Protect Access to Medications for Dying Medicare Beneficiaries
Sign the Reed/Thompson, Rockefeller/Roberts Letter

When a patient elects hospice, the hospice provides all of the care related to the terminal illness and related conditions. Patients at the end of life may also have several different medical conditions with which that they have struggled for years but are not related to the terminal condition. In these cases, the other medical conditions are not the responsibility of the hospice; they are the responsibility of the patient’s primary insurer, which is usually Medicare, and Medicare Part D for medications.

In 2012, the Office of the Inspector General (OIG) examined Medicare hospice patients whose medications were sometimes paid for by Part D rather than by the hospice. They found that in some cases, mistakes had been made, and Part D plans, not the hospice program, had paid for medications related to the patients’ terminal conditions. The OIG recommended that the Centers for Medicare and Medicaid Services (CMS) work to educate hospices, Part D plans, and pharmacies that the hospice should pay for all medications related to the terminal condition, and that CMS perform oversight to ensure that Part D is not paying for these drugs. NHPCO agrees with the report and does not debate that hospices are absolutely responsible for all medications and care related to the patient’s terminal condition.

In March 2014, CMS issued guidance to the Part D provider and hospice communities introducing a prior authorization process for how the two groups should determine who pays for which drugs once a patient enters hospice. Members of Congress have called for CMS to slow the process and convene the stakeholders to create the appropriate communication channels and processes for prior authorizations. However, CMS has provided little instruction and absolutely no infrastructure to ensure that hospices and Part D plans can successfully implement this process without impacting patient access to medications.

**What does implementation of the hospice and part D guidance currently look like?**

It’s the 84 year old man in Massachusetts dealing with terminal bladder cancer, standing at the pharmacy counter being told that Part D won’t pay for his unrelated cardiac medications because he’s on hospice. The man breaks down in tears, telling the pharmacist, “I need my meds. I will sign off hospice if I have to; please just let me have my meds.”

It’s the Ohio woman who is on hospice for COPD. She’s gone three days without the insulin necessary to treat the type 1 diabetes that she has had for decades.

And it’s also the independent pharmacy in Hot Springs, Arkansas, that is so overwhelmed by the confusion and chaos that they’ve decided not to fill any prescriptions for any hospice patient at all. And, this pharmacy is the primary source for medications for several local retirement communities.

There are hundreds of stories like these— and the number is growing.
What can Congress do?

Priority one must be to stop the impact of the implementation of this new policy on hospice patients, who are already medically fragile.

**NHPCO maintains that, given the impact on patients who are facing the final days, weeks or months of their lives, the prior authorization process for Part D beneficiaries who are on hospice must be halted.** Not rescinded, but temporarily halted. The policy itself is not the issue. The issue is that there is no existing infrastructure in place to support the Guidance by CMS and protect the patient.

Halting implementation would lift the prior authorization process and subsequent “reject code,” while an infrastructure is developed and put in place to ensure the Guidance is implemented as intended. We believe that an effective infrastructure, at a very minimum, should include:

1. A uniform prior authorization form/process that is required by CMS, with detailed instructions.
2. A robust communication infrastructure among relevant stakeholders. CMS needs to convene the Part D plans, pharmacies, and the hospice community in a unified manner to determine who the appropriate point person is for real-time communication on the authorization process, and identify the mechanism (existing CMS software, phone calls, etc.) that allows communication to take place in a timely manner. Currently, none of these entities is looking at the same information at any given time.
3. A revisiting of the blanket reject code that causes confusion at the pharmacy counter for patients who are paying their Part D premiums and expect coverage. We encourage the stakeholders to find a different approach to flagging the hospice election that does not involve a denial. The denial is slowing the prior authorization process down and scaring both the pharmacists and the beneficiaries.
4. A way to speed up the prior authorization process. With the proper communication infrastructure in place, there is no reason why a patient should have to wait 3-4 days without medications for a prior authorization process can be completed.

The Reed/Thompson and Rockefeller/Roberts letters both call on Administrator Tavenner to suspend the policy – just for a little while – so that an effective communicational and procedural infrastructure can be put in place. It is not an ideal choice, but it’s the only one that protects these vulnerable patients and their families during an already complicated and difficult time.

*Please contact Laura Rigdahl (Reed) or Lakecia Foster (Thompson) to be added to the House letter. Please contact Havi Glaser (Rockefeller) or Emily Mueller (Roberts) to be added to the Senate letter. For more information about hospice and Part D, go to [http://hospiceactionnetwork.org/get-informed/issues/part-d](http://hospiceactionnetwork.org/get-informed/issues/part-d).*