Part D exceptions and appeals

Jennifer Podulka and Emma Achola

October 6, 2017

Presentation overview

- Review of the exceptions and appeals process
- Data on exceptions and appeals outcomes
- Stakeholder concerns
- Electronic prescribing tools

Medicare Part D

- Medicare beneficiaries receive the Part D drug benefit by enrolling in a stand-alone prescription drug plan (PDP) or in a Medicare Advantage–Prescription Drug plan (MA–PD) for coverage of Part D drugs
- Plans must create and manage formularies
- Enrollees may request a formulary or tier exception
- If this request is denied, they may proceed through the appeals process

Exceptions and appeals process

Transaction rejected at the point of sale (e.g., pharmacy counter)

Part D plan issues a **coverage determination**

Part D plan issues a **coverage redetermination**

Independent review entity reviews plan's adverse redetermination

Administrative law judge reviews IRE's decision **(AIC ≥ $160)**

Medicare Appeals Council reviews ALJ's decision

Judicial review: Federal District Court **(AIC ≥ $1,560)**

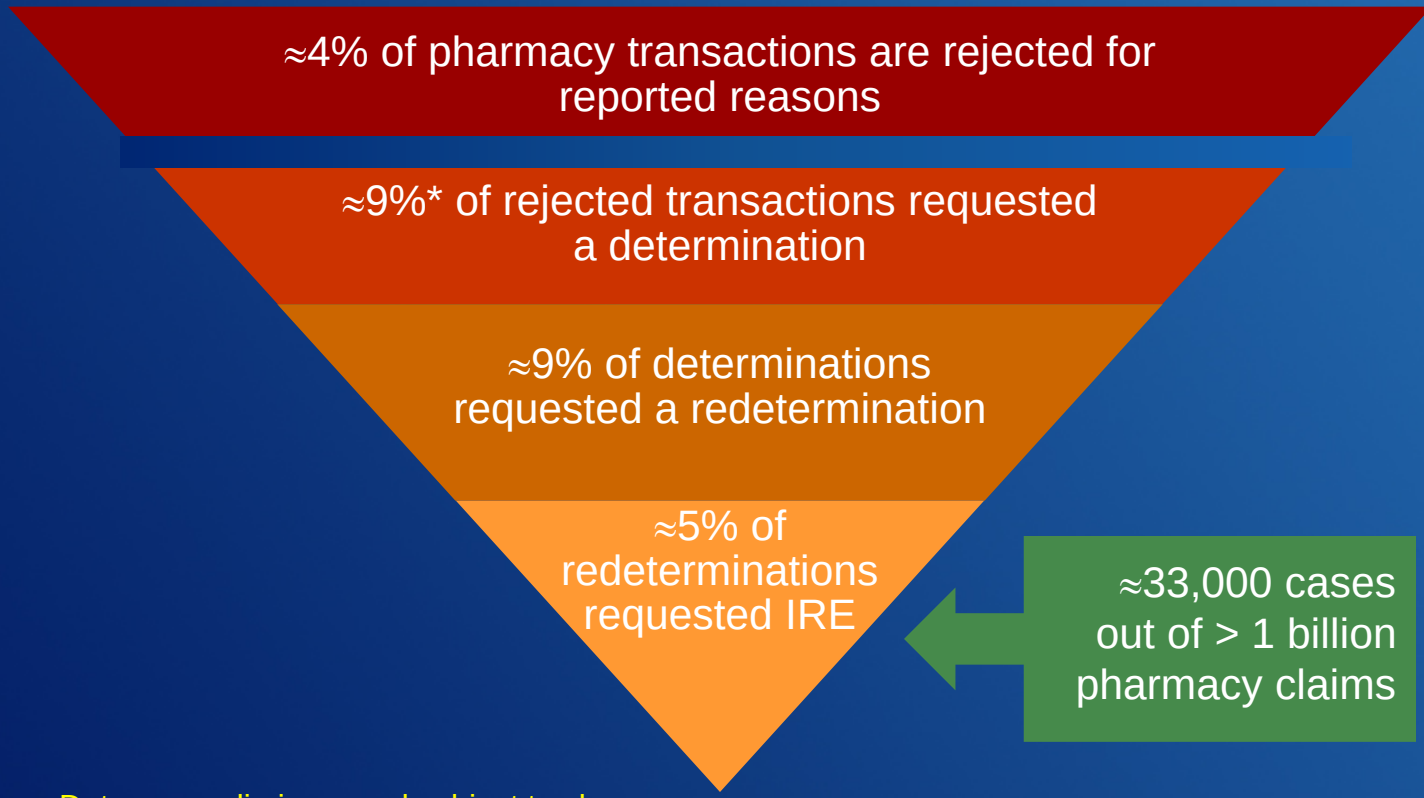
Note: IRE (independent review entity), ALJ (administrative law judge), AIC (amount in controversy). A request for a coverage determination or an appeal can be submitted by an enrollee, the enrollee's prescribing physician, or the enrollee's authorized representative. AICs shown are for 2017.
Source: Centers for Medicare & Medicaid Services.

MEDPAC

Data on exception and appeals outcomes

- Plans are required to report data on
  - transactions rejected at the point of sale
  - outcomes of the determination and redeterminations appeal steps
- Not all Part D plan data must be reported, and some that is reported does not pass data validation
- Exceptions and appeals data should be interpreted with caveats in mind

Few pharmacy transactions are rejected and appealed, 2015



Data are preliminary and subject to change.

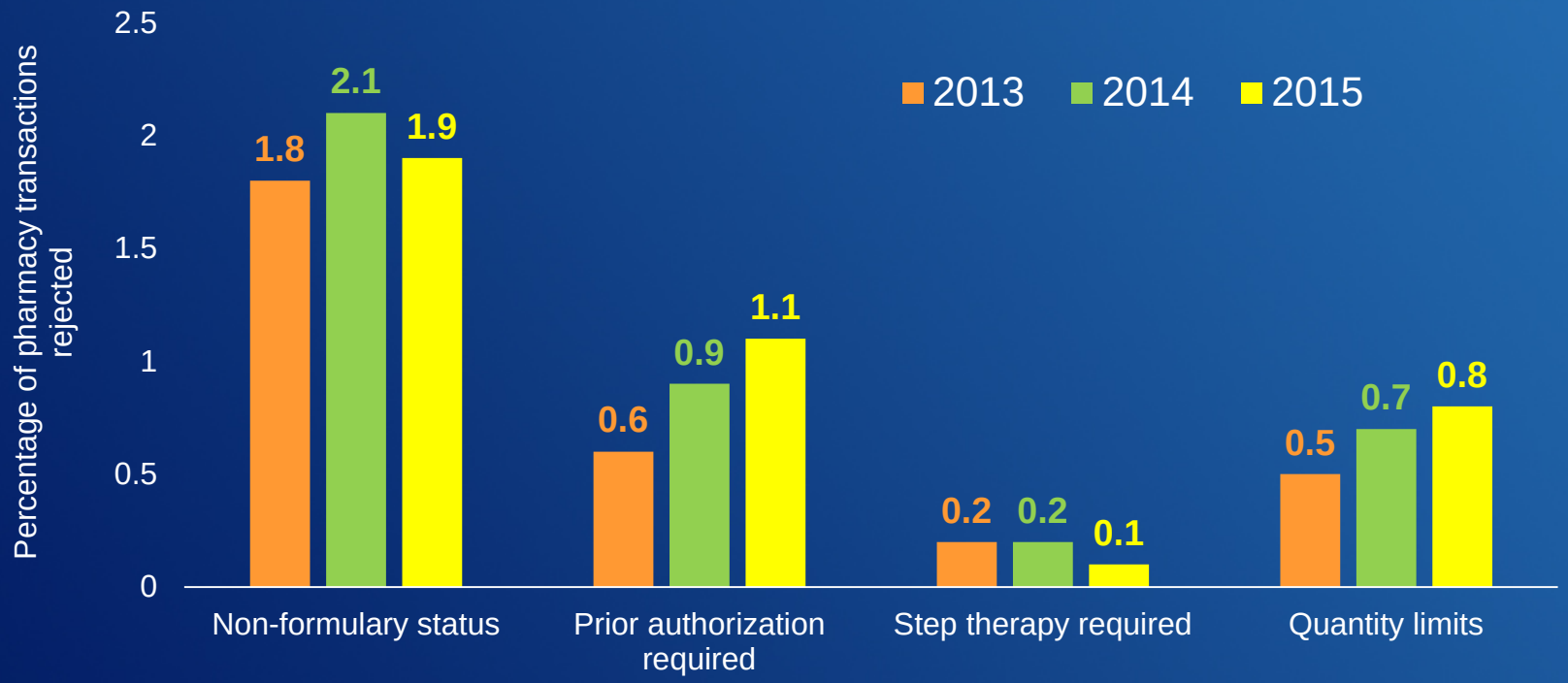
Note: IRE (independent review entity). The plan-reported and IRE data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that is reported does not pass data validation requirements. CMS specifically warns that data included in these data files may be incomplete and/or incorrect.

* Although requests for determinations could originate for tiering exceptions, in addition to reported pharmacy transaction rejections, plans are not required to report data on tiering exceptions in 2015. In 2013, tiering exceptions accounted for 3 percent of total coverage determinations.

Source: MedPAC analysis of CMS data on Part D plan exceptions and appeals data for 2015 and star rating measures for 2017.

MEDPAC

Reasons reported for Part D pharmacy transaction rejections, 2013–2015



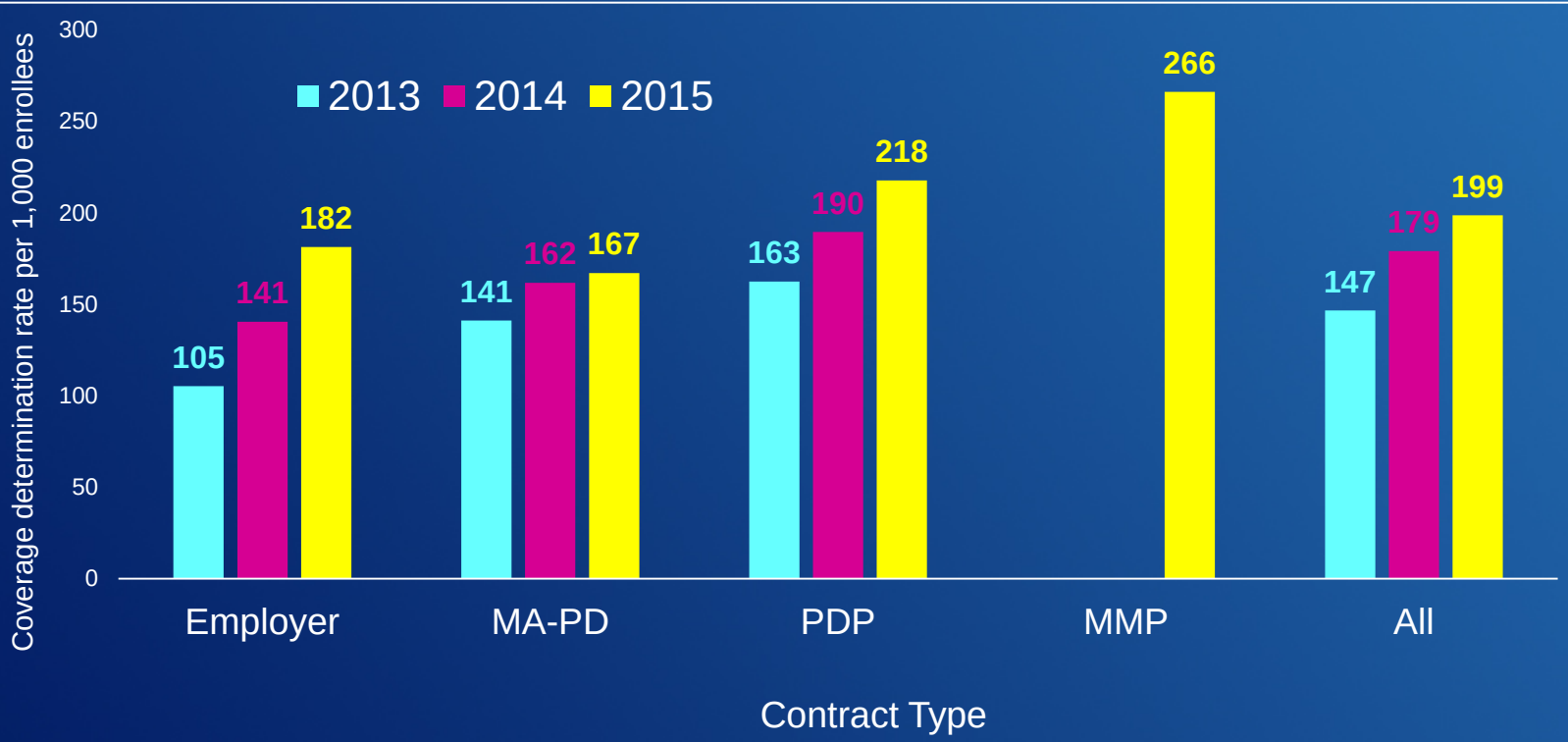
Data are preliminary and subject to change.

Note: Percentages are weighted by contracts' average enrollment over the plan year. Any pharmacy transaction rejections other than the six reasons listed are not required to be reported by plans. Plan-reported data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that is reported does not pass data validation requirements. CMS specifically warns that data included in these data files may be incomplete and/or incorrect.

Source: Centers for Medicare & Medicaid Services analysis of Part D required reporting 2017.

MEDPAC

Plan coverage determination rates per 1,000 enrollees, 2013–2015



Data are preliminary and subject to change.

Note: MA-PD (Medicare Advantage-prescription drug plan), PDP (prescription drug plan), MMP (Medicare-Medicaid plan). Percentages are weighted by contracts' average enrollment over the plan year. The sum of prior authorization decisions and exception decisions is used to approximate the total number of determination decisions in 2013. Due to the limited number of MMPs that were active for the full 2013 and 2014 reporting years, only 2015 data submitted to CMS by MMPs are included. Plan-reported data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that is reported does not pass data validation requirements. CMS specifically warns that data included in these data files may be incomplete and/or incorrect.

Source: Centers for Medicare & Medicaid Services analysis of Part D required reporting 2017.

MEDPAC

Reported plan coverage determinations, 2015

Contract type	Fully favorable to the enrollee request	Partially favorable to the enrollee request	Adverse to the enrollee request
Employer	63%	0%	37%
MA-PD	63	1	37
PDP	64	0	36
MMP	73	0	27
All	**64**	**0**	**36**

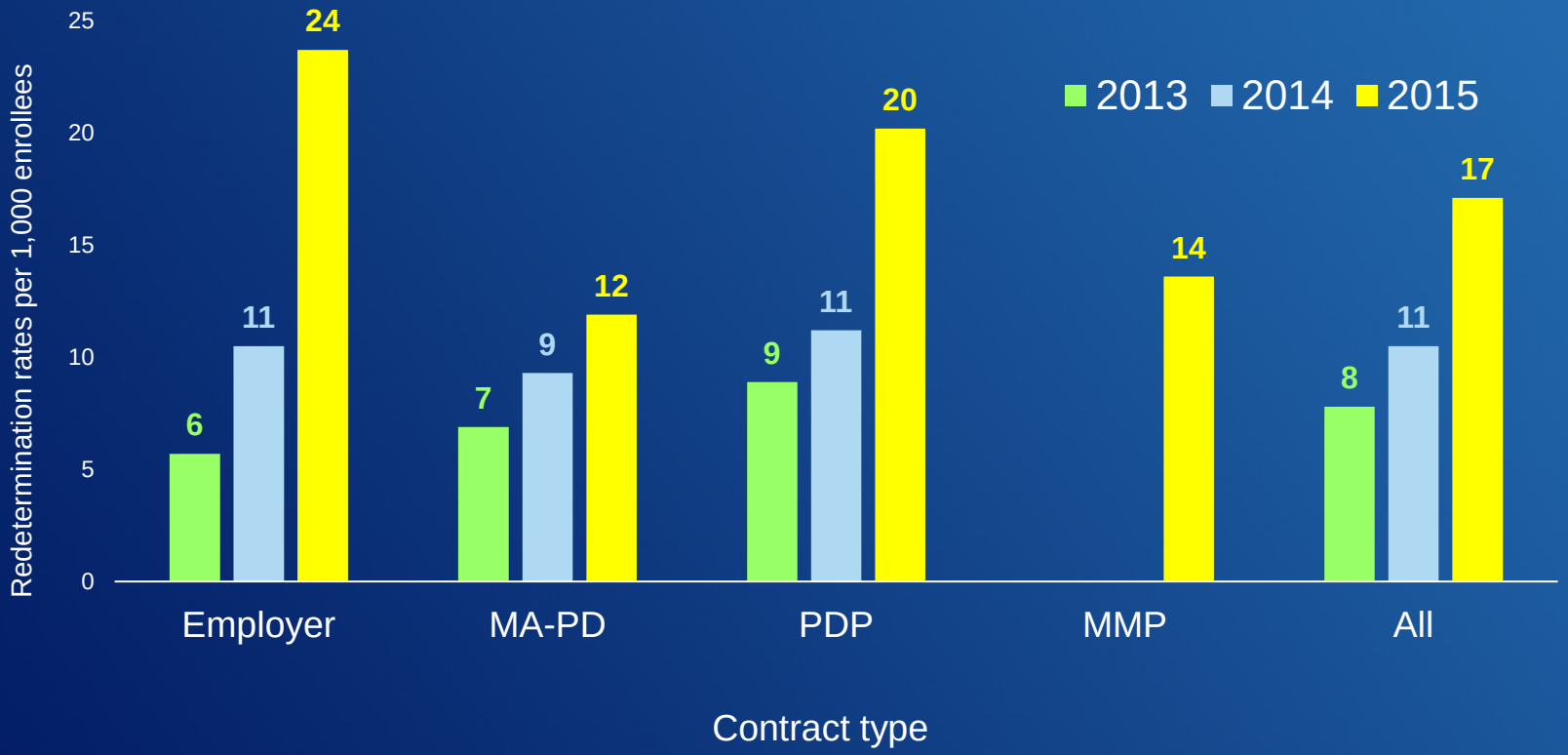
Data are preliminary and subject to change.

Note: MA-PD (Medicare Advantage-prescription drug plan), PDP (prescription drug plan), MMP (Medicare-Medicaid plan). Percentages are weighted by contracts' average enrollment over the plan year. Row totals may not equal 100 percent due to rounding. Plan-reported data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that is reported does not pass data validation requirements. CMS specifically warns that data included in these data files may be incomplete and/or incorrect.

Source: Centers for Medicare & Medicaid Services analysis of Part D required reporting 2017.

MEDPAC

Plan redetermination rates per 1,000 enrollees, 2013–2015



Data are preliminary and subject to change.

Note: MA-PD (Medicare Advantage-prescription drug plan), PDP (prescription drug plan), MMP (Medicare-Medicaid plan). Percentages are weighted by contracts' average enrollment over the plan year. The sum of prior authorization decisions and exception decisions is used to approximate the total number of determination decisions in 2013. Due to the limited number of MMPs that were active for the full 2013 and 2014 reporting years, only 2015 data submitted to CMS by MMPs are included. Plan-reported data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that is reported does not pass data validation requirements. CMS specifically warns that data included in these data files may be incomplete and/or incorrect.

Source: Centers for Medicare & Medicaid Services analysis of Part D required reporting 2017.

MEDPAC

Reported plan coverage redeterminations, 2015

Contract type	Fully favorable to the enrollee request	Partially favorable to the enrollee request	Adverse to the enrollee request
Employer	71%	0%	29%
MA-PD	67	1	33
PDP	71	1	29
MMP	62	3	36
All	**70**	**1**	**30**

Data are preliminary and subject to change.

Note: MA-PD (Medicare Advantage-prescription drug plan), PDP (prescription drug plan), MMP (Medicare-Medicaid plan). Percentages are weighted by contracts' average enrollment over the plan year. Row totals may not equal 100 percent due to rounding. Plan-reported data are incomplete and should be interpreted with caution. Not all Part D plan data must be reported, and some that is reported does not pass data validation requirements. CMS specifically warns that data included in these data files may be incomplete and/or incorrect.

Source: Centers for Medicare & Medicaid Services analysis of Part D required reporting 2017.

MEDPAC

Independent Review Entity (IRE)

- About 5% of redeterminations were appealed to the IRE in 2015
- Reported data are not available or not validated for the majority of plans
  - 71% in 2013 and 74% in 2015
- The IRE agreed with plans' redetermination decisions most of the time
  - 74% of the time in 2013 and 82% of the time in 2015

Data are preliminary and subject to change.

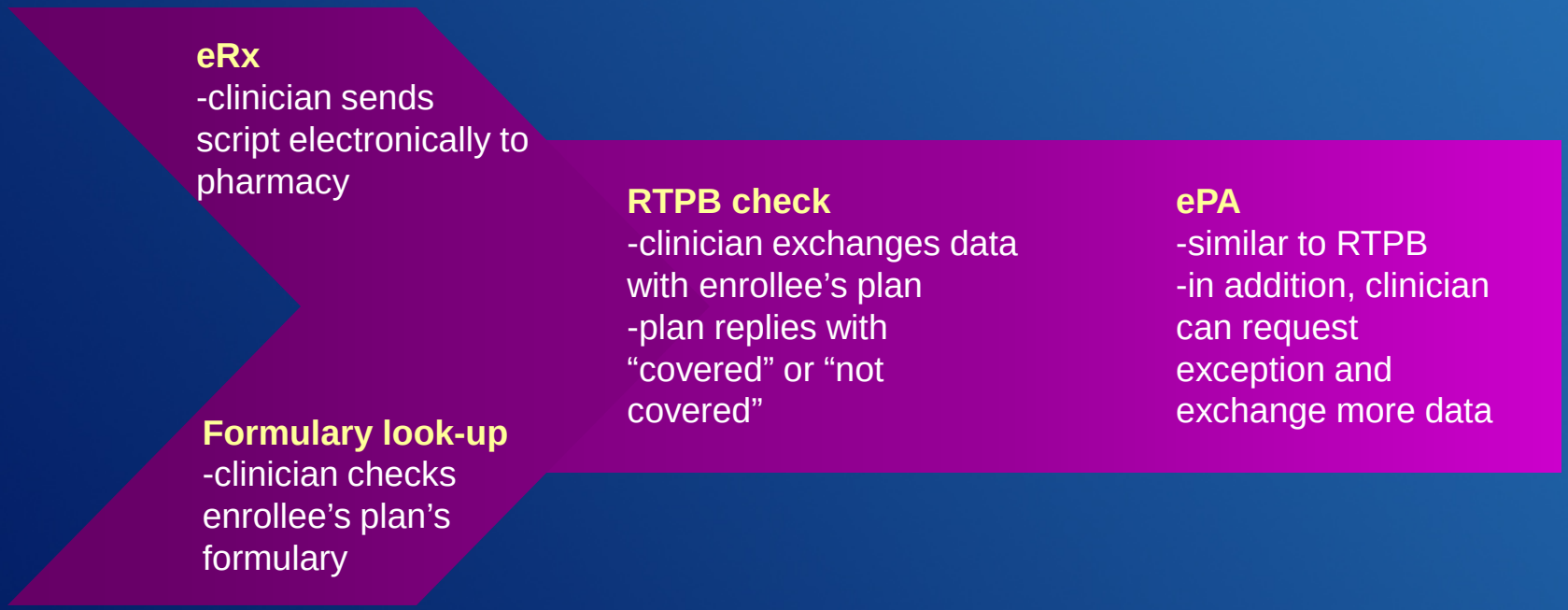
Exceptions and appeals outcomes vary at the plan level

- We grouped Part D parent organization's plans by type—MA-PD, PDP, employer, and MMP
- The 20 with the most pharmacy transactions in 2015 accounted for more than 80% of total reported pharmacy transactions
- We found variation in reported pharmacy transaction rejections and determination, redetermination, and IRE outcomes

Stakeholder concerns about the exceptions and appeals process

- Plans cite challenges in contacting prescribers and resolving requests in time
- CMS has found that several plan sponsors fail to comply with regulations
- Beneficiary advocates advise giving enrollees information about the reason for a plan denial at the point of sale

Continuum of electronic prescribing tools



Note: eRx (electronic prescribing), RTPB (real-time prescription benefit) check, ePA (electronic prior authorization).

Obstacles to full adoption of electronic prior authorization (ePA)

- No statutory requirements for ePA
- Large number of EHR and ePA vendors
- Multiple actors must coordinate
- Clinicians may bear the cost and must embrace practice pattern change

Summary

- Few pharmacy transactions are rejected for reported reasons
- Few cases are appealed to plans for coverage determination and redetermination
  - Plan decisions are usually in favor of the enrollee
- Few cases are appealed to the IRE
  - IRE usually upholds plan decisions
- Beneficiary advocates request detailed information when transaction rejected at point of sale
- ePA could reduce the need for exceptions and appeals, but there are obstacles to its full adoption