Part D exceptions and appeals

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Roadmap

- Overview of key concepts
- What is the beneficiary and physician perspective on appeals?
- How is the process working?
- Key findings

Key concepts

- *Exceptions process* – an enrollee may file a request for an exception for non-formulary drugs or an exception to tiered cost-sharing structure
- *Coverage determination* – any decision by plan regarding payment or benefits to which an enrollee believes he or she is entitled (e.g., a decision by a plan concerning an exceptions request)
- *Appeal* – any procedure that deals with the review of adverse coverage determinations made by a plan
- *Redetermination* – the 1st level of the appeal process, which involves a plan reevaluating an adverse coverage determination
- *Independent review entity (IRE)* – an independent entity contracted by CMS to review plan denials of coverage determinations
- *Reconsideration* – the 2nd level of the appeal process, which involves a review of an adverse coverage determination by the IRE
- *Grievance* – any complaint or dispute, other than a coverage determination or a late-enrollment penalty determination, expressing dissatisfaction with any aspect of plan operations

Findings from focus groups and interviews

- We conducted 12 beneficiary focus groups, 8 physician focus groups, and 17 interviews with beneficiary counselors
- Most interviewees were unaware of how the exceptions and appeals process works and did not distinguish between the different levels of appeals

Beneficiaries were generally satisfied with drug benefit

- A majority did not know they had appeal rights
- In each group, at least one beneficiary had asked for an exception to get a drug covered, experiences varied
- Disabled beneficiaries were more likely to be familiar with appeals

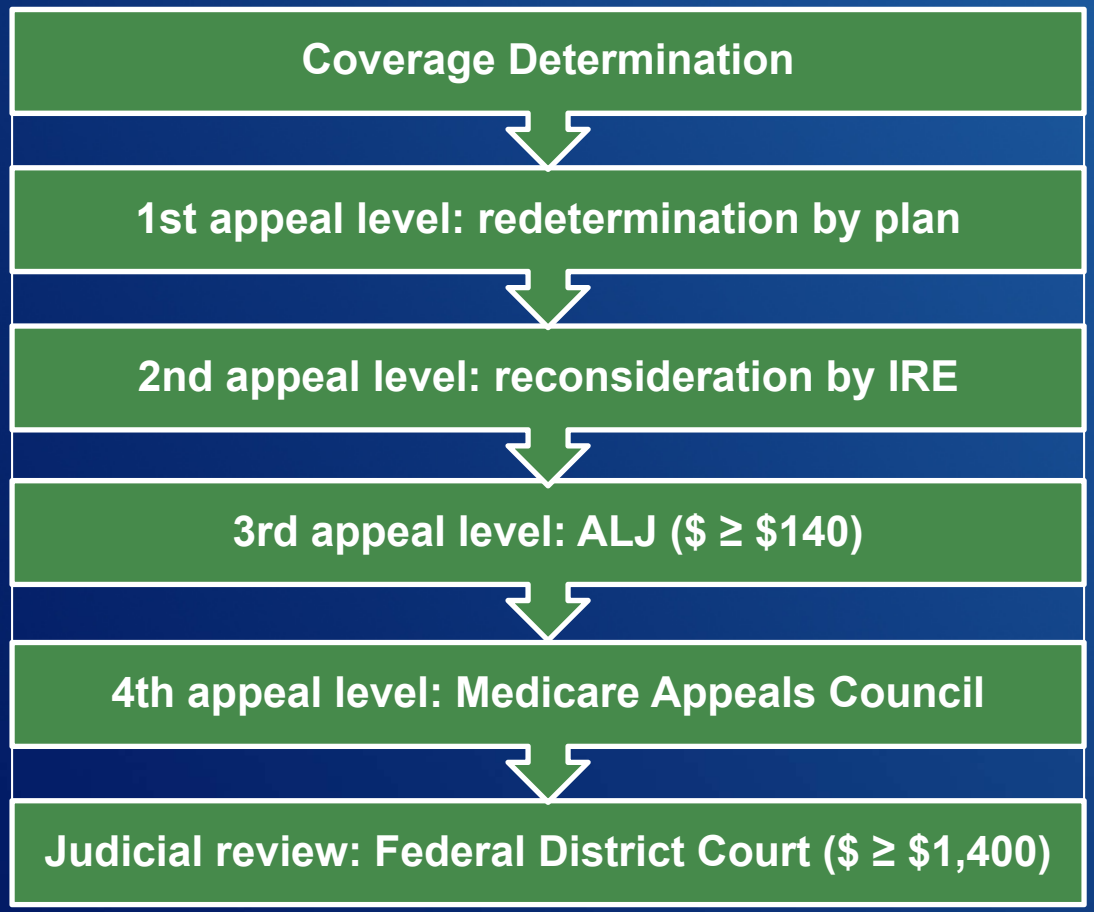
Physicians expressed frustration with all plan utilization management

- Physicians must demonstrate medical necessity to get an exception for patient
- In each group, physicians pointed to at least one plan with processes that were especially burdensome
  - Insistence on speaking to physician directly
  - No dedicated phone line for physician offices

Most counselors did not get involved in exceptions and appeals

- They saw these processes as a last option
- They encouraged beneficiaries to switch plans (if LIS), apply to manufacturers' assistance programs, or ask physicians for samples
- During open season, they tried to guide beneficiaries away from any plan using utilization management for a drug the beneficiary was taking

Part D's appeals process



Data we have are from this stage in the appeals process.

Note: IRE (Independent Review Entity), ALJ (Administrative Law Judge). For a case to move to the third level of appeals or higher, the amount in controversy must exceed the dollar thresholds specified by CMS. The amounts shown are for CY 2013.

How is Part D's exceptions and appeals process working?

- CMS' audit in 2012 found that plans are struggling the most with Part D coverage determination, appeals, and grievances
- Examples of the kinds of issues identified include:
  - Failure to make timely coverage determinations
  - Failure to notify the beneficiaries of their coverage decisions
  - Not making sufficient effort to obtain information needed to make an appropriate clinical decision
- Data for the 1st half of CY2013 show that the audit may have increased the number of appeals submitted to the IRE

MEDPAC Note: IRE (Independent Review Entity).

Analysis of appeals data, 2006 – 2013*

- Fewer appeals per 1,000 enrollees compared with MA (Less than 1 case vs. 3 to 8 cases under MA)
- More timely coverage decisions
- More appeals upheld by IRE (i.e., IRE agrees with plans' coverage decisions)
- Wide variation across plans in the percentage of cases upheld by IRE
- A large share of dismissals due to technical reasons suggests enrollees may be confused or are having difficulty navigating the appeals process

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Note: MA (Medicare Advantage), IRE (Independent Review Entity). *Data for 2013 are preliminary and are for the first six months of CY 2013.

How do we know if the exceptions and appeals process is working?

- Not clear what the "right" level of appeals is in Part D
  - Services provided under Part D (prescription drugs) fundamentally different from Part C (medical services)
- Low rate of appeals could mean (among others) that:
  - Enrollees are able to obtain the medications they need, or
  - Low awareness among the enrollees about their appeals rights, difficulty associated with navigating the process, and/or excessive administrative burdens.
- A plan with a large number of appeals AND a large number of cases that are reversed by the IRE may signal a problem with the exceptions and appeals process

Appeals related to Part D's late-enrollment penalty (LEP)

- Individuals enrolling in Part D outside of their initial enrollment period must have a proof of drug coverage that is comparable to Part D to avoid LEP
- Much higher number of penalty-related appeals reach the IRE compared with coverage-related appeals
  - Over 37,000 cases vs. about 14,000 cases for coverage-related cases in 2012
- Majority of the cases* are reversed by the IRE
- High reversal rate suggests that there may be issues with the process used by plans to verify enrollees' prior drug coverage status

MEDPAC *Excludes cases that are dismissed or withdrawn.

Findings from grievance data

- Most grievances filed are unrelated to coverage determinations, exceptions, and appeals
  - 3% related to coverage determinations, exceptions, and appeals
  - 62% related to issues with enrollment, a plan's benefits, or access to a pharmacy
- The average number of grievances for plans with 1,000 enrollees or more has fluctuated over time
  - Ranged from 5.6 to 11 grievances per thousand enrollees between 2006 and 2012

Findings from grievance data - continued

- Grievance rates per thousand enrollees among plans are low
- Some plans have high rates of grievances per 1,000 enrollees for multiple years
  - Enrollment averaged about 15,000 enrollees
  - Tended to be MA-PD plans (82%)
  - Average of 25 grievances per thousand enrollees
- Implications of these findings unclear

Summary

- Most beneficiaries are unaware of the how the exceptions and appeals process works and physicians find the process frustrating
- CMS program compliance audits show plans struggle the most with Part D coverage determinations, appeals, and grievances
- CMS audits may be one way to improve the exceptions and appeals processes used by plans
- Part D's appeals data show a mixed picture with improvements in some areas and potential issues in others
- High reversal rate observed for LEP-related appeals suggests potential issues with the process used by plans to verify enrollees' prior drug coverage status
- Most grievances are not related to coverage determinations, exceptions, and appeals

Implications of these findings on the appeals process

- Are there any aspects of the coverage determination, exceptions and appeals, and grievance process that should be improved?
- Are there any issues we should pursue further?
  - E.g., process used to determine enrollees subject to Part D's late-enrollment penalty
  - Others?