# Eli's Hospice Insider

## Survey & Certification: Regulatory Relief Proposal For Medication Management Gets Mixed Reviews From Hospice Industry

**Change would save hospices $80 million annually, CMS claims.**

Medicare is looking to take some drug-related duties off hospices' shoulders.

**Topic #1:** The hospice Conditions of Participation currently require providers to "ensure that the interdisciplinary group confers with an individual with education and training in drug management … who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet each patient's needs (§ 418.106(a)(1)),” notes the rule published in the Sept. 20 Federal Register.

When the **Centers for Medicare & Medicaid Services** finalized this CoP in 2008, it estimated a little more than half of hospices were using pharmacy benefit management companies to provide drugs and pharmacist services to each of their patients at a single bundled service rate. Now CMS estimates that as much as 95 percent of hospices are doing so.

CMS proposes eliminating the requirement altogether. "The vast majority of hospices, and thus the vast majority of hospice patients, will continue to receive such advice and guidance in the absence of regulation,” the agency concludes. "This proposed change would allow hospices to more seamlessly integrate the information provided by the drug management expert into routine interdisciplinary group meetings rather than having to use burdensome formulaic approaches that hospices currently implement in order to demonstrate compliance with the regulation.”

Hospices "will no longer need to assure a dedicated time in each interdisciplinary group meeting in order to be able to document that a specific conversation occurred among group members, and thus document compliance with the regulation,” CMS elaborates.

Also, "the number of hospice and palliative care nursing and physician specialty training and certification programs has rapidly expanded. As more hospice and palliative care nursing and physician specialists have entered the job market, more hospices are employing these clinicians with advanced skill sets,” the rule says. These clinicians "typically fill the role” of a PBM for some hospices, and CMS expects they will also continue to do so absent regulation.

"The requirements at § 418.106(a)(1) are no longer necessary to assure patient safety and the effectiveness of hospice care,” CMS maintains.

This should please those physicians who feel very able to handle hospice medication issues and don't see why they need to get input from a consulting pharmacist, expects attorney **Robert Markette Jr.** with **Hall Render** in Indianapolis.

The current requirement is "one more burden on an already burdened interdisciplinary group,” Markette observes. It's nice to see an unnecessary component of the ICD removed, when applicable.

**On the other hand:** "While many hospices have PBMs, we do believe that there is still a need to have a knowledgeable person doing medication review and discussing patients and their drug profiles in person and on a regular basis,” offers **Judi Lund Person** with the **National Hospice & Palliative Care Organization**. "A physician, nurse, or pharmacist could fill that role,” she allows. But "hospice providers have some concerns for patient safety with this proposal for burden reduction,” Lund Person says.

**Topic #2:** The current CoPs require hospices, at § 418.106(e)(2)), to: "(1) Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family; (2) discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the

patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and (3) document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.”

Furnishing the hospice P&Ps for drugs actually proves confusing for many patients and their caregivers and offers little to no benefit, CMS acknowledges. "Hospice policies and procedures are typically written in ways that are not easily understood by the general public. Hospice clinicians spend more time than expected explaining technical terms and otherwise translating the policies and procedures into layperson's terms.”

Therefore, CMS proposes eliminating the requirement to furnish the hospice P&Ps to patients, and replacing it with "a requirement that hospices provide information regarding the use, storage, and disposal of controlled drugs to the patient or patient representative, and family, which can be developed in a manner that speaks to the perspectives and information needs of patients and families,” the rule says. "This information would be provided in a more user-friendly manner, as decided by each hospice, which we believe can improve comprehension and maximize the effectiveness of the education effort.”

Hospices would be allowed to choose their own format for the drug information under the proposal, but CMS proposes "to require that, regardless of the format chosen, this information must be provided to patients and families in a manner that allows for continual access to the information on an as-needed basis in order to assure that patients and families have information available when they need it.” The agency is soliciting input on whether the format should be paper or electronic, among other specifics.

"Cutting down what you have to hand out” is positive, Markette judges. Especially when patients can't understand much of it anyway.

**Cost benefit:** CMS estimates these two drug-related changes will save hospices $80 million annually.