National Hospice and Palliative Care Organization

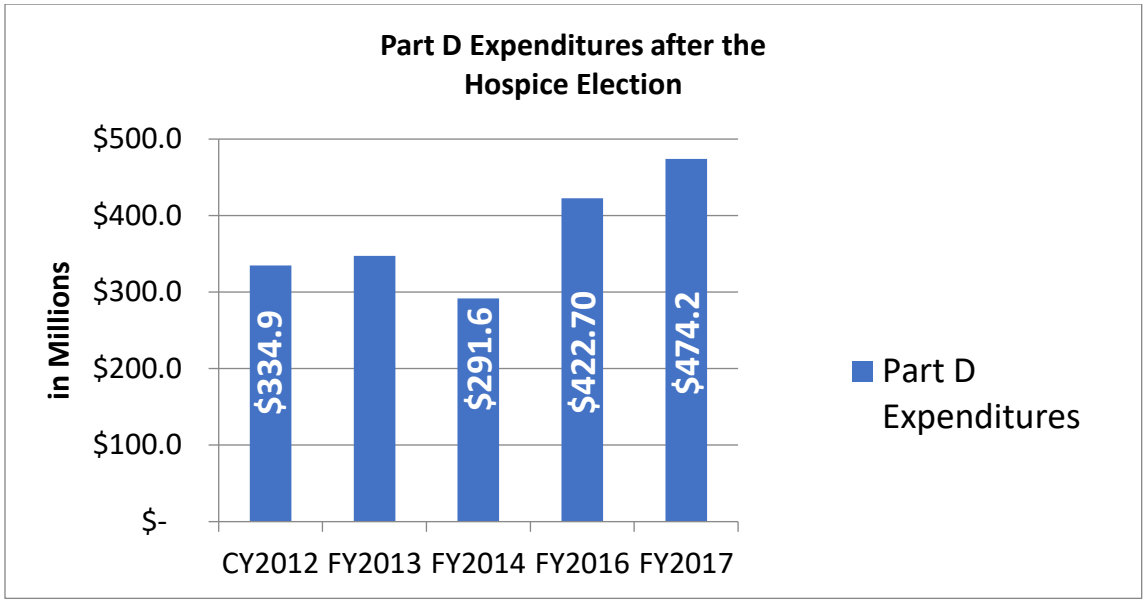
Regulatory Alerts

NHPCO Leading Person-Centered Care

OIG Report on Part D and Hospice

To: NHPCO Provider Members
From: NHPCO Regulatory Team
Date: August 28, 2019

On August 27, 2019, the Health and Human Services Office of Inspector General (OIG) released a report entitled *"Medicare Part D Is Still Paying Millions For Drugs Already Paid For Under The Part A Hospice Benefit"*. In this report, the OIG reiterates what CMS has stated since the beginning of the Medicare Hospice benefit, that the Social Security Act and Federal regulations specify that hospices are responsible for covering all drugs for the palliation and management of a beneficiary's terminal illness and related conditions. CMS has frequently stated that in its 1983 final rule implementing the hospice benefit, it interpreted related conditions broadly, indicating **that hospices were required to cover virtually all care that terminally ill patients need.** The OIG identifies increased and significant Part D spending after a Medicare beneficiary has enrolled in hospice, as shown below.



2012 OIG Report on Hospice and Part D: This OIG report follows a report issued by the OIG in June 2012 entitled *Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice*. That work focused on identifying four classes of prescription drugs commonly prescribed for hospice patients, analgesic, anti-nausea, laxative, and anti-anxiety drugs and disease-specific drugs for two diseases—chronic obstructive pulmonary disease (COPD) and amyotrophic lateral sclerosis.

The 2012 OIG report led to significant discussion and NHPCO advocacy around a CMS proposal that prior authorization be required on **all** drugs for beneficiaries who have elected hospice. NHPCO advocated for a more limited prior authorization and communication process, so in July 2014, CMS rescinded the prior authorization for all policy in favor of a policy on only the four classes of common end-of-life drugs and directed Part D plan sponsors to remove prior authorization requirements for other categories of drugs. CMS also developed and circulated a form (the A-3 Reject form) that could be used to communicate and coordinate between sponsors, hospices and prescribers.

FY2019 OIG Report on Hospice and Part D Findings: In this 2019 report, the OIG conducted a review of 200 Part D records for patients in 2016. They report that 86 of the 200 Part D records should have been paid for by the hospice. Hospice providers in the study concurred. The OIG report believes that the Medicare program paid twice for these drugs – once under the Part A hospice benefit and again under Part D. Their findings state:

- "On the basis of our sample results, we estimated that the Part D total cost was $160.8 million for drugs that hospice organizations should have paid for under Part A.
- Additionally, although hospices told us that they should not have paid for **108 of the sampled Part D drugs associated with the remaining $261.9 million of the $422.7 million total cost, a review of CMS communications with hospices and sponsors between 2012 and 2016 suggests otherwise—hospice organizations or hospice beneficiaries, not Part D, should have paid for many of these drugs**."
- CMS has not developed or required controls to ensure that Part D is not paying for hospice-covered drugs. Table 2 shows the reasons hospices gave for not providing the drugs. The reasons seem very familiar to almost any hospice provider.

Table 2: Hospice Reasons for Not Providing Drugs

Reasons	Number of Errors
The hospice had no knowledge that the medication was prescribed by an outside physician, filled by an outside pharmacy, or both.	36
The hospice had no knowledge that the medication was ordered by nursing home staff and filled by an outside pharmacy.	13
The hospice miscoded the drug as non-covered.	11
The drug was dispensed close to the hospice admission, so the hospice election was not yet processed in the Part D sponsor's system.	7
The pharmacy that dispensed the drug was aware of the patient's hospice election but billed Part D in error.	6
The hospice thought a third party was paying or they would have covered the prescription.	1

Hospice Organizations Should Have Paid for Drugs Used to Treat Secondary Diagnoses, Comorbidities, and Preexisting Conditions

- *Secondary Diagnoses:* CMS stated that many health problems are brought on by underlying conditions because bodily systems are interdependent; it is often not a single diagnosis that represents the terminal prognosis but the combined effect of several conditions.
- *Comorbidities:* CMS also stated that the presence of comorbidities is recognized as potentially contributing to the overall status of an individual and should be considered when determining the terminal prognosis.
- *Preexisting Conditions:* CMS stated that longstanding, preexisting conditions are included in the hospice bundle of services, and that the original implementing regulations for hospice articulate a set of requirements that do not distinguish between preexisting, chronic, or controlled conditions.

Hospice Beneficiaries May Have Been Liable for the Cost of the Drugs
Guidance from CMS states that a hospice beneficiary should pay for drugs when the beneficiary:

(1) chooses to continue a drug that the hospice determined is no longer effective in the intended treatment, may be causing additional negative symptoms, or both or
(2) requests a drug that is not on the hospice formulary and refuses to try a formulary-equivalent drug. Neither Part D nor the hospice should pay for a drug when one of these conditions occurs.

OIG Recommendations To CMS

The OIG states that "CMS must do more to avoid paying twice for the same drugs. As OIG has previously recommended, CMS should work directly with hospices to ensure that they are providing drugs covered under the hospice benefit. In addition, we recommend that CMS should develop and execute a strategy to ensure that Part D does not pay for drugs that should be covered by the Part A hospice benefit, which would save at least an estimated $160.8 million a year in Part D total cost, with potentially much higher annual savings associated with the drugs that hospices said they were not responsible for providing. This strategy should include working with Part D sponsors and seeking whatever authorities are necessary to develop proper controls."

CMS Response

In written comments on our draft report, CMS stated that "its current efforts will address the issue and help ensure there is no disruption in beneficiary access, indicating that it will continue to engage in meaningful activities to reduce duplicate payment in this area, such as ensuring hospice providers are proactively educating beneficiaries on covered services and items (including drugs) and Part D drug plan sponsors are appropriately applying prior authorization criteria and coordinating with hospice providers on drug coverage issues."

OIG Response to CMS Response

Although the OIG acknowledged CMS's efforts after the 2012 report, they "disagree that they will adequately address the issue because the duplicate payments persist. We [OIG] continue to recommend that CMS develop controls to stop the duplicate hospice drug payments."

Members should consider the following:

1. Know that NHPCO is already very involved in discussions with Part D and CMS about these issues and welcome your thoughts and feedback on this OIG report.
2. Review your current practices for determining relatedness. Use the *NHPCO Determining Relatedness to the Terminal Prognosis Process Flow* and its companion *NHPCO Determination of Hospice Medication Coverage* to help you think about medication coverage in your own agency.
3. Consider/reconsider expanding what your hospice covers for medications. Think carefully about your policy in light of this OIG report.
4. Let NHPCO know what resources your hospice will need. This is likely to be an issue under increasing Medicare scrutiny and agencies should be prepared for requirements for additional documentation to justify why a medication is not related.

Questions should be directed to regulatory@nhpco.org with Part D in the subject line.

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