June 23, 2014 (*)

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Tavenner:

The undersigned organizations are writing to express our concern regarding the Center for Medicare & Medicaid Services' (CMS) recent guidance for Medicare-certified hospices and Part D plan sponsors entitled, "Part D Payment for Drugs for Beneficiaries Enrolled in Hospice – Final 2014 Guidance" (Guidance).[1] The Guidance establishes a procedure to limit instances in which a Part D plan inappropriately covers prescription medications related to a hospice beneficiary's terminal condition.

While we appreciate that CMS seeks to ensure that the appropriate entity pays for medications, we believe this policy places an undue burden on hospice patients. Most importantly, we are concerned that the Guidance places the beneficiary at the center of potential disagreements between hospice providers and Part D plans—essentially requiring dying patients to navigate payer disputes. As such, we urge CMS to replace the Guidance with a more suitable solution. In particular, we strongly urge CMS to suspend the current policy directing Part D plans to place prior authorization requirements on *all* prescriptions for hospice beneficiaries. We request that CMS bring together all relevant stakeholders, including beneficiary advocates, hospice providers, Part D plans and pharmacists, to collectively work through these issues.

When a beneficiary elects hospice care under Medicare, the hospice is required to pay for drugs associated with the terminal illness or related conditions. Part D processes the medications for conditions unrelated to the terminal illness. As evidenced by a recent analysis from the Office of the Inspector General (OIG), medications that should be covered by the Medicare hospice benefit have sometimes been paid for by Part D plans.[2] In an attempt to prevent this outcome, the Guidance requires all prescribed medications for hospice patients that are billed to Medicare Part D to be rejected for payment, by being subject to a prior authorization requirement.

In order to work as intended, the process outlined in the Guidance relies on the goodwill and timely assistance of multiple parties—including the pharmacy, hospice, Part D plan and prescriber, who may or may not be affiliated with the hospice. Whenever a beneficiary or family caregiver attempts to fill a prescription at a pharmacy, the Guidance directs the pharmacy to contact the prescriber to determine whether the medication is related to the terminal illness. If the medication is related to the terminal illness, the pharmacy is directed to bill the hospice for the cost of the medication.

If the medication is *not* related to the terminal illness or the determination of relatedness is unclear, the pharmacy cannot fill the prescription. Instead, the pharmacy is expected to provide the standardized pharmacy notice that outlines beneficiary appeal rights. In these instances, beneficiaries, who in this case are terminally ill, must subsequently request a formal coverage determination from their Part D plan to access their prescribed

[1] CMS, Center for Medicare, Memorandum to All Part D Sponsors and Medicare Hospice Providers, "Part D Payment Policy for Drugs for Beneficiaries Enrolled in Hospice – Final 2014 Guidance" (March 10, 2014).
[2] Department of Health and Human Services, Office of the Inspector General (OIG), "Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice" (A-06-10-00059) (June 2012).

medication. From there, CMS directs Part D plans to engage in a chain of communication with multiple parties to determine the medication's relatedness to the beneficiary's terminal condition.

In addition to its reliance on the goodwill of all involved parties, the Guidance assumes that beneficiaries will be appropriately educated at the pharmacy counter about how to secure a coverage determination from their Part D plan when prior authorization is required. In our experience, Medicare beneficiaries denied a medication at the pharmacy counter are often confused by how to move forward and are unaware of their appeal rights. Additionally, as acknowledged by CMS, the existing standardized pharmacy notice is not tailored to situations involving hospice, meaning that hospice patients, with a limited life expectancy, will lack clear, concise and targeted information about how to secure a medication when refused at the pharmacy counter.

CMS acknowledges that clarity is needed surrounding the intersection of hospice and Part D. To this end, CMS recently issued proposed rulemaking that solicits input on this subject.[3] In the absence of clear definitions and rulemaking directed to hospice providers and Part D plans, we expect disagreements between payers. When these disputes occur, hospice beneficiaries must rely on inadequate information at the pharmacy counter and a burdensome and ineffective Part D appeals system to access needed medications.

Given the concerns outlined above, we believe the Guidance is premature, subject to differing interpretation, and already creating barriers for dying patients who are trying to access necessary medications. According to initial reports, some hospice patients are already paying out-of-pocket for their drugs, going without needed medication, or revoking their hospice benefit altogether in order to access their medicine through Part D.

In sum, we urge CMS to halt this Guidance until a workable alternative is developed that does not place the burden of resolving payment disputes squarely on the shoulders of terminally ill Medicare beneficiaries.

Sincerely,

AARP
AFT Retirees
Alliance for Aging Research
Alliance for Retired Americans (ARA)
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Hospice and Palliative Medicine (AAHPM)
American Academy of Neurology (*)
American College of Emergency Physicians (*)
American Federation of State, County and Municipal Employees (AFSCME)
American Geriatrics Society
American Health Care Association (AHCA)
American Medical Association (AMA) (*)
American Osteopathic Academy of Orthopedics (*)
American Osteopathic Association (*)
American Society of Clinical Oncology (*)
American Society of Consultant Pharmacists (ASCP)
American Society of Hematology (*)

[3] 79 Federal Register 26538 (May 8, 2014).

Association of American Medical Colleges (*)
Association for Gerontology and Human Development in Historically Black Colleges and Universities (*)
Association of Professional Chaplains (APC) (*)
B'nai B'rith
Center to Advance Palliative Care (CAPC) (*)
Center for Medicare Advocacy, Inc.
Coalition for Supportive Care of Kidney Patients (*)
College of American Pathologists (*)
Hematology/Oncology Pharmacy Association (HOPA)
Hospice and Palliative Nurses Association (HPNA)
International Association for Indigenous Aging – IA2
LeadingAge (*)
Medicare Rights Center
Military Officers Association of America (MOAA) (*)
National Alliance on Mental Illness (NAMI) (*)
National Association for Home Care & Hospice (NAHC)
National Association of Professional Geriatric Care Managers
National Association of State Long-Term Care Ombudsman Programs
National Association of States United for Aging and Disabilities (NASUAD)
National Coalition for Hospice and Palliative Care (*)
National Committee to Preserve Social Security and Medicare (NCPSSM)
National Consumer Voice for Quality Long-Term Care
National Council on Aging (NCOA)
National Hospice and Palliative Care Association (NHPCO)
National Senior Citizens Law Center (NSCLC)
OWL – The Voice of Women 40+
Social Work Hospice and Palliative Network (*)
Visiting Nurse Associations of America

(*) *Note: This letter is updated from an identical letter dated June 11, 2014 to reflect additional organizations that have signed-on, as marked by an asterisk.*