the needs of the beneficiaries and if not, then must consider alternative non-formulary agents. However, if a patient requests a non-formulary medication that the interdisciplinary health care team deems it necessary and reasonable, then if the beneficiary receives the requested medication, the hospice is not responsible for coverage and this medication may not be charged to the Medicare Part D program. The beneficiary must assume the cost of any coverage beyond that deemed reasonable and necessary.

Communication of Hospice Elections and Information among Plans and Pharmacies
Upon enrollment in the hospice benefit, a beneficiary files a Notice of Election (NOE) filing indicating the place of service for hospice coverage. Part D sponsors receive beneficiary hospice data on the daily transaction reply report (DTRR) that is based on the date of the NOE filing. Part D sponsors then report the information to its Part D networks. Details of the hospice information reported on the DTRR may be found on page 8 of the CMS memorandum.

A hospice election continues until the beneficiary revokes the benefit, is discharged, or passes away. The initial certification and benefit period is for 90 days and then subsequently consist of another 90-day period and an unlimited number of 60-day periods.

CMS’ Previous Guidance on Payment of Claims Billed to Medicare Part D
In the 2012 Call Letter, CMS suggested that unless pharmacies have information available at the point-of-sale, sponsors should pay claims for Part D billed medications that should have been billed to Medicare Part A and retrospectively determine payment responsibility. In the final 2014 call letter, CMS indicated that when a Part D sponsor receives a DTRR showing that the beneficiary has elected hospice, the sponsor must ensure that controls are in place to ensure that billing is made to Medicare Part A by using prior authorization (PA) on analgesics, laxatives, antiemetics, and antianxiety medications. CMS encouraged plan sponsors to use “pay and chase” to recover claims.

CMS’ New Guidance on Billing Hospice Benefit
- The hospice plan of care must include all services necessary for palliation and management of the terminal illness and related conditions. Some medications used prior to the hospice election may be included if necessary for palliation and management.
- Medications used by the beneficiary prior to the hospice election but discontinued under the hospice plan of care by the interdisciplinary team because they are no longer necessary for palliation and management or may cause negative side effects may not be billed to Part D or Part A and are the responsibility of the beneficiary. The beneficiary will also be responsible for payment if he or she requests a medication not on the hospice formulary and not deemed necessary and appropriate for palliation and the beneficiary refuses a formulary agent first.
- Medications used for conditions outside of palliative care or unrelated to the terminal illness may be covered by Part D; however, CMS notes that the circumstances of this coverage are rare. Therefore, CMS recommends that sponsors place beneficiary-level PA for all medications for hospice beneficiaries to determine eligibility for Part D coverage. In cases where a medication is covered by Medicare Part D, the hospice must
immediately provide to the plan sponsor the written documentation necessary to meet the requirements of the PA. CMS then expects the Part D plan sponsor to accept this documentation that the drug is not covered by the hospice care plan. Later, the plan sponsor may seek review by a CMS Independent Reviewer to determine whether coverage is actually appropriate for Part D coverage.

- Hospice providers must coordinate with Part D plan sponsors to determine medications that are completely unrelated to the terminal illness or conditions to determine payment responsibility.
- If a sponsor provides coverage for Part D medications and later receives an NOE from the hospice provider, it must review all claims paid during the election period to ensure eligibility for Part D payment and communicate with the hospice provider to ensure coverage. The hospice provider must provide the appropriate documentation to plan sponsor upon request. Medications deemed the payment responsibility of the beneficiary or the hospice must be deleted from the plan’s Prescription Drug Event (PDE) record and recover payment from the responsible party. CMS notes that this process may be completed without pharmacy involvement for payment recovery or payment reversal.

**Overview of the Independent Review Process**

Plans or hospice providers that disagree on coverage may contact CMS for an independent review. The determination of the independent reviewer is final for hospice providers and plans, but beneficiaries may continue the appeals process through either Medicare Part A or Part D. Medical review would determine whether the drug is:

- Reasonable and necessary, related to the terminal illness or related conditions and therefore the hospice responsibility; or,
- Waived through the hospice election and is the beneficiary’s responsibility; or,
- Unrelated to the terminal condition or illness the thus the beneficiary’s responsibility.

AMCP will provide comments to CMS on this guidance. If you would like to provide input, please email mcarden@amcp.org by Tuesday, December 17, 2013.