Date: April 11, 2010

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare

Medicare Enrollment and Appeals Group
(FCHJ)

- Develops national policy for eligibility, enrollment and entitlement for Medicare Parts A, B, C, and D to assure effective administration of the original Fee-for-Service (FFS) Medicare program, the Medicare Advantage (MA) program and the prescription drug benefit (including employer sponsored group Medicare Advantage and prescription drug plans). Plans, develops, and issues operational policy, business requirements, systems validation, operational procedures, and instructional material for the establishment and maintenance of the Medicare Beneficiary Database.

- Develops national policy and oversees operational activities related to the Medicare Parts A, B, C, and D claims-related hearings, appeals, grievances and other dispute resolution processes that are beneficiary-centered.

- Responsible for leading CMS' efforts for Medicare's FFS limitation on liability requirements (Section 1879), the refund requirements for physicians (Section 1842(l)) and medical equipment and supplies (Sections 1834(a)(18), 1834(j)(4), and 1879(h)). Coordinates and collaborates with the Center for Medicare on physician and durable medical equipment, prosthetics, orthotics and supplies policy and with the Office of Clinical Standards and Quality on medical necessity policy.

- Develops, evaluates, and reviews regulations, guidelines, and instructions required for the dissemination of appeals and enrollment policies to Medicare beneficiaries, Medicare contractors, MA plans, prescription drug plans (PDPs), CMS Regional Office consortia, including the Consortium for Medicare Health Plans Operations (CMHPO), Chief Operating Officer (COO), beneficiary advocacy groups and other interested parties.

- Resolves critical policy issues related to Medicare enrollment and appeals for MA plans, PDPs, States, and contractors, including oversight of activities related to Part D auto-enrollment and creditable coverage.

- Provides policy and operational direction to, and maintains regular liaison with Regional Office consortia, including CMHPO, COO; MA organizations, PDPs, and FFS contractors (including Qualified Independent Contractors (QICs)), the Departmental Appeals Board, the Department's Office of Medicare Hearings and Appeals, States, and other partners.

Date: April 11, 2010

Medicare Enrollment and Appeals Group
(continued)

- Oversees the QICs and coordinates resolution of policy and operational and quality assurance issues with relevant CMS components.

- Analyzes, interprets and develops legislative proposals, regulations and policies to streamline and continuously improve Medicare's enrollment and appeals policies.

- Performs analyses, coordination and support related to litigation and/or settlement materials, and reviews by oversight bodies (e.g., Government Accountability Office and Office of the Inspector General) related to Medicare's beneficiary appeals, enrollment and limitation of liability.

- Develops beneficiary notification materials and provides technical subject-matter expertise to others who publish documents related to appeals and beneficiary dispute resolution issues and processes (e.g., *Medicare and You*).

- Serves as the focal point for issues related to a variety of Federal standards affecting private health insurance coverage, including those pertaining to its administration of the Medigap program, Title I of the Health Insurance Portability and Accountability Act and the Consolidated Omnibus Budget Reconciliation Act. Responsibilities would include developing related regulations, guidance and educational materials and liaison with States, employers, and unions with respect to these issues.

- Develops and implements regulations, guidance, operational procedures and outreach for the creditable coverage notice requirements for certain entities under the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

- In collaboration with the Business Operations Staffs in the Center for Medicare and the Office of Acquisition and Grants Management, Chief Operating Officer, develops and negotiates procurement contracts which include the development of contractor specifications, work statements, and evaluation criteria to support group programmatic functions, as needed. Evaluates, assesses, and monitors contractors' performance to ensure compliance with contractor requirements and the Federal Manager's Financial Integrity Act.