Medication Coordination and Coverage in Hospice

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Objectives

• Describe steps involved in medication coordination at the end of life
• Discuss the revised Medicare guidance for medication coverage
• Apply the regulation to three different clinical cases
Goals of Medication Management

• Best care for the patient
  - Drug-drug interactions
  - Appropriate medication and metabolite levels in a dying patient
  - Achieve therapeutic goals
  - Avoid side effects and adverse reactions

• De-Prescribing

• Improving the value
Medication Coordination

R.A.C

1. Medication Reconciliation
2. Medication Appropriateness
3. Medication Coverage
Medication Reconciliation R.A.C

Obtain AND Verify a Complete AND Accurate list of Current Medications AND Match to Actual Prescribed Medication
Medication Appropriateness

R.A.C

Review all medications including over-the-counter drugs, vitamins and herbs. Then assess: **D.E.N.I.M.S**

- Duplicates
- Effectiveness
- Necessity
- Interactions
- Monitoring requirement
- Side effects
Medication Coverage

R.A.C

• March: Medicare Part D plan sponsors will require prior authorization on all unrelated medications for hospice patients

• July: Revised Guidance-Prior authorization ONLY required for 4 classes of drugs when the drug is NOT related to the terminal prognosis
What are the 4 Classes?
What are the 4 Classes?

- Analgesics
- Anti-emetics
- Laxatives
- Anti-anxiety
COP 418.106

“Drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.”
Concerned about Medicare paying twice for prescription drugs for beneficiaries in hospice
• Reviewed 198,543 hospice beneficiaries who received 677,022 prescription drugs through part D that potentially should have been covered under the hospice benefit
• Part D paid $33,638,138 to pharmacies
Coexisting or additional diagnosis could be related or unrelated to the hospice patient’s terminal illness.

Medications that provide palliation and management of the patient’s terminal illness and related conditions need to be covered under Medicare hospice benefits.
Find the Right Balance!!!
Terminal, Related, Comorbid

- **Terminal Diagnosis**: The condition determined to be primarily responsible for the patient’s admission to hospice

- **Related**:
  - Secondary conditions or related diagnoses that directly emerge or result from the terminal illness
  - Comorbid conditions that are interconnected with the terminal illness and impact prognosis
Unrelated

• Conditions or diagnoses that are independent of the terminal illness
  - Glaucoma in a patient with end stage melanoma
i'm confused.
no wait...
maybe i'm not.
Medication Payment Responsibility

- **Hospice:**
  - Medications that are related to terminal diagnosis, secondary diagnoses, or any related co-morbid conditions contributing to the terminal prognosis

- **Medicare Part D Plan Sponsor:**
  - Medications that are completely unrelated to the hospice diagnosis or any other contributing conditions
  - If unrelated but in 4 categories, then will require a prior authorization

- **Patient:**
  - Medications that have been determined to be related but providing no symptom relief and thus not palliative in nature
Three Types of Patients

1. “Less is more. Don’t let me be sore”
2. “Together Forever”
3. “This medication is from my specialist”
“Less is more. Don’t let me be sore”

61 year old woman with end stage lung cancer with metastasis to spine. Meds include:

- MS Contin 30 mg every 12 hours
- Hydrocodone/APAP 5/325 every 4 hours as needed
- Decadron taper for pain and anorexia
- Albuterol nebulizers for wheezing
- Lipitor 10 mg daily
- Fentanyl Patch
What to do?

- **R.A.C** (Reconciliation/Appropriateness/Coverage)
- **DENIMS** (Duplicates-Effectiveness-Necessity-Interactions-Monitoring requirement-Side effects)
- Related/un-related
- Benefits/Burdens
- Formulary/preferred
- Therapeutic alternatives
Some medications that were for the treatment of the terminal illness and/or related conditions prior to hospice admission will be discontinued as determined by the hospice IDG and discussed with patient/family because medications are no longer effective and/or causing additional negative symptoms.

These medications would not be covered under the Medicare hospice benefit (not reasonable or necessary for the palliation of pain and/or symptom management).
CMS Memo 12-6-13

- If beneficiary still chooses to have these medications filled through his/her pharmacy, the costs would be a beneficiary liability (not the Medicare hospice benefit, or Medicare Part D benefit)
78 year old nursing home patient with dementia and atrial fibrillation who meets hospice guidelines for end stage dementia (FAST scale of 7E, more than 10% weight loss, recent aspiration pneumonia). Meds include:

- Donepezil (Aricept), memantine (Namenda), and Warfarin
- Has dry heaves after taking donepezil
“Together Forever”

• Dementia Drugs:
  - Benefit-questionable in end stage dementia
  - Burden: Insomnia (2-14%), nausea (3-19%), diarrhea (5-15%), accident (7-13%), infection (11%)
Anticoagulation at EOL

- Thromboembolic disease in cancer patients
  - Patients are a higher risk of thromboembolism
  - Patients are at higher risk of bleeding

Therapeutic benefit of AC

QOL; Symptom burden; cost of monitoring
Anticoagulation at EOL

- Nonvalvular atrial fibrillation
- Anticoagulation does not affect (reduce) symptoms
- AC reduces the absolute risk of stroke by approximately 4% per year
- Median LOS in hospice is < 20 days
- If risk were evenly distributed over time, this would be a 0.22% absolute reduction in stroke risk while enrolled in hospice.
Time Needed for Benefit

- Is the medication related to the terminal diagnosis or related condition? Yes...but...
- How long does it take for medication to render effect?
  - Anticoagulants for stroke prevention – years
  - Statins in vascular dementia – years
  - Antihypertensives in vascular dementia – years
Discontinuation of Statins

• Discontinuation of statin therapy in patients with limited life expectancy improved overall quality of life without compromising survival.
• Multicenter, un-blinded trial, presented at the annual meeting of ASCO

CMS Memo 12-6-13
Clarifying Payment Responsibility

• The hospice POC must include...
  – (C). If a beneficiary requests a drug for his/her terminal illness or related conditions that is NOT on the hospice formulary...
  – and the beneficiary refuses to try a formulary equivalent first...
  – or is determined by the hospice to be unreasonable or unnecessary for the palliation of pain and/or symptom management...
  – the beneficiary may opt to assume financial responsibility for the drug.
    • No payment for the drug will be available under Part D.
“This medication is from my specialist”

- 74 year old man with end stage colon cancer with bone metastasis and history of COPD, glaucoma, and hypothyroidism.
- Meds include:
  - Naproxen
  - Morphin: Long acting and short acting
  - Levothyroxine
  - Albuterol nebs
  - Glaucoma eye drops
  - Senna
Possibly Not Related

- Medications used to treat chronic, unrelated medical conditions:
  - Allergy Medications
  - Thyroid Replacement
  - Estrogen Replacement
  - Glaucoma Medication
  - Chronic Depression???
Discontinuing Medications

- Risk/Benefit ratios
- Life-expectancy
- Goals of care
- Why is this medication needed now?
Medication Monitoring

• Cholesterol lowering medications
• Diuretics when intake is decreased
• Warfarin
• Antihypertensives
• Oral hypoglycemic agents
• Antipsychotics
• Anticholinergics
• ...

What to say? What to do?

“I was told by my mom’s doctor that she should take this medication till the day she dies”

“Taking the medication was the right thing to do when she was started on it. Now, there have been changes in her condition and in her body. She will not tolerate this medication without significant side-effects. At this time, this medication may harm more than help.”
Drug-Induced ER Admission in Elders

- 2007-2009 data used to estimate:
  - Frequency and rates of hospitalization after ER visits for ADRs in older adults (> 65 years old)
- Nearly half were in adults ≥ 80 years
- Nearly 2/3 were due to unintentional OD's
- Four medications/medication classes were implicated
1-R.A.C (Reconciliation/Appropriateness/Coverage)
2-D.E.N.I.M.S (Duplicates-Effectiveness-Necessity-Interactions-Monitoring requirement-Side effects)
3- Coverage:
   . Related
   . Unrelated
   . Related but not indicated
References:

- CMS Guidance
- AAHPM 2014

**Who Let The Drugs Out, And Who’s Providing Them?**

We did. We let the drugs out. And we’d do it again.

Mary Lynn McPherson, Pharm.D., BCPS, CPE
Ann Broderick, MD, MS
Joan K. Harrold, MD, MPH
Case of a 94 year old man with end stage Alzheimer’s Dementia

- 94-year-old Asian man residing at a nursing facility who has been in and out of the hospital for aspirations.
- PMH: Alzheimer’s dementia, DM 2, hyperlipidemia, HTN, chronic kidney disease stage 3, COPD, gout, BPH, degenerative disc disease, chronic lumbar pain, hypothyroidism, paroxysmal a fib...
Case Continues

- **M.D.**: “How was he 6 months ago?”

- **ARN**: “Six months ago the patient was in the independent side of the Sunny View West facility and was alert and oriented x1, some intelligible words but forgetful. ADL of 5/6 and PPS of 50%.”
Case Continues

- **M.D.**: “How is he now?”
- **ARN**: “He is confused. He has less than 5 intelligible words in Chinese. PPS is 40%, ADL is 6/6.”
# Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Form</th>
<th>Route</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Donepezil</td>
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<td>Tab</td>
<td>Oral</td>
<td>QHS</td>
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<td>tab</td>
<td>oral</td>
<td>QD</td>
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<td>Flomax</td>
<td>0.4 mg</td>
<td>cap 24h</td>
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<td>Liter</td>
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