Policy:	MA.6113
Title:	**Hospice and Part D Coordination of Benefits**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	*/s/ Michael Hunn 12/16/2024*
Effective Date:	11/01/2016
Revised Date:	12/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy ensures that Hospice, and OneCare Part D, programs appropriately pay for prescription drugs respective to each benefit, while ensuring Member access to needed prescription medications.

II. POLICY

A. Drugs Covered Under the Hospice Benefit

1. The Hospice plan of care must include all services necessary for the palliation and management of a Member's Terminal Illness and related conditions, including drugs and biologicals.

    a. Drugs and biologicals covered under the Medicare Part A Hospice benefit are excluded from coverage under Medicare Part D.

    b. Medications that were used prior to Hospice election that will continue as part of the Hospice plan of care are be covered under the Part A Hospice benefit if those drugs are necessary for the palliation and management of the Terminal Illness and related conditions.

2. A Member's coexisting and/or additional diagnoses related to the Terminal Illness are covered under the Hospice benefit.

3. CalOptima Health shall place Member-level Prior Authorization (PA) requirements on four (4) categories of prescription drugs to prevent duplicate payments for Members receiving Hospice services:

    a. Analgesics;

    b. Antinauseants;

    c. Laxatives; and

    d. Antianxiety drugs (anxiolytics)

4. CalOptima Health shall make a reasonable effort in verifying Hospice status and may use:

    a. Infocrossing;

    b. Provided documentation such as: Hospice Notice of Election (NOE), Notice of Termination or Revocation (NOTR); and

    c. Hospice Provider's discharge summary.

B. Coverage Determination

1. CalOptima Health and/or the Pharmacy Benefit Manager (PBM) shall use good judgment to determine whether the drug in question is Medically Necessary for the Member in Hospice care, and which party is responsible for payment. If necessary, CalOptima Health and/or the PBM shall communicate with the Hospice Provider to coordinate care and establish Coverage Determination.

2. In cases where the Member has revoked Hospice and reverts to the standard Medicare benefits, CalOptima Health shall follow transition guidance, in accordance with CalOptima Health Policy MA.6110: Transition Process.

C. Retrospective Recoveries

1. If questionable Prescription Drug Event (PDE) records are identified as a duplicate payment, CalOptima Health's Pharmacy Management Department shall notify the PBM to delete the PDE records and shall resolve Retrospective Recoveries directly with the Hospice Provider or the Member, whichever is applicable, without involving the pharmacy; that is, without recouping funds from the pharmacy or requiring the pharmacy to reverse the original claim.

2. Any deleted PDEs shall be removed from the Member's True-Out-Of-Pocket (TrOOP) and/or Part D covered drug costs and the Member's medication coordination of benefits shall be revised to reflect those updates.

III. PROCEDURE

A. Point-Of-Sale (POS) Override

1. When CalOptima Health receives information from the Hospice Provider or Prescriber that a drug within the "four (4) categories" is used for a diagnosis unrelated to the Terminal Illness, CalOptima Health will provide a POS override for the Member for the drug. The "four (4) categories" are:

    a. Analgesics,

    b. Antinauseants,

    c. Laxatives, and

    d. Antianxiety drugs (anxiolytics).

2. This communication shall not be considered a Coverage Determination.

3. This communication shall be documented on OMB Form 0938-1269: Hospice Information for Medicare Part D Plans, or similar.

B. Prior Authorization Process

1. The PBM adjudicates a pharmacy claim for a Member who has elected Hospice and rejects the claim with the National Council for Prescription Drug Programs (NCPDP)-approved reject codes:

Code	Description
A3	This Product May Be Covered Under Hospice – Medicare A
75	Prior Authorization Required
569	Provide Notice: Medicare Prescription Drug Coverage and Your Rights

2. CalOptima Health's Pharmacy Management Department shall use POS messaging stating, "Hospice Provider – Request Prior Authorization for Part D Drug Unrelated to the Terminal Illness or Related Conditions" or "Hospice Provider – Request PA" and include the twenty-four (24)-hour Pharmacy Help Desk phone number for the Provider to call.

3. When the dispensing pharmacy receives the claim reject codes with associated messaging, the pharmacy shall contact the Member, or Prescriber, to determine if the Hospice should cover the drug.

4. If the drug is a Hospice-covered drug, the dispensing pharmacy shall submit the claim to the responsible Hospice Provider.

5. If the drug is not a Hospice-covered drug, or neither the Member nor Prescriber knows whether the Hospice should cover the drug, the dispensing pharmacy shall provide the standardized pharmacy notice (CMS Form 10147: "Prescription Drug Coverage and Your Rights") to the Member or Prescriber, which explains their right to request a Coverage Determination and instructs them on how to contact CalOptima Health for assistance or to request coverage.

6. In cases where the Prescriber is unaffiliated with the Hospice Provider or unable to complete the PA, CalOptima Health shall contact the Hospice for coverage explanation.

    a. In such instances, the Hospice Provider may provide verbal explanation why the drug is unrelated to the Terminal Illness (and therefore covered under Part D), and/or shall complete the PA form with the explanation and submit it to CalOptima Health by facsimile, or mail.

    b. CalOptima Health may fax an informational copy of the PA form to the Hospice when the Prescriber was determined to be unaffiliated.

    c. To ensure care coordination, Prescribers who are unaffiliated with the Hospice Provider shall attest that they have coordinated with the Hospice.

7. If the Hospice Provider or the Prescriber does not provide the required explanation regarding why the drug is unrelated to the Terminal Illness or related conditions, Part A/Hospice coverage cannot be ruled out, or the PA criteria is unfulfilled then CalOptima Health shall notify the Member that the drug is not covered under Part D.

8. Upon receiving and accepting the explanation or the complete PA form, CalOptima Health shall instruct the pharmacy on how to override the POS edit and shall provide written notification to the Member by mail within the required timeframe as set forth in CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination. If the Prescriber initiated the PA, the Prescriber shall also receive written notification in accordance with CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination.

9. The applicable adjudication time frame of twenty-four (24) hours for expedited requests or seventy-two (72) hours for standard requests begins when the Hospice Provider or Prescriber responds to the request for information or provides clinical explanation of why the drug(s) are unrelated to the Terminal Illness or related conditions.

10. If CalOptima Health has paid for dugs prior to receiving notification of the Member's Hospice election, CalOptima Health shall perform a subsequent retrospective review of claims paid within the Hospice election period.

11. CalOptima Health shall conduct outreach to the Hospice Provider or Prescriber to make retrospective determinations of payment responsibility for the drugs.

C. OMB Form 0938-1269: Hospice Information for Medicare Part D Plans Form

1. The form will facilitate coordination between Part D sponsors, Hospices, and pharmacists.

2. Two (2) primary uses of the form are to:

   a. Document that a drug is unrelated to a beneficiary's terminal prognosis and/or to convey a beneficiary's change in Hospice status; and

   b. For Hospice Providers to communicate and update the medications list from the beneficiary's plan of care.

3. The form can be used:

   a. Prospectively (i.e., prior to the submission of claim to Part D), to prevent a drug claim from rejecting at the POS when a drug in any of the four categories is prescribed for a condition that is unrelated to a beneficiary's terminal prognosis and the beneficiary is prepared to procure the drug. In this case, the Hospice Provider completes and submits this form to CalOptima Health to ensure that the OneCare Member can access the drug at the POS.

   b. Retrospectively by the Hospice Provider or Prescriber and submitted to CalOptima Health. CalOptima Health shall accept it and use it to satisfy the Centers for Medicare & Medicaid Services (CMS) requirements and allow for normal processing of the claim. If a Coverage Determination is requested by the OneCare Member prior to CalOptima Health's receipt of the documentation, CalOptima Health must contact either the Prescriber or the Hospice Provider to complete and submit the form.

4. Upon receipt of the form by CalOptima Health:

   a. When the necessary information has been provided, CalOptima Health, or the PBM, shall override the A3 reject for the medications listed as being unrelated to the terminal prognosis. In addition, CalOptima Health shall concurrently obtain and review the information necessary to promptly determine whether any applicable drug-specific UM

requirement has been satisfied (or, alternatively, whether an exception to that UM requirement has been requested); or

b. CalOptima Health shall use the information submitted on and with the form as Best Available Evidence (BAE) to update the Member's Hospice enrollment status and will ensure that the Member's Hospice information is reflected in the sponsor's systems until a Transaction Reply Report (TRR) is received from CMS with the updated election/termination information.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health
C. CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination
D. CalOptima Health Policy MA.6110: Transition Process
E. Hospice Frequently Asked Questions (FAQ), Issued by CMS 08/06/2014
F. "Part D Payment for Drugs for Beneficiaries Enrolled in Hospice – Final 2014 Guidance," Health Plan Management System (HPMS) Memorandum, Issued 03/10/2014
G. "Part D Payment for Drugs for Beneficiaries Enrolled in Hospice – 2015 Guidance," Health Plan Management System (HPMS) Memorandum, Issued 07/18/2014
H. "Proposed Prior Authorization Form for Beneficiaries Enrolled in Hospice," Health Plan Management System (HPMS) Memorandum, Issued 10/10/2014
I. Approved Form for Collection of Hospice Information for Medicare Part D Plans. March 24, 2015.
J. Social Security Act, §1861(dd)
K. Title 42, Code of Federal Regulations (C.F.R.), §§ 418.106 and 418.202(f)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2016	MA.6113	Hospice and Part D Coordination of Benefits	OneCare OneCare Connect
Revised	11/01/2017	MA.6113	Hospice and Part D Coordination of Benefits	OneCare OneCare Connect
Revised	10/01/2018	MA.6113	Hospice and Part D Coordination of Benefits	OneCare OneCare Connect
Revised	11/01/2019	MA.6113	Hospice and Part D Coordination of Benefits	OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2020	MA.6113	Hospice and Part D Coordination of Benefits	OneCare OneCare Connect
Revised	09/01/2021	MA.6113	Hospice and Part D Coordination of Benefits	OneCare OneCare Connect
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Revised	09/01/2023	MA.6113	Hospice and Part D Coordination of Benefits	OneCare
Revised	12/01/2024	MA.6113	Hospice and Part D Coordination of Benefits	OneCare

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Coverage Determination (CD)	Any decision made by CalOptima Health regarding: 1. Receipt of, or payment for, a prescription drug that a Member believes may be covered; 2. A tiering or Formulary Exception request; 3. The amount that the plan sponsor requires a Member to pay for a Part D prescription drug and the Member disagrees with the plan sponsor; 4. A limit on the quantity (or dose) of a requested drug and the Member disagrees with the requirement or dosage limitation; 5. A requirement that a Member try another drug before the plan sponsor will pay for the requested drug and the Member disagrees with the requirement; and 6. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement.
Duplicate Payment (Pharmacy)	Any Part D payment made where the date filled is within the dates of the Member's Hospice election and the drug payment is the responsibility of the Part A Hospice benefit.
Hospice	A program of care for beneficiaries who are terminally ill to live comfortably, where the focus is on comfort and not on curing an illness. The Hospice is responsible for covering all drugs and biologicals for the palliation and management of the Terminal Illness and related conditions.
Hospice Beneficiary	Beneficiary who is eligible for Medicare Part A and has elected Hospice care. In this policy, a Member will be considered a Hospice Beneficiary.
Infocrossing	The entity providing Medicare eligibility and enrollment services under an agreement with CMS.
Medically Necessary/ Medical Necessity	The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
Member	A beneficiary enrolled in a CalOptima Health program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Prescriber	For the purposes of this policy, refers to a practicing medical Provider or mid-level practitioner who prescribes a medication for a Member.
Prescription Drug Event (PDE)	A summary record of a prescription filled under Medicare Part D. Every time a beneficiary fills a prescription under Medicare Part D, the Medicare drug plan sponsor must submit a PDE record to CMS. The PDE record contains prescription drug cost and payment data that enables CMS to make payments to plans and otherwise administer the Part D benefit.
Prior Authorization (Pharmacy)	The formulary restriction which requires approval from CalOptima Health before the requested medication is covered.

Term	Definition
Provider (Part D)	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.
Retrospective Recoveries	When payment has been made by a Part D plan sponsor for a prescription drug under a Member's Medicare Part D plan and is later identified to be the financial responsibility of another payer, such as a Hospice Provider under Medicare Part A, the process to collect payment from the responsible payer is retrospective recovery.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
True Out-of-Pocket (TrOOP) Costs.	True Out-of-Pocket (TrOOP) Costs are the payments that count toward a Part D beneficiary's Medicare drug plan out-of-pocket threshold. TrOOP costs determine when a beneficiaries' catastrophic coverage will begin.