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Reimbursement: Are You Ready For The Hospice Drug Coverage Burden That Starts May 1?

The good news is that Part D plans have to take your word for it on unrelatedness for now.

In only a few weeks, you can expect a double whammy of significantly increased administrative burden and additional financial liability due to a new prior authorization requirement for hospice patients' drugs unrelated to the terminal illness.

The **Centers for Medicare & Medicaid Services**' March 10 memo on the Part D PA requirement softens language compared to the draft CMS issued Dec. 6. And the new memo spells out a PA process where the prior memo left the details vague.

But the basics of the memo stay the same for all drugs a hospice patient takes, the default answer to who is responsible for payment is the hospice, stresses consultant **Susan Balfour of Hospice Fundamentals**. Under CMS's new PA procedure, "your challenge is to successfully identify those medications for which you are not responsible and to make and document a sound case for why not," Balfour says.

The new memo's statement that "we expect drugs covered under Part D for hospice beneficiaries will be unusual and exceptional circumstances" appears to tell Part D sponsors to presume a denial for any requests related to hospice patients, says attorney **Robert Markette Jr**. with **Hall Render** in Indianapolis. "After the original guidance, some sponsors were simply denying everything. CMS says that is not the intent, but their statements sure seem to point in that direction."

Bottom line: "If you start with a presumption of denial, then the hospice will have to overcome that burden to avoid paying out of pocket," Markette observes.

How The Process Works

Under the newly outlined process that takes effect May 1, Part D plans (called "sponsors") will automatically reject any drug claim for a hospice patient. When the pharmacy receives the rejection, it will contact the beneficiary or prescriber to determine whether the hospice provider should cover the drug.

If the answer is "yes," the pharmacy will submit its claim to the hospice. If the answer is "no," the pharmacy will direct the beneficiary or prescriber to contact the Part D plan to start the PA process.

Once the Part D plan starts the PA process, the prescriber or the hospice may provide the plan with an explanation of why the drug is unrelated. How exactly that will work seems to be up to individual plans.

Trouble spot: "To ensure care coordination, we believe prescribers who are unaffiliated with the hospice provider, in addition to providing the explanation regarding why the drug is unrelated to the terminal illness or related conditions, should also attest that they have coordinated with the hospice provider and the hospice provider confirmed the unrelatedness of the drug," CMS says in the memo.

A third option: If the drug is related to the terminal illness but the hospice determines it is not covered, the hospice must inform the beneficiary of her liability for the drug's cost.

Hospices don't have to wait for a pharmacy to submit a claim for a drug, however. They can also initiate the PA process themselves, as many commenters on the initial memo suggested. "We agree ... that this approach would go far to avoid

any issues associated with data lags or the workload associated with fulfilling PAs," CMS says in the new memo. "Initiating communication prior to a claim submission, such as at hospice election, will provide early notice of the election to the sponsor and limit retrospective recoveries."

Under this option, the hospice gives the Part D plan a statement providing an explanation of why the drugs are unrelated to the terminal illness or related conditions. "When hospice providers provide this documentation, sponsors should accept it and use it to satisfy the PA requirements," CMS directs.

Burden Of Requirement Is Clear

"There is definitely an additional burden to this," Balfour says of the PA requirement. "The magnitude of the burden will depend on how sound a process a hospice already has in place to identify the terminal, related, and secondary and unrelated diagnoses, both at the time of admission and periodically throughout care."

"Submitting written documentation to the Part B sponsors will be time-consuming," warns attorney **Marie Berliner** with **Joy & Young** in Austin. And "on the documentation side, there will be the additional burden of having to document in greater detail any team, patient, or family discussions regarding relatedness, discontinuation of medications, and possibly providing notice of patient financial responsibility to the patient."

The burden will be especially heavy when "no explanation should be needed," Markette says. "For example, a provider treating a patient for lung cancer where the patient has also been recently diagnosed with Parkinson's. It should be obvious that the Parkinson's med has nothing to do with the palliation of the patient's lung cancer, but I have already seen denials in that scenario. A provider should not have to prove the Parkinson's is unrelated."

Consider These Pros In The New PA Process

The new PA process outlined in the memo contains some definite advantages for hospices, however. Foremost is that the Part D plan is required to accept the hospice's statement that a drug is unrelated, no questions asked.

The procedure for when a hospice initiates the PA process is "very straightforward" and should "lead to less medication hold-ups going forward," Balfour believes.

The wealth of procedural specifics included in the memo is also good for the most part, since it will limit the variances that the hundreds of Part D plans across the nation can introduce into the process.

The procedures in this memo respond to the need for "a more structured process in place to assure that every Medicare beneficiary's right to access medications unrelated to the terminal hospice diagnoses or related conditions is protected," Balfour believes.

Plus: "If structured correctly and if there is ultimately a sound independent review process, this may also serve to protect hospices from the recent attempts from various quarters of CMS to expand hospice financial responsibility to include pretty much everything that a beneficiary requires, regardless of whether or not it is something necessary for the terminal illness or related conditions," Balfour tells **Eli**.

Watch Out For Blanket Denials

But this procedure also contains some major cons in addition to the added workload, experts warn.

For example: CMS's comments about Part D drug coverage for hospice patients being "unusual and exceptional" may fuel blanket denials, Markette worries. "That is almost certainly going to continue to make life difficult."

While the hospice-initiated PA process seems simple, "once hospice care is underway and prescriptions come in for unrelated medications, the process gets a little murky," Balfour cautions. The variations related to which party provides the PA information and the new process that requires an "unaffiliated prescriber" □ a non-hospice employed practitioner □ to complete an attestation that he or she has coordinated with the hospice and that the hospice has confirmed the unrelatedness of the drug could cause big headaches.

"I can't help but think that this will turn out like the home health face-to-face requirement," Markette worries. "It may only apply in a smaller number of cases, but I can see hospices having a hard time getting physicians to provide more information."

The lack of a dispute resolution process could be a problem. CMS's instructions to Part D plans to accept hospices' statements of drug unrelatedness at face value should mitigate the need for dispute resolution, Berliner predicts. But "there are always unknown factors associated with creating a new process, especially if it adds another administrative layer to claims processing or resolution," she acknowledges.

Data Red Flags May Point The Way To Abusers

As the PA process gets underway, expect CMS and its contractors to keep tabs on hospices with a high volume of supposedly unrelated drugs. Unscrupulous providers "could try to push costs over to Part D," Balfour expects. "We're not talking about difference of clinical opinion here we certainly expect those but instead either laziness or intentional cost shifting. Data mining being what it is, we expect that those hospices will be identifiable and may find that there are consequences to their actions."

Raising the bar on unrelatedness: CMS plans to issue a rule proposing a dispute resolution process for relatedness determinations for 2015. Thus, expect CMS to repeal its directive to Part D plans to accept without question hospices' statements on drugs' unrelated status at the same time.

Note: The March 10 memo, which contains a flow chart of the new PA process, is at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Part-D-Payment-Hospice-Final-2014-Guidance.pdf.