

# HEALTHCARE RIGHTS REVIEW

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CENTER FOR MEDICARE ADVOCACY, INC.

Washington, DC Office • 1101 Vermont Ave, NW • Suite 1001 • Washington, DC 20005 • (202)216-0028

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## HOSPICE AND PRESCRIPTION MEDICATIONS

### - THE PROBLEM -

Who pays for a hospice patient's prescription medications? When will Medicare Part D plans be responsible for coverage of prescription drug medications and when will the traditional Medicare hospice payment sources apply? With the advent of Medicare Part D, this question, always tricky, will get even trickier.

### INTRODUCTION

#### HOSPICE CARE

Hospice care is available to Medicare beneficiaries who have been diagnosed with a terminal illness and who have a life expectancy of six months or less, assuming that the terminal illness runs its normal course. When a Medicare beneficiary elects the hospice benefit, she becomes eligible for comprehensive palliative treatment for the terminal illness. However, in electing the hospice benefit, the beneficiary also waives Medicare coverage for curative care related to the terminal illness.

In order to receive Medicare coverage for hospice care, Medicare beneficiaries who elect the hospice benefit must also select a Medicare certified hospice provider. While the beneficiary is enrolled in the certified hospice provider's program, the hospice provider is paid a per diem. During this period, the Medicare Conditions of Participation require that the hospice provider render the palliative care necessary to ameliorate the beneficiary's pain or other discomfort. This palliative care includes the provision of medications related to the individual's terminal illness. At most, hospice providers may charge hospice patients a \$5.00 co-payment for the cost of the provided medications.

#### MEDICARE PART B

Medicare Part B covers the cost of prescription drug medications when they are usually not self administered and are administered during a visit to a physician's office. Part B, under defined circumstances, also covers (this is not a comprehensive list): Durable Medical Equipment (DME) Supply Drugs; Immunosuppressive Drugs; Hemophilia clotting factors; Oral Anti-Cancer Drugs; Oral Anti-Emetic Drugs; Pneumococcal vaccine; Hepatitis B vaccine; Influenza vaccine; Antigens; Erythropoietin; Parenteral Nutrition; and Intravenous Immune Globulin provided in the home.

## MEDICARE PART D

As of January 1, 2006, some prescription drug coverage will be available to Medicare beneficiaries under the new Medicare Part D. Medicare beneficiaries who decide to participate in Medicare Part D will have to affirmatively enroll in a Medicare Part D plan. Each Part D plan will have a formulary which will cover at least two members of each class of medications approved by the Food and Drug Administration. However, according to the law, the Part D plans are prohibited from covering the following medications (except as supplemental benefits): agents when used for anorexia, weight loss, or weight gain; agents when used to promote fertility; agents when used for cosmetic purposes or hair growth; agents when used for the symptomatic relief of cough or colds; prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale; barbiturates; and benzodiazepines. Additionally, according to the law, Part D plans are prohibited from covering non-prescription medications, except when used as a part of plan utilization management (step-therapy) programs. When used as part of a plan utilization management program, non-prescription drugs can be provided by the Part D plan at no cost to enrollees.

Medicare Part D will also not cover medications for which coverage is available under Part A or Part B, as the medications are “prescribed and dispensed or administered” with respect to the individual. If, however, medications that are sometimes covered by Part A or Part B are prescribed or administered such that they will *not* be covered by either Part A or Part B, they may be covered by Part D.

## WHO SHOULD PAY FOR THE HOSPICE PATIENTS’ MEDICATIONS

After January 1, 2006, which entity (the hospice, Medicare Part B, the beneficiary’s Part D plan, or the beneficiary) should pay for a hospice patient’s medications will depend in large part on the medication’s purpose.

### 1. Is the Medication related to Palliation of the Terminal Illness?

First and foremost, if the medication is related to the *palliation* of symptoms caused by the beneficiary’s terminal illness, then it should be paid for by the hospice provider. If, on the other hand, the medication is related to the *curative* treatment of the beneficiary’s terminal illness, its cost will *not* be covered by the hospice program, Part B, *or* the beneficiary’s Part D plan. It will not be covered by the hospice program, because the hospice program is not responsible for coverage of curative treatment. It will not be covered by Medicare Part B or the beneficiary’s Part D plan, because when the beneficiary elected the hospice benefit, he waived Medicare coverage for curative treatment of his terminal illness.

For instance, if Mr. Aubo is diagnosed with terminal cancer and admitted to a hospice program and is then prescribed chemotherapy for the purpose of shrinking his tumors so as to decrease his pain, then the chemotherapy is palliative and should be billed to the beneficiary’s hospice program. If on the other hand, Mr. Aubo’s chemotherapy is prescribed to vanquish his cancer, then the treatment is curative. Therefore, it will not be covered by the hospice program, Part B, or Part D.

If, however, Mr. Auboix wishes to pursue curative treatment, he may revoke his hospice benefit, and return to regular Medicare. Should he choose this option, his medically reasonable and necessary curative treatments, including medications, should be covered by regular Medicare.

## **2. Is the Medication related to the Terminal Illness?**

If a Medicare beneficiary has a non-terminal medical condition for which she was receiving a medication that was covered by Part B and then is admitted to a hospice program for a different illness that is terminal, the medication that the beneficiary was receiving coverage for under Part B continues to be covered by Part B and should not be billed to the hospice program or the beneficiary's Part D plan.

For instance, if Mrs. Bailey has a history of chronic obstructive pulmonary disease (COPD) for which she was receiving the medication albuterol sulfate through a nebulizer (which is durable medical equipment) that was covered by Part B, and then Mrs. Bailey was admitted to a hospice program with end-stage acquired immunodeficiency syndrome (AIDS), both Mrs. Bailey's albuterol sulfate and her nebulizer would continue to be billed to Part B. This is because when Mrs. Bailey elected hospice care, she did not waive Medicare coverage for care not related to her terminal illness.

An exception to the above scenario would occur if there was a change in how the Part B drug was "prescribed and dispensed or administered" such that it was no longer coverable by Part B. Let's take the example of Mr. Cranston. He has a long-standing diagnosis of Multiple Sclerosis for which he has been receiving Avonex injections which have been covered by Medicare Part B because they have been administered incident to a physician's visit. Subsequently, Mr. Cranston was diagnosed with the terminal diagnosis of end-stage dementia. He was admitted into a hospice program and is no longer physically capable of making the monthly visits to his physician's office. Since he can no longer get to his physician's office, Part B will no longer cover his Avonex injections. However, so long as Avonex is on Mr. Cranston's Medicare Part D plan's formulary, Mr. Cranston's Avonex can now be billed to his Medicare Part D plan. In the event that Avonex is not on Mr. Cranston's Part D plan, his representative should exercise Mr. Cranston's right for appeal under the plan's Exceptions process. If Mr. Cranston had capacity, he would be able to appeal on his own behalf and thus would not need a representative.

If a beneficiary has a terminal illness but also has a chronic condition for which she was receiving a medication that was covered by her Medicare Part D plan, and she elects the hospice benefit, her medication for the non-terminal chronic condition will still be covered by her Medicare Part D plan. For instance, if Mrs. Davis has end-stage congestive heart failure and she also has a diagnosis of diabetes for which she was receiving Part D coverage of her insulin and the medical supplies associated with the injection of insulin (syringes, needles, alcohol swabs, and gauze), if she enrolls in a hospice program, her Part D plan will continue to pay for her insulin and related medical supplies.

## **3. What if the Patient is Receiving Inpatient Care?**

As a general rule, when a Medicare beneficiary is hospitalized or receiving care within a skilled nursing facility and Medicare Part A is paying for that care, the beneficiary's medications are covered as part of the Medicare Part A benefit. However, if the beneficiary has elected hospice and is hospitalized or receives care within a skilled nursing facility because he is at a hospice *inpatient level of care*, then his prescription medications related to his terminal illness should be paid for by the

hospice program. That is, if Mr. Elliot has terminal liver cancer and has elected the hospice benefit, and has been receiving hospice care in his home, but develops pain that cannot be managed in his home, and is thus brought to the hospital because he is at the hospice *inpatient level of care*, then while he is at the hospital for pain management, all of his medications related to his terminal illness should be paid for by the hospice program.

Alternatively, if Mr. Elliot was hospitalized not due to an exacerbation of his terminal illness, but because he fell and broke his hip, so long as he did not revoke his hospice benefit, his medications related to his terminal illness should still be billed to the hospice program, but his other medications should be covered under the Medicare Part A hospital benefit. Were Medicare Part A to pay for his stay in the hospital for three days, and then he were to be transferred to a skilled nursing facility for rehabilitation under the Medicare Part A skilled nursing facility benefit, and he were not to revoke his hospice benefit, then his medications related to palliation of his terminal illness would still continue to be billed to the hospice program and his other medications should be covered by the Medicare Part A skilled nursing facility benefit.

If Mr. Elliot is living in the skilled nursing facility and Medicare Part A is not paying for skilled nursing facility care, but he is receiving Medicare covered hospice care, then the cost of medications would be covered in the same way as they would have been had Mr. Elliott received his hospice care within his own home.

## **CONCLUSION**

Palliative medications related to a terminal illness prescribed to a beneficiary who elected the Medicare hospice benefit should be paid for by the beneficiary's hospice provider. Curative medications related to the beneficiary's terminal illness will not be paid for by the hospice provider, Medicare Part B, or the beneficiary's Medicare Part D plan. Medications prescribed for the treatment of illnesses not related to the beneficiary's terminal illness should be billed to Part B, when they are coverable by Part B, and when they are not coverable by Part B, they should be billed to the beneficiary's Part D plan. If however, the beneficiary receives inpatient care that is covered by Part A, for a medical condition not related to the beneficiary's terminal illness, then the medications not related to the terminal illness should be covered under the Part A hospital or skilled nursing facility benefit.

## **RESOURCES**

- 42 C.F.R. § 418.1 et seq.
- 42 C.F.R. § 410.1 et seq.
- Medicare Benefit Policy Manual, CMS Pub., 100-2, 15 Covered Medical and Other Health Services
- 42 C.F.R. § 423.1 et seq.
- 42 C.F.R. § 409.13
- 42 C.F.R. § 409.25
- 42 C.F.R. § 409.36



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Questions? Call Samantha Allard at the Center for Medicare Advocacy's Connecticut office:  
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