Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Town of Lexington, Massachusetts
Docket No. A-12-94
Decision No. ER9
September 24, 2012

DECISION

The Town of Lexington, Massachusetts (Plan Sponsor) appeals a June 11, 2012 notice from the Centers for Medicare & Medicaid Services (CMS) of its determination that there has been an overpayment under the Early Retiree Reinsurance Program (ERRP). Specifically, CMS determined that a reimbursement request made by the Plan Sponsor for the plan year ending June 30, 2010 was $372.18 less than the amount already paid by CMS for that plan year, resulting in an overpayment.

For the reasons discussed below, I uphold CMS's determination.

Applicable Regulations and Guidance

Established by section 1102 of the Patient Protection and Affordable Care Act, Pub. L. No. 11-148 (Act), ERRP is a temporary program that provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees. The Act states that "[t]he term 'health benefits' means medical, surgical, hospital, prescription drug, and other benefits as shall be determined by the Secretary . . . ." Act, § 1102(a)(2)(A). The implementing regulations similarly state that "*Health benefits* means medical, surgical, hospital, prescription drug, and other benefits as specified by the Secretary[.]"[1] 45 C.F.R. § 149.2.

The implementing regulations further provide that a submission of claims for reimbursement "consists of a list of early retirees for whom claims are being submitted, and documentation of the actual costs of the items and services for claims being submitted, in a form and manner specified by the Secretary." 45 C.F.R. § 149.335(a). Prior to April 2011, CMS permitted plan sponsors to submit requests for reimbursement

[1] The regulations except from this definition "benefits specified at 45 CFR 146.145(c)(2) through (4)," i.e., accident coverage, disability income coverage, liability coverage, and coverage issued as a supplement to liability insurance.

without the claim list required by section 149.335(a) on the condition that each plan sponsor would substantiate the reimbursement received at a later date.

CMS's guidance provides that CMS will review each claim list and generate a Claim List Response File that indicated whether errors were found on the Claim List and, if errors were found, identified the specific records with errors and the type of error(s) found. *See* Claim List Response File Reference Guide, available at http://www.errp.gov/download/ERRP_Claim_List_Response_File.pdf; *see also* Common Question H1000-45 (indicating that automated claim list review process was available beginning October 3, 2011). CMS uses a "reason code" to identify each type of error. *See id*. CMS notifies the plan sponsor by e-mail that the Claim List Response File is available and, if applicable, that the reason code constitutes an "adverse reimbursement determination" that may be appealed by the plan sponsor within 15 days of receipt of the e-mail. *See Explanation of the Appeals Process for the Early Retiree Reinsurance Program*, available at http://www.errp.gov/download/ERRP_Explanation_of_the_Appeals_Process.pdf;[2] *see also* 45 C.F.R. § 149.500(d), (e).

A plan sponsor that receives a Claim List Response File identifying errors must subsequently submit an error-free claim list. CMS then sends the plan sponsor–

> a reimbursement determination email indicating the amount of CMS' reimbursement determination. To the extent the sponsor disagrees with the amount of the determination (for example, the sponsor believes CMS calculated the amount of the subsidy incorrectly), this would constitute an adverse reimbursement determination. Therefore, upon receiving this email, the sponsor may submit an appeal. (However, if the plan sponsor did not timely appeal any previous adverse reimbursement determination regarding early retirees or rejected claims or codes, the sponsor has no right to appeal the reimbursement determination calculation, to the extent the appeal seeks to indirectly challenge that previous determination).

Explanation of the Appeals Process for the Early Retiree Reinsurance Program at 3.[3]

[2] The version of this document on CMS's ERRP website is dated March 27, 2012. However, the provisions to which this decision refers are unchanged from the original version (dated October 3, 2011).

[3] On August 30, 2011, the Secretary delegated her authority to review appeals of adverse reimbursement determinations to the Chair of the Departmental Appeals Board.

Case Background

On June 11, 2012, CMS notified the Plan Sponsor by e-mail of its determination "that there has been an overpayment in the amount of ($372.18) with regard to" the Plan Sponsor's Application ID 1020000235 for the plan year ended June 30, 2010. CMS stated specifically that the "sum of reimbursable costs . . . that was submitted with the reimbursement request referenced in this email [Application ID 1020000235] was less than the sum of such costs submitted with previous reimbursement requests for the same plan year. As a result, ERRP reimbursements received from prior reimbursement request(s) resulted in an overpayment that must be returned to CMS." CMS also stated in pertinent part: "If you disagree with the reimbursement request amount specified in this email, such amount constitutes an adverse reimbursement determination, which the Plan Sponsor . . . may appeal, pursuant to ERRP regulations at 45 CFR Part 149, subpart F. The Plan Sponsor has 15 calendar days from the date of this email, to submit its appeal." The e-mail also referred the Plan Sponsor to the *Explanation of the Appeals Process for the Early Retiree Reinsurance Program.*

By letter dated June 20, 2012, the Plan Sponsor stated that it was appealing "the Overpayment Request in the amount of $362.18." The full explanation of the basis for the appeal reads as follows:

> The Town of Lexington, Massachusetts was eligible to participate in the ERRP program. We received a reimbursement for the first/second plan year of the program, based on aggregate claims data submitted according to the initial HHS guidelines. In April 2011, HHS changed the reporting requirements for claims, from aggregate to a claims detail list, and also then included a list of exclusions that were not known at the time of the reporting of aggregate claims data for the first plan year. The result of this change was 'rejected' claims for the first plan year, after the reimbursement was received by the Town.
>
> HHS/ERRP is now requesting that the Town 'pay back' a portion of the reimbursement received. We are appealing this overpayment requests and are requesting that as a Massachusetts municipality, that we be exempt from any and all overpayment requests. We find this matter to be unacceptable and unfair, given the state of municipal finances for FY13. We believe that the implementation of the ERRP program was not well thought out. Changes in procedures and requirements after the fact are understandable but place an undeserved burden on Massachusetts municipal employers.

Discussion

The Plan Sponsor's principal argument on appeal appears to be that CMS did not provide adequate notice of what items and services would be reimbursable under ERRP because

CMS identified excluded items and services on a "list of exclusions" after the Plan Sponsor submitted its initial reimbursement request. For the reasons discussed below, I conclude that this is not a valid basis for reversing CMS's overpayment determination and that the Plan Sponsor's other arguments have no merit.

In its response to the appeal, CMS says it assumes that by "list of exclusions," the Plan Sponsor meant to refer to several lists of codes "representing[ing] items or services that do not satisfy the ERRP statutory and regulatory definition of health benefits because they are not covered under Medicare, and therefore may not be submitted to ERRP." CMS Response at 4. However, CMS asserts that the Plan Sponsor's "claim list . . . did not include any such codes[.]" *Id*. Indeed, the Plan Sponsor does not allege that its claim list included the cost of any items or services not covered by Medicare, much less specifically identify any such costs. Thus, even if CMS failed to provide adequate notice of excluded items or services, the Plan Sponsor has not shown that it was adversely affected.[4]

The Plan Sponsor also complains that the claims were rejected after it was reimbursed because CMS because "HHS changed the reporting requirements for claims, from aggregate to a claims detail list[.]" Even if the Plan Sponsor was initially paid on the basis of an aggregate claim, however, the Plan Sponsor could not reasonably expect to retain federal funds for costs that it could not later substantiate.

The Plan Sponsor argues in addition that, as a Massachusetts municipality, it should be "exempt from any and all" requests to refund an overpayment "given the state of municipal finances" for fiscal year 2013. This is in essence a request for equitable relief. The Plan Sponsor does not point to anything in the ERRP regulations or in CMS's guidance that authorizes the Secretary or the Board Chair to reverse an overpayment determination by granting such relief.

[4] In other appeals before me, CMS alleged that before any plan sponsor submitted its first reimbursement request, CMS published other guidance indicating that items and services not generally covered by Medicare would not be reimbursable under ERRP. *See Town of Auburn, Massachusetts*, DAB No. ER7, at 4 (Sept. 19, 2012); and *Town of Auburn, Massachusetts*, DAB No. ER8, at 4 (Sept. 19, 2012).

Conclusion

For the foregoing reasons, I uphold CMS's June 11, 2012 determination of an overpayment in the amount of $372.18.

/s/
Constance B. Tobias, Chair
Departmental Appeals Board