The Medicare Appeals Process:

Reforms Needed to Ensure Beneficiary Access

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EXECUTIVE SUMMARY

Medicare provides health coverage for more than 61 million Americans.[1] Given that the incidence of cancer increases with age, the Medicare program is vitally important to millions of Americans who are undergoing active cancer treatment, are cancer survivors or who have not yet developed cancer. Yet, without Congressional action in the next few years, the Medicare Trust Fund, will become insolvent.[2] Considering the forthcoming pressure to shore up this essential health program, Congress is apt to consider policies that would shift costs more to enrollees and/or tighten program benefits. To the extent that Congressional action results in the use of more utilization management tools the result would likely mean beneficiaries would more often have to use the appeals process in order to access medically necessary products and services.

Public and private payers increasingly employ a variety of measures to minimize their liability for paying for high-cost services, such as cancer therapies.[3] As a result, cancer patients increasingly have to go through appeals or exceptions processes in order to access medically necessary drugs or services – either because their prescribed product or service is subject to utilization management tools or because their insurer may choose not to cover a particular therapy or service as part of its benefit design. Without coverage for a needed service or treatment, cancer patients face having to pay the full cost out of pocket or making the difficult decision to forego care that could save their lives.

To better understand how the Medicare program's appeals process works for beneficiaries who have a history of cancer, this paper analyzes the existing appeals processes used by the Medicare program by walking through the Medicare Part A and B appeals process (including a discussion of an expedited process) using hypothetical patient profiles as illustrations. The paper then details the process used by Medicare private plans – Part C and D plans – to control costs and the process a beneficiary would undergo to obtain access to a Part C or Part D covered benefit. The paper concludes with

[1] According to the 2020 Medicare Trustees' Report, in 2019 Medicare covered 61.2 million people: 52.6 million aged 65 and older and 8.7 million persons with disabilities. 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Apr. 22, 2020. Available at https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.

[2] According to the Congressional Budget Office (CBO), absent intervening Congressional action the Medicare Hospital Insurance Trust Fund (which funds Medicare Part A) will become insolvent in fiscal year 2024, two years earlier than CBO predicted in March 2020 (prior to the pandemic). Congressional Budget Office. The Outlook for Major Federal Trust Funds: 2020 to 2030. Sept. 2020. Available at https://www.cbo.gov/system/files/2020-09/56523-Trust-Funds.pdf.

[3] American Society of Clinical Oncology Statement on the Impact of Utilization Management Policies for Cancer Drug Therapies. DOI: 10.1200/JOP.2017.024273 *Journal of Oncology Practice* 13, no. 11 (Nov. 1, 2017) 758-762.

recommendations for specific policies that would improve Medicare appeals and exceptions processes for both patients and the providers who treat them.

KEY FINDINGS

The Medicare Appeals Process is Overly Complex: The Medicare appeals processes are confusing and can be cumbersome and time-consuming. There are many rules and requirements regarding what can be appealed, what is needed to file an appeal, the timeframes by which an enrollee has the opportunity to file an appeal, and timeframes under which a decision is made. Beneficiaries can be at a disadvantage if they are unfamiliar with the system.

Cumulative timeframes may create barriers to care: From a beneficiary's perspective, the number of levels of review can be daunting and can deter a beneficiary from filing an appeal. In addition, multiple levels of appeal delay a beneficiary's access to medically appropriate products or services. Even though the appeals process allows for expedited consideration, each level of review has various timeframes by which the reviewing entity must act. Adding up all of those timeframes can result in a beneficiary – even one experiencing, by definition, exigent circumstances for which expedited review is warranted – who is unable to access the product or service that is on appeal for several days or weeks (depending on how many levels of review are undergone). On the provider side, providers report delays in being able to provide cancer care because of having to wait for approval from Medicare plans (Medicare Advantage (MA) or Part D plans) to override utilization management tools.

Evidence suggests that plans' initial denials are often overturned: In 2019, the Health and Human Services (HHS) Office of the Inspector General released a report on the Part D appeals process and found that enrollees and providers appealed very few preauthorization and payment denials, but among those that were appealed, Medicare Advantage (MA) plans overturned 75 percent of their own denials.[4] This data suggests that MA plans' default is to deny claims, regardless of the medical necessity involved.

Lack of information on the utilization of the appeals process hinders progress: Medicare does not routinely publish information about the utilization of the appeals process – including information sorted by program and level of appeal. Without that information, it can be challenging to ascertain what specific improvements are needed.

Many beneficiaries do not exercise their appeals rights: Unfortunately, it is not known how many beneficiaries do not exercise their appeals rights, either because they were not informed of their right to appeal or because they were daunted by the process. Beneficiaries might choose to pay out of pocket for services that should be covered by Medicare or choose to forgo care altogether instead of appealing, which could have negative implications for their overall health and wellbeing.

[4] U.S. Department of Health and Human Services-Office of Inspector General. Some Medicare. Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs. Revised September 2019. Accessed April 2020. https://oig.hhs.gov/oei/reports/oei-09-16-00411.pdf.