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CMS Updates Hospice Coverage Policy for Medications…Again!
July 2014

The Centers for Medicare and Medicaid Services (CMS) recently released an updated guidance and standard prior authorization (PA) form for medication coverage for hospice beneficiaries. It supersedes a guidance released on March 10, 2014 (but implemented on May 1, 2014). The provisions of the updated guidance were effective upon release on July 18, 2014, but CMS expects full implementation by sponsors by October 1, 2014. CMS did *not* provide a comment period. You may access the guidance document here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf

The March guidance caused confusion among hospice organizations, Part D plans, and beneficiaries because it required beneficiary-level prior authorization (PA) for all medications prescribed to hospice-eligible individuals. Hospices were required to provide documentation to Part D plans on whether a medication was "related to" or "unrelated" to the hospice coverage. Confusion ensued because CMS was not specific on the level of documentation necessary for "related" or "unrelated" determinations; as a result, questions remained about coverage that in some cases resulted in access problems for beneficiaries. CMS' goal for the hospice benefit is to ensure that beneficiaries receive appropriate care. CMS released this latest guidance to provide a solution to the issues that arose from the March guidance. For more detailed information on requirements for the hospice benefit and a summary of previous CMS policy in this area, click here to download an AMCP analysis.

Prior to releasing the most recent guidance, CMS also sought feedback from organizations, providers, and beneficiaries on definitions of "terminal illness" and related and unrelated medications in conjunction with the 2015 proposed rule for hospice payment policy. Comments were due in early July and AMCP's comments to the proposed rule may be found here:
http://www.amcp.org/uploadedFiles/Production_Menu/Policy_Issues_and_Advocacy/Letters,_Statements_and_Analysis_-_docs/2014/CMS-AMCPComments2015hospiceproposedrule_July2014.pdf.

Coverage of Medications Related and Unrelated to the Terminal Illness

The Medicare hospice benefit covers medications and biologics related to the terminal illness under the Medicare Part A program. Medications unrelated to the hospice care, for example, those that treat an underlying condition, are covered under Medicare Part D. To ensure that beneficiaries receive appropriate access to medications, CMS encourages Part D plans to place beneficiary-level PA based on national drug codes for four categories of medications: analgesics, antiemetics, laxatives, and anxiolytics. The Department of Health and Human Services Office of Inspector General (OIG) identified these medications in a 2012 report as being potentially paid by *both* Medicare Part A and Medicare Part D, thus causing increase costs to beneficiaries and the Medicare program. CMS also instructs hospice providers to avoid sending prescriptions for medications statutorily excluded from Part D, including cough and cold products; most vitamins; and over-the-counter drugs, for payment by Part D plans.

100 North Pitt Street | Suite 400
Alexandria, VA 22314
800 827 2627 | 703 683 8416
Fax 703 683 8417
www.amcp.org

CMS expects plans to use the normal compliance and review activities for other classes of medications outside of those identified in the OIG report. Medications prescribed for conditions unrelated to the terminal illness and transmitted to Part D plans may be subject to CMS-approved managed care pharmacy tools, including quantity limits, step therapy, and PA.

Coverage determinations pending from previously rejected claims based on the May guidance for medications unrelated to the terminal illness should be considered covered without the need for Part D sponsors to receive additional documentation.

Communication by Hospice Providers to Medicare Part D Plans

Hospice providers must communicate information related to Part D coverage to a plan prior to claims submission. While CMS does not consider this communication a coverage determination or a PA request, the information may be used by the part D plan to override the beneficiary-level hospice PA at the point of sale. Federal law requires hospice providers to provide a comprehensive assessment of a beneficiary's condition and medications related and unrelated to the terminal illness. This medication information in the plan should be the basis of the hospice provider's proactive communication to the Part D plan.

PA Process for Medications in the Four Classes of Medications Related to the Terminal Illness

Hospice providers will be encouraged to use the PA form to transmit information to the Part D plan, which will use it to pay claims submitted at the point-of-sale (POS). Beneficiaries or their representatives who received a rejection may request a coverage determination either from the prescriber or hospice provider. CMS encourages hospice providers to provide as "compassionate first fill" for beneficiaries who have difficulty obtaining it at POS. If a medication is unrelated to the terminal illness, the hospice provider should contact the Part D plan for recovery of the payment.

Hospice providers may provide a statement to the Part D plan indicating that the medication is related or unrelated to the terminal illness. No other document to the plan is necessary, but hospices must maintain records of the clinical basis for the statement and provide it upon request.

Standard PA Form

The National Council for Prescription Drug Programs (NCPDP) has created a standard PA form that may be used to make a coverage determination. Hospice providers may include a list of medications that are unrelated to the terminal illness with a space to provide a rationale, but this rationale does not require clinical justification.

Retrospective Review and Recovery of Medications in the Four Classes

Certain claims could be subject to retrospective review, specifically, those paid by Part D plans for medications in the four classes prior to receiving notification of a beneficiary hospice election. The Part D plan should contact either the prescriber or the hospice provider to determine payment responsibility. For medications considered a hospice responsibility, the Part D plan and the hospice should negotiate repayment. If beneficiaries are responsible for payment, a Part D plan should send notice of recovery to the beneficiary.

CMS encourages Part D plans and hospice providers to resolve billing issues without involving the retail pharmacy for purposes of reversing and rebilling. However, if the claims originate from a long-

term care pharmacy that also serves as the hospice pharmacy, then reversing and rebilling may be necessary.

Communication Between Pharmacy and Part D Plan Regarding Hospice Coverage
CMS encourages pharmacies to fax documentation presented by a beneficiary at the POS to the Part D sponsor regarding hospice coverage. CMS encourages plans to accept information from the pharmacy regarding medications unrelated to the terminal illness to override the POS PA. CMS encourages pharmacies to proactively communicate information with beneficiaries about the hospice benefit.

Treatment of Beneficiary Complaints to Part D Plans ass Coverage Determination Requests
Part D plans must process beneficiary complaints as a coverage determination.

Hospice-Related Complaints and Star Ratings
CMS clarifies that most complaints are reported to the CMS regional office and are not attributable to the plan. However, CMS encourages plans to act upon PAs quickly once the prescriber or hospice responds.

If you have questions regarding this guidance, please contact Mary Jo Carden, AMCP Senior Director of Regulatory Affairs, mcarden@amcp.org.