Letter from Medicare Beneficiary Groups

September 20, 2018

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2322A Rayburn House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Chairman
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

The Honorable Richard Neal
Ranking Member
Ways and Means Committee
U.S. House of Representatives
1139E Longworth House Office Building
Washington D.C. 20515

Dear Chairmen and Ranking Members:

On behalf of Medicare beneficiaries, advocates, and stakeholders supporting Medicare, we are writing to ask you to include the bi-partisan Senate provision, Sec. 2111, "Automatic escalation to external review under a Medicare part drug management program for at-risk beneficiaries", in the final, comprehensive opioid legislation to assure auto-escalation of Part D appeals to the Independent Review Entity (IRE). The lack of auto-escalation[1] unduly burdens Part D enrollees and hinders their access to Part D drugs.

The Comprehensive Addiction and Recovery Act included auto-escalation in new Medicare Part D lock-in programs. The provision "locks-in" a beneficiary at risk to misuse a frequently abused drug to certain prescribers and pharmacies. As part of the patient protections, Congress included automatic escalation to external review for Part D appeals for beneficiaries "locked-in" to ensure beneficiaries would not have delayed access to necessary drugs. However, the final regulations implementing the lock-in do not include the auto-escalation protection.

[1] Auto-escalation is different from auto-forwarding which occurs in Part D appeals processes when a plan sponsor fails to make a decision within the required time frame. In these cases, the plan must auto-forward the case to the IRE and notify the enrollee that the plan forwarded the case.

Recently, the press has covered numerous stories of beneficiaries who need access to opioids for pain but are prevented from accessing them because of well-meaning government policies to stem the opioid epidemic. A Virginia newspaper[2] describes the difficulties patients who legitimately suffer from chronic pain have when trying to obtain opioids. One patient had to call eight doctors before finding a physician who would treat her, but only after signing a contract mandating time consuming urine testing and regularly scheduled pill counts. Another article[3] explains how a former law enforcement officer in constant pain contemplated suicide after his doctor had cut off the opioids that had helped him endure excruciating back pain from a motorcycle crash. Auto-escalation of appeals of "locked-in" status will ensure that those patients who legitimately need a frequently abused drug to treat chronic pain do not experience further delays while negotiating the rules of appeals process.

Although the Medicare Advantage (Part C) program served as the model for implementation of the Part D benefit in 2006, not all aspects of the Part C appeals process were incorporated into the Part D appeals process created in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act). In the Part C program, "reconsideration determinations" or redeterminations conducted by the plan sponsors are automatically escalated to the Part C IRE. However, the Part D appeals process does not include the auto-escalation of benefit denials to the IRE (also called the Part D Qualified Independent Contractor).

While an enrollee who is dissatisfied with the results of a redetermination by the plan has a right to reconsideration by the Part D IRE, the enrollee or an appointed representative must initiate the escalation to the next level of appeal. The enrollee or an appointed representative must file a written request (letter or fax) for an appeal with the Part D IRE within 60 days of the date of the adverse redetermination by the Part D plan sponsor. The written appeal process is often confusing to enrollees, their representatives and their prescribers. Supplying elements for the appeal can be confusing, especially when an enrollee does not use the model appeal/reconsideration request form. For example, Part D plans are typically known by different names, and enrollees are often confused by the brand vs. generic names of drugs.

The lack of auto-escalation is a significant barrier to the entire Part D appeals process. Data prepared by the Part D IRE shows that Part D appeals rates are significantly less than Part C. While the Part C appeal rate has increased since 2006, the Part D appeals rate has not increased significantly despite changes to improve notification to beneficiaries about the appeals process and to allow health care professionals to request IRE reconsiderations of Part D coverage determinations on behalf of enrollees without having to obtain signed appointment of representative forms.

Part C Reconsideration Appeal Rate, Per 1000 Enrollees

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[2] Dyson, Cathy. "Chronic Pain Patients 'Treated Like Criminals*.*" *The Free Lance-Star*. Appearing in *U.S. News and World Report.* 08/18/2018. https://www.usnews.com/news/healthiest-communities/articles/2018-08-19/chronic-pain-patients-says-theyre-treated-like-criminals.

[3] Ehley, Briana. "How the opioid crackdown is backfiring". *Politico.* 08/28/2018. https://www.politico.com/story/2018/08/28/how-the-opioid-crackdown-is-backfiring-752183

Contract Year	Part C Reconsideration Appeals	Part C Enrollment	Appeal Rate / 1000 Enrollees
2006	22,303	7,405,312	3.01
2007	27,998	8,669,618	3.23
2008	44,166	10,039,544	4.40
2009	61,627	11,120,953	5.54
2010	62,422	11,735,818	5.32
2011	68,517	12,356,306	5.55
2012	109,636	13,587,492	8.07
2013	119,239	14,848,606	8.03
2014	46,747	16,270,582	2.87
2015	46,377	17,532,429	2.65
Average	**60,943**	**12,356,666**	**4.87**

Part D Reconsideration Appeal Rate, Per 1000 Enrollees

Contract Year	Part D Reconsideration Appeals	Part D Enrollment	Appeal Rate / 1000 Enrollees
2006	12,977	23,579,204	0.55
2007	11,036	24,168,418	0.46
2008	16,541	25,636,831	0.65
2009	20,733	26,814,113	0.77
2010	18,959	27,810,505	0.68
2011	13,752	29,329,046	0.47
2012	14,131	31,599,967	0.45
2013	16,208	35,667,604	0.66
2014	22,690	37,637,310	0.60
2015	33,407	39,440,367	0.85
Average	**17,314**	**29,138,111**	**0.59**

Includes both Medicare Advantage Prescription Drug Plans and Prescription Drug Plans

Congress should clarify its intent with respect to the Medicare lock-in and extend the same beneficiary protection to all Part D beneficiaries to ensure they do not have delayed access to necessary drugs.

Sincerely,

Aging Life Care Association®
Alliance for Retired Americans
American Association on Health and Disability
American Society on Aging
Arthritis Foundation
California Health Advocates
Caregiver Action Network

Center for Medicare Advocacy
GIST Cancer Awareness Foundation
HealthyWomen
International Foundation for Autoimmune & Autoinflammatory Arthritis
Justice in Aging
Lakeshore Foundation
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
Medicare Rights Center
Mental Health America
National Association for Home Care & Hospice
National Association of Social Workers (NASW)
National Association of State Long-Term Care Ombudsman Programs (NASOP)
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Multiple Sclerosis Society
United Spinal Association
U.S. Pain Foundation
VNAA/ ElevatingHOME
WISER (The Women's Institute for a Secure Retirement)