

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Part D and Hospice

Moderator: Jill Darling
April 8, 2014
1:00 p.m. ET

Operator: Good afternoon. My name is (Aaron) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Part D and Hospice Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you like to ask a question during this time simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you (Aaron). Hello everyone. Good morning and good afternoon. My name is Jill Darling and I'm in the CMS Office of Communications. Thank you for joining today's Special Open Door Forum on Part D and Hospice. We will keep this to as close of an hour.

So I will pass it on to Deb Larwood who's the Technical Advisor in Part D.

Deb Larwood: Thanks Jill.

I would imagine that most of you have downloaded the slide presentation and I will be working kind of off that but there's really no need to have downloaded it if you haven't already.

A small disclaimer if you have that the information provided in the slide deck. It is only intended to be a general summary; it's not intended to take the place of either a written law or a regulation.

We encourage everyone to review the specific statute regulations and other interpretative materials for a full and accurate statement of their contents.

To be paid under Part D, a drug must meet the definition of a Part D drug. The Social Security Act defines Part D drugs and that definition explicitly excludes drugs that are available under Part A or Part B.

As a result, since Hospice is a Part A benefit, drugs covered under the Hospice benefit for an individual cannot be covered under Part D.

CMS issued guidance all the way back in 2010 noting this exclusion and directing sponsors to communicate with their network pharmacies to ensure that Hospice drugs were not billed to Part D.

In 2012, the OIG issued a report of their review of Part D claims for drugs for hospice beneficiaries. Their review is focused on four categories of prescription drugs which the OIG had identified as typically used to treat symptoms generally experienced at the end of life. These drugs included analgesics, antiemetics, laxatives and antianxiety drugs.

The OIG identified over 600,000 claims for drugs that potentially should have been covered under Hospice and recommended that CMS require plan sponsors to develop controls to prevent Part D payments for drugs that are actually covered under the Hospice benefit.

In response to that recommendation in April 2013, we issued the 2014 Call Letter in which we strongly encouraged plan sponsors to place beneficiary-level prior authorization requirements on the four categories of drugs that were used in the OIG's review for beneficiaries in Hospice.

Call Letters are issued for the Part D program in April each year to prepare Part D sponsors for new requirements or remind them of old existing requirements so that they can prepare their bids that are due in CMS in June,

and we'd like to give them 60 days with the Call Letter so that they can prepare.

As a result, in April each year, we're kind of already planning for the following calendar year's coverage year. So the guidance, even though it was issued in April, would not have been necessarily effective until the following calendar year. So we did that last April with the idea that they would be placing prior authorization requirements on those four categories of drugs.

Later in 2013, the CMS Center for Program Integrity completed their review of 2011 and 2012 data reporting prescriptions just for analgesics paid under Part D during the Hospice election period. Based on their review, Part D sponsors were directed to delete the data from their CMS records and recover overpayments from the hospices.

After the August release of the 2014 Hospice PPS Final Rule, we became aware of the need to clarify our Part D policy. Working with Part A Hospice staff, we drafted clarifying guidance which was issued on December 6th for industry review and comment. We received 130 comments on that guidance. Based on our review of those comments, we developed the final 2014 guidance for Part D sponsors and issued the memo on March 10th. I'm certain you're aware of that guidance, and it is available on the CMS website, on the Hospice page of our website.

In that memo, we directed plan sponsors to place beneficiary-level prior authorization requirements on all drugs for beneficiaries who have elected Hospice in order to prevent duplicate payments for drugs covered under the hospice benefit or waived through the beneficiaries' hospice election.

A number of hospices in commenting on the draft guidance suggested that hospices have the opportunity to initiate communication with Part D sponsors before a claim is submitted, in order to provide early notice to Part D sponsors of the hospice election, revocation, or termination, as well as to identify any drugs that the hospice has determined to be coverable under Part D and provide an explanation of why the drug is unrelated to the terminal illness and related conditions.

We agreed that this would reduce the lag in reporting time of getting the hospice election information to the Part D sponsor and reduce any delays in beneficiary access to drugs under Part D because the prior authorization edits could be overridden prior to a claim submission.

Therefore, we included the option for this prospective communication in the final guidance. Hospices may elect to do it or not. There is a lot to be said for it, but there is certainly no requirement that you do it.

It is important to note that the prospective communication process was not proposed in the draft guidance. Plan sponsors had no foreknowledge of it and could not anticipate and plan for the new process.

As a result, sponsors will require at least some time to establish processes for accepting information directly from the hospices and for processing that information. And you can see the pains of the new process, many of you, and the pain is on both sides, on your side [hospices] as well as the Part D side that you are ready to pick up the phone and call and let them know about hospice elections or about the drugs and provide the information that they need to override prior authorization edits.

They [Part D sponsors], however, were not necessarily prepared to receive information when you first initiated the process. That is, were not prepared to accept it. They [Part D sponsors] didn't have processes in place. They didn't have procedures setup. And some of them obviously react much faster than others and you see the variability and their ability to take this information and to act upon it.

In fact, I'm sure that from the e-mails that I've received and the other information that I've heard that you may be getting responses such as, "We [Part D sponsors] know nothing about this"; "We've not been told anything about this"; or "We don't know what to do." But that is the result of them not having any knowledge of this before the March 10th memo. They [Part D sponsors] got it at the same time that you [hospices] did.

So, we are hopeful that once these processes are in place, Part D sponsors will be better prepared to accept the information and to act upon it and we expect

that some of the problems that you [hospices] have been experiencing, such lengthy hold times, will be addressed.

Additionally, the prior authorization edits must be met for each drug paid for a hospice beneficiary under Part D. This means that an explanation as to why the drug is unrelated to the terminal illness and or related conditions must be provided for each drug that you are having the – or expecting Part D to cover. They – the PA requirements- once they're satisfied should not be necessary for each refill however.

When a claim for a hospice beneficiary is received, if the prior authorization edits were not previously overridden for the drug, the sponsor will be using existing standard PA processes. Plan sponsors have been using prior authorization as a utilization management tool since the beginning of the Part D program.

So, many pharmacies and prescribers are familiar with it. All of them, no, but many of them will be. In fact, many of you have potentially have had to meet prior authorization requirements for other insurers as well. And this process probably isn't going to be that much different from that which you've experienced with them.

The industry through the National Council for Prescription Drug Program has developed reject coding that we expect to be used to identify these claims. In addition to the reject coding, we specify that the sponsor should return point-of-sale messaging that states "hospice provider requests prior authorization" and provides the sponsor's pharmacy Help Desk phone number.

Note that these are not claims denials. What they are is a reject that indicates that additional – additional information is required for the plan sponsor to process the claim.

One of the slides in the deck includes the industry approved codes. These are A3, this product maybe covered under Hospice Medicare A75, prior authorization required and 569 which directs the pharmacy to provide the beneficiary with a notice that is entitled, "Medicare Prescription Drug

Coverage and Your Rights”. This notice will instruct the beneficiary regarding how to initiate the prior authorization process.

When a pharmacy receives the reject code and the messaging, a number of possible scenarios can take place depending on the pharmacy, how busy they are, if the beneficiary or the family members are known to them, et cetera. Minimally, they will inform the person at the counter that a prior authorization is required and hand them the notice. Others may offer to assist by calling the prescriber, or the hospice, or the plan sponsor.

The prior authorization, however, must be initiated by one of the following: the beneficiary, the beneficiary's appointed representative and in that – I mean, a representative who is appointed by the beneficiary to represent them and not somebody else appointed by someone else to represent the beneficiary, or the prescriber. So, the beneficiary, an appointed representative, or the prescriber can request the coverage determination.

Once the prior authorization is initiated, the sponsor will contact the prescriber or the hospice and we have indicated that the Part D sponsor should accept either a verbal or written explanation of why the drug is unrelated. Once the Part D sponsor receives the explanation of unrelatedness from the hospice or the prescriber, the sponsor must adjudicate the coverage determination within 24 hours for an expedited request or 72 hours for a standard request. So the clock starts for the Part D sponsor to complete their work at the point that they received the information from the prescriber or the hospice that the drug is unrelated.

Many commenters on the draft guidance requested a standard prior authorization form. We were unable given the time to create and get approval for a standard form. However, we did compile a list of data elements which we would expect to see on a prior authorization form. We've encouraged the sponsors to use these elements and only these elements on a form that would be used exclusively for hospice prior authorization. We believe this will provide reasonable uniformity for 2014. The data elements are in the March 10th guidance in Attachment 2.

There will be no dispute resolution process and in that I mean, a process to handle disputes between Part D sponsors and the hospice over whether it's (a drug's) related or unrelated to the terminal illness or related –conditions.

The prior authorization documentation will support coverage of the drug under Part D. The fact that there is no dispute resolution process for any disagreements between Part D sponsors and hospices does not affect the beneficiaries' appeal rights. Beneficiaries retain the right to appeal Part A coverage determination through the Medicare fee-for-service process and Part D coverage determinations through the Part D appeals process.

When sponsors receive notification of a member's hospice election and that means either through the reporting that CMS does to the sponsors or from the hospice as part of the prospective communication, the sponsor should determine if they have paid for drugs on or after the date of the election. If so, the sponsor should contact the prescriber, or the hospice, to retrospectively determine payment responsibility for those drugs.

If a drug is determined to be the hospice's or beneficiary's responsibility, we will direct the Part D plan to work directly with the responsible party, negotiate with them in order to recover the payment. So, our expectation is that if the – if a claim has been paid for a drug that is related and it is a – should have been a hospice responsibility that they will contact the hospice and work with them to recover the payment.

If however, the responsible party is the beneficiary because the drug was waived, or they elected to take a drug that was off formulary despite the hospices' direction to try a formulary drug, then the recovery would be through the beneficiary.

I've gotten a lot of questions about how a hospice can identify which Part D plan to contact and I guess the kind of the obvious and perhaps the easiest, (I don't know), is to ask the beneficiary or their family whether they – whether the beneficiary has Part D and ask to see their membership card and copy down the information.

The alternative however, is to ask a hospice pharmacy, and it's either the pharmacy that the hospice operates or a pharmacy that would be under contract to the hospice, to submit a standard electronic eligibility query known as an E1. The pharmacy must provide information identifying beneficiary on the E1 query and submit it to the CMS Part D transaction facilitator. The facilitator will attempt to find a match in the Part D eligibility database. If a match is found, the query response back to the pharmacy will identify the plan sponsor, provide the sponsors online billing information as well as their pharmacy Help Desk phone number.

A hospice cannot request an E1. These are pharmacy transactions. If a hospice pharmacy does not currently have E1 capability, there are instructions available on the facilitator Web site which is, and I hate reading, but there doesn't seem to be much of an alternative here.

Their Web site is [http://](http://medifacd.relayhealth.com/e1/getting-setup), and this is all one word, medifacd, so it's M-E-D-I-F-A-C-D as in dog, all one word all lower case, relay health, again, all one word R-E-L-A-Y-H-E-A-L-T-H.com/ little E, 1, / getting (hyphen) setup, there is no www here. It's- (<http://medifacd.relayhealth.com/e1/getting-setup>) – the way I read it is the correct way. We're going to be posting some FAQs and I will include this as one of the questions so that you will have the Web site available.

You can also send me an e-mail, and I'll zip it off to you to, if you didn't capture it. If a hospice is interested in identifying all of the Part D enrollees in its existing census, you'll need to either ask all the beneficiaries or do an E1 query for each person.

Hospices can initiate communication or fulfill a prior authorization through the sponsor's 24-hour Help Desk. And I know that some of you have attempted to do this and have had some problems, but this our expectation and hopefully by the time May the 1st rolls around all processes will be in place including this.

To facilitate sponsor communication with hospices, CMS will be making hospice contact information available to sponsors through our health plan

management system. And this is the information that will not – this is not a Web site so, this is information that will be available only to the Part D sponsors through this system. But your identifying information will be available to them so that they can reach out to you as well. Although we initially proposed an effective date of March the 1st, – the effective date of the policy clarification will be May the 1st and the policy will be applied prospectively.

During the first four months of 2014, sponsors really have a number of options that they can be pursuing. They may be following the 2014 Call Letter guidance and have implemented prior authorization on the OIG's four categories of drugs.

They could have anticipated a policy to place prior authorization on all drugs as indicated in the December 6th memo and have implemented already that approach. Or they may have continued a pay-and-chase policy which was acceptable. Although we discouraged it, we did not preclude it. And they may have continued to pay-and-chase awaiting final guidance for 2014. Again, all of those are acceptable approaches that you may see as you're working with the Part D plans.

We recognized Part D guidance was ambiguous and there were no objective criteria for Part D sponsors to apply in making Part D versus A coverage and payment determination. Thus, we expect no further auditing of Part D drug claims for hospice beneficiaries by the OIG or CMS for 2014 or prior years.

There may and it's a slim possibility, there may be a very tiny number of residual claims from the Center for Program Integrity review of claims for analgesics, and these will still require resolution. I think we had hit or surpassed 99 percent. So the number will be tiny indeed. But if they come up, they will still require resolution.

There may be instances in which a Part D sponsor refuses to pay. We've directed plan sponsors in 2014 to accept a prescriber's or a hospice's explanation of why a prescription drug is unrelated. But this is an expectation, not a requirement that we can enforce.

There are also other reasons the sponsors may refuse to pay. For example, the prescriber or the hospice has explained why a drug was prescribed, but not why it is unrelated. A Medicare Advantage plan that provides Part D drug coverage will have a lot more information regarding an individual's medical condition than a stand-alone Part D plan will have. And it does not help to say that a drug was prescribed for a particular condition when they don't know what the terminal illness is. So it's incumbent upon a prescriber or the hospice in providing the explanation to make it clear why it is unrelated.

In addition, every Part D sponsor has a network of pharmacies with which they contract. If the dispensing pharmacy is out of network, emergency access conditions must be met for an out-of-network pharmacy to be used. If these conditions aren't met, the drugs cannot be covered under Part D because it's not considered a Part D drug unless it has been accessed at a network pharmacy or an out-of-network pharmacy under the emergency access conditions. So, that would be another reason of why a sponsor might refuse to pay.

Another reason is if the drug is a non-formulary drug or requires a prior authorization under the sponsor's utilization management program and those requirements are not met. These would be prior authorization requirements that were drug-specific as opposed to those of the hospice prior authorization which is beneficiary-specific.

In cases where both a beneficiary-level PA and a drug-specific PA are necessary, we encourage the sponsors to address both concurrently to avoid any additional delay in the beneficiary accessing the drug.

If you have questions regarding Part D and hospice or issues that you wish to raise, they should be sent to the Part D policy mailbox that is Part D policy, all one word @cms.hhs.gov, PartDpolicy@cms.hhs.gov. Please include a hospice in the subject line that will reduce the delay in routing these to the appropriate person.

And that's all I have. I guess we can address any questions.

Jill Darling:

Yes. We can go into the Q&A session please.

Operator: As reminder ladies and gentlemen, if you like to ask a question, please press star then the number one on your telephone keypad. If you'd like to withdraw your question, please press the pound key.

And again, please limit your questions to one question and follow-up to allow other participants time for their questions. If you require any further follow-up, you may press star one again to remain on the queue.

Your first question comes from the line of Kate Wright from the Hospice of Jefferson County your line is now open.

Kate Wright: I don't think I knew that it was open the whole time. I don't have a question though, so I apologize.

Operator: Your next question comes from the line of Judi Lund-Person from NHPCO your line is now open.

Judy Lundy-Person: I thank you for the presentation today. I have a question about the statements you made that CMS' expectation that the Part D plan would pay based on the PA, but then that was not enforceable. Would you help us understand that?

Deb Larwood: Sure. We have – we cannot require something that is not in regulation. But we signal through sub-regulatory guidance our expectations of the Part D sponsors. What has traditionally occurred is there's a signaling that at some point in time if they are – if we feel that we need a regulation to ensure compliance with our guidance that we will undertake rulemaking. But we cannot require that the sponsors do anything that is not in regulation.

Tracey McCutcheon: Judi, this is Tracey McCutcheon. I would just point out that, generally speaking, our sponsors are very alert to these signals, that they make every effort to comply. And if there are issues with compliance, they can be reported and we'll work with the party. It's strictly a legal matter and I'm sure you're familiar with that as well, you know, on your end about the difference in statute and between regulatory guidance ...

Judy Lundy-Person: Absolutely. Thank you.

Operator: Your next question comes from the line of Kelly Erola from Hospice in Savannah your line is now open.

Kelly Erola: My question is if Part D agrees to accept the hospices' reasoning for the drug being non-related and paid for it, and then changes their mind three or four months down the line, can they come back retrospectively and demand payment from the hospice?

Deb Larwood: We don't see any reason why that would happen. We have told the Part D sponsors that having that documentation will cover them in case of an audit, they have the documentation to substantiate their – the fact that the drug is coverable under Part D. There would be really no reason for them to come back and counter that at some subsequent point.

Kelly Erola: Thank you.

Operator: Your next question comes from the line of Janet Martinich from Hospice of Lansing your line now open.

Janet Martinich: What if a beneficiary refilled their medication a day or so before coming on to hospice? How does that work?

Deb Larwood: It'd be coverable under Part D; it's prior to the hospice election.

Janet Martinich: Thank you.

Operator: Again, if you like to ask a question, please press star one on your telephone keypad. And if you wish to withdraw your question, please press the pound key.

Your next question comes from Scott Smith from Consolo Services Group your line is now open.

Scott Smith: Thank you. Again, I would like to ask kind of a remedial question. I represent an electronic medical record program and we're trying to figure out exactly how to support our users and this process will be the memos that you

you're answering from December 6th and March 10th. Will those give us explicit instructions on how we might possibly come up with ways to support our users in this process?

Deb Larwood: The only thing I can say is take a look at them and see how far they get you. The other alternative is to work with NCPDP. It has a hospice task group and they are the standard setting organization. They would be in a position to potentially assist as well.

Scott Smith: OK. Could you repeat that? What was that work group?

Deb Larwood: It's the National Council Prescription Drug – for Prescription Drug Programs, NCPDP.

Scott Smith: .org. OK. Good. Thank you.

Deb Larwood: Yes. And they have a hospice task group.

Scott Smith: OK. Thank you.

Deb Larwood: You're welcome.

Operator: Your next question comes from the line of Gina Annese from Tender Loving Care. Your line is now (inaudible).

Gina Annese: Hi. We read all the letter and information that was given to us. And it talks about that a patient can appeal a decision if the hospice determines the medication is not related. The Plan D says the patient's medication, is hospice related and it actually isn't, does the patient or family appeal that decision as well?

Deb Larwood: That's really under the guidance that we've issued for this year. There's really no reason for a Part D sponsor, if a hospice or the prescriber has provided a real explanation, a coherent clinical explanation as to why the drug is unrelated, that they should claim it's related. That's their ticket to go ahead and pay.

Gina Annese: OK. Thank you so much.

Operator: Your next question comes from the line of Jeff Reid from Sharp Health Care your line is now open.

Jeff Reid: Yes. And just a basic question, is there going to be an encore presentation of this?

Deb Larwood: There will be transcript and audio recording that will be put together for this.

Jeff Reid: Thank you.

Deb Larwood: You're welcome.

Operator: Your next question comes from the line of Sandy Cox from Mission Pharmacy your line is now open.

Sandy Cox: Hi, I have a question regarding – well, I'm at the pharmacy and we're getting some claims that are rejecting the prior authorization for people who have been in the hospice in the past but aren't currently hospice. And they're telling us that the doctors still need to do prior authorization for them.

Deb Larwood: Well ...

Sandy Cox: Is that sort of something that changes?

Deb Larwood: It depends on really why they're asking for the prior authorization. If they think that prior – if they think that the beneficiary is still in hospice because the termination or the revocation has not made it to our system to get reported to them and get uploaded in their system, which can take probably about five days from the time that it hits the common working file, you're familiar with that, through to going out the door, then what you could do in those instances is to contact the Part D sponsor and be in there and tell them that they've terminated or revoked their election, or send them a copy of whatever documentation there is ...

Sandy Cox: Yes.

Deb Larwood: ... kind of the opposite of an NOE. Is there one or 2no?

Katie Lucas: If they were discharged for no longer being terminally ill then they would have a NOMNC, or Notice of Medicare Non-Coverage. If they moved out of the hospice's service area or if they were discharged for cause, there wouldn't be paper work given to them. If the beneficiary revoked, the beneficiary provides the paperwork to the hospice.

Deb Larwood: OK. So that's, you know, I would think that that kind of falls into the prospective communication, only in this case it's not really prospective. Well, I guess it is. It's before the reporting makes it to the Part D sponsor through normal reporting processes.

So, those are best possible explanations. I can't imagine that if the election we're showing is terminated, unless it was a paper claim that was paid and they're seeking reimbursement for it, for the time that the individual was in the hospice— that they would be looking back and requiring a prior authorization when the individual is no longer in hospice if that information is available to them already, that is, there's been a termination or revocation.

So, I would say probably the best thing to do is to reach out and find out why they want it and see if there's information that you can supply to override a need for the prior authorization.

That would be of any level of prior authorization based on the hospice election, there might be a drug level of prior authorization on the drug if the drug had one on the Part D formulary to get this. So, there are different reasons for – and types of prior authorization.

Sandy Cox: Right and what I came across is that even if any time in their life that they were with hospice, it's coming up on the Med D plans that they were hospice at one time and now they're requesting prior auth.

Deb Larwood: Well, we can make it clear when we're having a conversation with the Part D sponsors that that's not the approach to take.

Sandy Cox: OK. Since; we're getting a lot of rejections regarding that.

Deb Larwood: OK. Well, thank you for letting us know.

Sandy Cox: You're welcome.

Operator: Your next question comes from the line of Norman Vadeboncoeur from Preferred Pharmacy Solutions your line is now open.

Norman Vadeboncoeur: Thank you. I have a question. I actually am a certified technician working on a long-term care pharmacy and this particular program is causing us lots of grief. Because we're getting – every patient that we have has hospice, it's getting – all of their medications rejected because the Med D plan doesn't want to cover anything because the patient has some hospice and we have to find a way to get the doctor or the hospice plan to contact them and let them know what medications should not be on that list. But in the meantime, they're rejecting everything. And this is creating a lot of work for us here at the pharmacy.

Tracey McCutcheon: This is Tracey McCutcheon. We understand, and this guidance that we put out is the best we could do for 2014 to provide a means for getting Part D payment.

Norman Vadeboncoeur: But there should be something we could do to help the folks that are in the long-term institutionalization mostly the skilled nursing homes or nursing homes, assisted living and stuff like that.

And the problem that we're having is that, you know, every medication that we try to supply is getting held up or we're trying to send out a short supply in the interim or trying to get the prior authorization situation straightened out between the Med D and the hospice. And we have difficulty getting the hospice information too among other thing but that's another story.

Tracey McCutcheon: I can appreciate that but at least when you're in the long-term care situation you should have a relationship with both the hospice and the Part D plan.

Norman Vadeboncoeur: You would think so, but we don't. Sorry.

Jill Darling: We'll take the next caller please.

Operator: Certainly. Your next question comes from the line of (Thomas Sorley) from VNA of Greater Lowell Hospice. Your line is open.

Female: Hi. Can you tell me what would be considered an adequate explanation of drugs that are unrelated to the terminal illness?

Deb Larwood: An adequate explanation would be a coherent clinical explanation of why it's unrelated.

Female: So if the patient has cardiac disease but their terminal diagnosis is cancer, if you write the medication is for preexisting cardiac disease that is not related to terminal diagnosis of cancer is that acceptable?

Deb Larwood: We would have – I mean, it has to be looked at on a case-by-case basis and what the Part D pharmacy would consider.

Currently right now, what we are asking you to do is to make sure that you say if it is unrelated and have a clinical explanation as to why. So you put those things through and then for 2014 that is what we are asking you to do.

Tracey McCutcheon: But I think this is true like the example that you gave sounded like a reasonable one and ...

Dr. Simpson: For 2014 that sounds like a reasonable thing to do.

Deb Larwood: What we're trying to say is that we don't want you to just make a statement that the medication is unrelated to the terminal illness and related conditions. That's not sufficient. There needs to be an explanation such as the one that you gave specifically ...

Female: OK.

Deb Larwood: ... of what the implications for and why you believe that's not related to the terminal illness in related condition.

Dr Simpson: Yes, we would prefer that you don't say because the doctor said so.

Deb Larwood: The sponsor should not accept that.

Dr Simpson: Right. For 2014, that would go through.

Randy Thronset: And I would just like to highlight that's not making any statement with regards to whether or not there's an agreement that the Part D sponsor necessarily agrees with the reasoning that you're giving.

It's just that, as Doctor Simpson said, for 2014 that's the requirement; that an explanation be provided and that it be reasonable, which is what Deb was saying. It's not to say that there's an agreement– that would in fact justify or otherwise – that the drug was necessarily unrelated. But for 2014, Part D sponsors have been told to accept that sort of explanation. That doesn't speak to future years.

Female: OK. Thank you.

Female: OK.

Operator: Again, if you wish to ask a question, please press star one on your telephone keypad. If you like to withdraw your question, please press the pound key.

Your next question comes from David Boal from Agape Hospice your line is now open.

David Boal: Good afternoon. I've got patients that are already being denied even though the implementation isn't until May 1st but I have a particular home care patient that was not notified until she received the bill from the pharmacy and then in the explanation of benefits. And I thought the Part D sponsor was supposed to go back to the prescriber or the hospice.

I'm just trying to figure out where do I go from here? Do I contact the pharmacy? Did they drop the ball or do I contact the Part D sponsor directly?

Deb Larwood: I think I'd start with the Part D sponsor to get an explanation on what's going on and then figure out how you need to proceed from there.

David Boal: OK, Thank you.

Operator: Your next question comes from the line of Mary Anne Bressan from Hospice of New Jersey. Your line is now open.

Mary Anne Bressan: Thank you very much for today's presentation. We do have a case that we're working on and it sounds like everyone else is facing the same thing. We actually have a patient that revoked, and we can't get anyone to listen to us even the number on the back of her Medicare card that the patient has not been on service and she's not being allowed to get her medication.

And is there going to be an expected support line or something to get us through this so that our patients that are no longer on service whether they revoked or discharged for non-medical eligibility will be supported and they'll not go through these stressful situations?

Deb Larwood: Well, there is the pharmacy HelpDesk phone number which is supposed to be available to you for this purpose. I can reiterate that the idea of hospices reaching out in providing information to the Part D sponsors is a new concept to them. And some of them have not yet figured out how they're going to handle everything.

They have – there's an existing process that we have for sponsors to take information and use it until they get the data from us. And one of the things that I will be communicating to the Part D sponsors is the same kind of approach should be used in these instances as well.

So, they should be a little more – become a little more receptive to taking information and acting on it, then requiring that they get the – and not – to not take any action until they hear from CMS. So, we can make that clear and hopefully that will resolve some of these.

Katie Lucas: One other thing, on this patient, had you filed the final claim for this patient that revoked?

Mary Anne Bressan: Yes. Yes, we have. Yes, we have.

Katie Lucas: Was it a short time frame after filing the final claim that this problem occurred?

Mary Anne Bressan: Yes.

Katie Lucas: It may just be that it hadn't flowed through the system.

Mary Anne Bressan: OK on its onsite. Thank you so much. Is there a number for the pharmacy helpline that you can share?

Deb Larwood: Each sponsor has their own pharmacy Help Desk number. You could try doing an E1 query and get the pharmacy Help Desk number.

Mary Anne Bressan: Thank you.

Tracey McCutcheon: Or call the number on the beneficiaries card and ask them how to get to the ...

Mary Anne Bressan: But that's the number we had been calling, and that – and note that that's the exact number we have used on several occasions in the last several days and we're not getting anywhere with it.

Tracey McCutcheon: You need to ask them not to help you but to give you the pharmacy Help Desk number.

Mary Anne Bressan: OK. Thank you.

Operator: Your next question comes from the line of Marla Cummins from Wabash Miami Hospice your line is now open.

Marla Cummins: My question is that understanding that only the beneficiary or their legal representative can start this PA program or can the hospice do that as well on their behalf?

Deb Larwood: No, the hospice cannot initiate the PA process. What you can do is to provide information and prospectively before claim is filed. But the actual process for coverage determination has to be initiated by the beneficiary and their authorized representative or the prescriber.

Marla Cummins: Once the hospice determines something is not covered then we have to let the patient know that they're going to have to call their Part D and the start the PA process?

Deb Larwood: No, you can reach out to the Part D plan. It's just that that's not a really a prior authorization process. What that is is giving them the information that they would need to override the PA requirement before the beneficiary or somebody submits a claim for processing.

Marla Cummins: But once the claim has been processed that the hospice hasn't done that ahead of time then the beneficiary has to do the prior approval process.

Deb Larwood: Yes. The beneficiary...

Marla Cummins: OK.

Deb Larwood: ... or their representative or the prescriber. Any of the three of them can initiate it after a claim has been submitted.

Marla Cummins: All right, thank you.

Operator: Your next question comes from the line of Richard Marlin from Allen's PharmaServ. Your line is now open.

Richard Marlin: Thank you. This is kind of a follow-up to the last question. If we've had the experience where some of the Part Ds had been willing to take information from the pharmacy others have not, it's very inconsistent. However the hospice, if they were to try to get to the Part D plan prospectively, how do they do that? Because the Helpdesk members have no clue what's going on with this process and there is no dedicated numbers most of the time for the hospice to call to even conduct this kind of a procedure.

I just want to know if you're requiring or expecting or requesting that the Part D set up a special phone number or what have you for hospices to contact them prospectively because there's no mechanism it appears at this time.

Deb Larwood: Right. The existing mechanism is the pharmacy Helpdesk phone number. I know that in our conversations with some of the Part D sponsors they actually have a separate hospice line and they have done trainings with the people who man those phones on hospice on our requirements with regard to the prior authorizations and accepting information and the whole nine yards. I mean, they're – they've been very proactive.

You know, we have over 400 Part D plan sponsors and their preparedness, their level of preparedness is going to vary greatly. And as I pointed out the process where they're taking information from the hospice was something that was not in the draft guidance so they found about it on March 10th.

And some of them had been very actively pursuing getting things in place. And others as you can imagine have not been quite as well. But there's the learning curve and I think as we worked our way through it, things will get better.

Richard Marlin: It seems to me that in some regard here, with the timing of how you put out these draft guidance as you really put the cart before the horse without making sure that the plans had time to get their processes setup before making it effective. Because there – again as other callers have said, they are rejecting, you know, everything that we've had to go through four or five phone calls and processes for one patient.

So, I would hope that in the future as you're preparing these guidelines that you give all the information out appropriately so the people have time to get set up. This was done on a very short notice and really threw everybody under the bus kind of, so to speak. So I appreciate the call.

Jill Darling: Yes, Thank you very much for your wrap up. And that will be everything for our (two-week) session. We appreciate everybody listening in and for all your questions. And again, if you do have any questions for the final 2014 guidance, it can be sent to the Part D policy e-mail address, that's partdpolicy@CMS.hhs.gov.

Thank you everyone and have a great day.

Operator: This concludes today's conference call, you may now disconnect.

END