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July 1, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1609-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs and Beneficiaries Enrolled in Hospice [CMS-1609-P; RIN 0938-AS10]

Dear Sir or Madam:

The National Community Pharmacists Association (NCPA) welcomes the opportunity to submit comments on the proposed rule, *Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs and Beneficiaries Enrolled in Hospice*. NCPA represents the interests of pharmacist owners, managers and employees of more than 23,000 independent community pharmacies across the United States. Together they employ over 300,000 full-time employees and dispense nearly half of the nation's retail prescription medicines. In addition, approximately 40% of the long-term care market is serviced by an independent community pharmacy. Independent community pharmacists are proud to play a vital role in the Medicare Part D program, and have been on the front lines of providing medications, related counseling, and auxiliary services for beneficiaries since the introduction of the Part D program.

While the Centers for Medicare & Medicaid Services (CMS) stated that this proposed rule would only affect Medicare hospices, and would have no effect on other provider types, NCPA contends that pharmacies that service hospices and their patients are impacted by current hospice payment guidance, and will continue to be affected by any future policies regarding Part D coordination with hospice payments. While we support the intent of CMS to ensure that the appropriate entity provides coverage for medications, we believe current policies have created additional barriers to access for hospice patients, and placed undue strain on other stakeholders – hospices, plan sponsors, and pharmacies – with potential detriment to patient care in an already vulnerable population. We appreciate the recent hospice and Part D stakeholders meeting CMS hosted to begin the dialogue on coverage determination, and look forward to any additional guidance the Agency can provide in the interim. NCPA will provide community and long-term care (LTC) pharmacy's perspective in response to the solicitation of comments on coordination of benefits process and appeals for Part D payment for drugs while beneficiaries are under a hospice election.

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NCPA would like to stress that in any policy discussions or decisions, we must all remain cognizant that the patient population affected is in a fragile state, and their quality of life and care should remain a top priority. Just because these types of complaints are not being documented in the CMS complaint tracking module does not mean they do not exist or that patients are not upset. All stakeholders who serve these patients must be willing to assume accountability for ensuring that these patients have timely access to the vital medications they need. This process can be greatly facilitated by CMS with the establishment of consistent, standardized processes for determining payment responsibility, payment recovery when the incorrect entity has paid, and resolving of payment disputes. Having such processes in place, as well as greater education and outreach to all stakeholders will enhance and streamline the hospice benefit, without impeding patient care.

NCPA has previously shared our concerns in comments to the 2014 Call Letter with mandating additional beneficiary-level prior authorization requirements for hospice drugs. We understand the efforts to curb the duplicative billing of medications, however increasing the amount of drugs subject to prior authorizations is not an adequate solution. Prior authorizations are a drug utilization management tool, to ensure the safe, appropriate, and cost-effective use of selected medications or class of drugs, usually based on clinical guidelines. We do not believe they should be used in a blanketed approach to determine appropriate payer coverage, and we are concerned that this could lead to greater abandonment of medications out of frustration with the process, further compromising the health of these patients. As we have witnessed since the policy went into effect May 1, 2014, the drastic increase in drugs now subject to prior authorizations create greater beneficiary confusion, undue burden on community pharmacies, and delays in care to Medicare's frailest and most vulnerable populations.

We would like to take this opportunity to share the experiences of our members since the policy regarding Part D Payment for Drugs for Beneficiaries Enrolled in Hospice took effect. For pharmacies which are the contracted provider for LTC facilities, medications are required to be delivered and administered within a reasonable time. These pharmacies are providing the drug at-risk, and do not know at the time of dispense where their payment will come from. Although the Agency intends for coverage determination to be made from payer to payer, the pharmacy is inevitably caught in the middle. Oftentimes the pharmacy first learns of a patient's election of hospice upon rejection from the plan sponsor when submitting a claim. Upon receiving the Part D rejection, the pharmacy contacts the hospice provider to initiate a Prior Authorization. In the meantime, the pharmacy will go ahead and dispense the medication and then must wait to see which payer to bill the product to.

As CMS solicits comments on processes the Agency is considering to facilitate coordination and payment between Part D sponsors and hospices, NCPA would like to stress the need for consistency and communications for all parties involved. Due to the variability in awareness from the hospices on the new policy, and the vast differences in how plan sponsors are handling the prior authorizations, pharmacies have expended countless staff hours devoted solely to billing issues. The administrative time spent by all parties has been significant and not necessarily resulted in better patient care. Pharmacies have reported requiring a billing person to work full time on this issue alone, which puts patients at a disadvantage and adds significant, non-reimbursable costs to the pharmacy just to track down the appropriate payer or fill out additional paperwork.

It is critical that there be a communications pathway back to the pharmacy once the prior authorization process has been initiated, and therefore NCPA supports the requirement that a Part D sponsor determine Part A versus Part D coverage at point-of-sale for any drugs for beneficiaries who have elected the hospice benefit, in addition to standard reject coding messaging currently in place. Community pharmacists have been placed in the difficult situation of denying the patient their much-needed medications, oftentimes without any additional information to provide to the beneficiary or their caregiver, other than to contact the plan sponsor. Providing pharmacists with additional information that indicates a hospice is involved, and

additional explanation is needed to confirm the drug is unrelated to the terminal illness will be helpful. Additionally, pharmacies often do not receive any communication to reprocess hospice patient claims once the prior authorization has been approved, leaving the pharmacy no other choice than to make multiple attempts to reprocess and hope the claim will adjudicate and be paid, each time paying fees to adjudicate.

While not included in the scope of this proposed rule, NCPA urges CMS to provide specific guidance on how audits to determine the proper payer should be conducted, and to establish enforceable actions on any party that is not cooperating. With the wide variation in how hospice election is currently communicated to plan sponsors, and drug coverage determinations made, this leads to an opportunity for audit abuse and large sums of recoupment from pharmacies. Pharmacies today are appropriately identifying and working with the hospice providers to complete retroactive drug coverage determinations. However due to circumstances beyond their control, pharmacies are penalized and forced to reverse all the claims which could not be validated, often due to the lack of response from hospice agency and/or inability to identify hospice election/provider. Pharmacies have lost payment for thousands of claims not confirmed to be hospice, leaving no option for the pharmacy to be paid for these claims, after the medication has been dispensed. In the event plan sponsors are required to make retrospective claims adjustments, we strongly recommend the prohibition of recoupment of pharmacy claims that have not been positively confirmed as the responsibility of hospice based on documented based available evidence at time of dispense.

We recognize that there currently is not a robust coordination of benefits infrastructure to effectively manage coverage determination, and data lags which prevent this from being a timely process. Pharmacies often feel that their hands are tied while awaiting information, cooperation, and communications from others regarding hospice-election information. Any information that can be provided in a proactive manner, such as a hospice initiating communication to the Part D sponsor by reporting a beneficiary's hospice status, would be a positive improvement. We urge CMS to take actions to improve the information flow related to hospice elections; increase accountability associated with conveying this information to vested parties; identify an enforcement contact if a party fails to cooperate; and protect against unfair audit abuse practices. NCPA appreciates the attention from CMS on this important issue, and the opportunity to provide our perspectives and recommendations.

Sincerely,

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National Community Pharmacists Association (NCPA)