
Explanation of the Appeals Process for the Early Retiree Reinsurance Program

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Scope of this guidance

This document provides operational guidance regarding how plan sponsors participating in the Early Retiree Reinsurance Program (ERRP) would submit a request for appeal of an adverse reimbursement determination pursuant to 45 CFR Part 149, Subpart F, and how the appeals process works. Pursuant to 45 CFR §149.500(d), an adverse reimbursement determination is a determination constituting a complete or partial denial of a reimbursement request. This includes a determination regarding whether a given individual whom the sponsor has submitted to CMS as an early retiree in advance of a reimbursement request satisfies the substantive criteria for being an early retiree for the entire time period claimed by the sponsor or whether a claim submitted in advance of a reimbursement request is for a “health benefit,” as defined by the ERRP statute, regulation and other ERRP guidance. The appeals process is not an opportunity for a plan sponsor to identify new individuals who may qualify as Early Retirees or to seek reimbursement for new claims for health benefits not previously submitted to CMS.

The HHS Secretary has delegated her authority to accept and review appeals of adverse reimbursement determinations to the Chair of the HHS Departmental Appeals Board (Board), who will designate one or more Board Members to decide each appeal.

This guidance does not address the requirement in 45 CFR § 149.600 for a plan sponsor to disclose previously reported data inaccuracies or the provision in 45 CFR § 149.610 permitting plan sponsors to request a reopening of a reimbursement determination. Separate guidance regarding these provisions has been published because the processes for disclosing data inaccuracies and for reopening are different from the appeals process, are established under different regulatory authorities, and address different circumstances.¹ The appeals process applies, however, to original, and revised, reimbursement determinations that are adverse to a plan sponsor.

What determinations may be appealed?

As stated earlier, Pursuant to 45 CFR § 149.500, a plan sponsor may appeal an adverse reimbursement determination, which is a determination constituting a complete or partial denial of a reimbursement request. An adverse reimbursement determination may be issued in different

¹ See www.errp.gov for this separate guidance.

ways, depending on the nature of the adverse reimbursement determination, as discussed in the following paragraphs.

The amount of any reimbursement request is intrinsically linked to CMS' determination regarding whether a given individual (whom the sponsor has submitted to CMS as an early retiree in advance of a reimbursement request) satisfies the substantive criteria for being an early retiree for the entire time period claimed by the sponsor.² Thus, we interpret the definition of "adverse reimbursement determination" in 45 CFR §149.500, to include such determinations. An adverse reimbursement determination on whether an individual satisfies the criteria for the entire time period is appealable, as follows. After a sponsor submits an Early Retiree List in advance of a reimbursement request, CMS will assemble and post on the ERRP secure website, and/or transmit mainframe to mainframe to the sponsor (depending on the sponsor's preference and/or how it sent its Early Retiree List) a response file specifying whether each individual on the list satisfies the definition of an early retiree, and for what periods of time. To the extent the response file for any given individual contains Reason Code 11 (not an early retiree due to Medicare eligibility), Reason Code 12 (not an early retiree due to death), or Reason Code 36 (not an early retiree due to age), for some or all of the period of time the sponsor claims the individual to be an early retiree, the email notifying the plan sponsor of the availability of the response file will state that the sponsor has a right to appeal CMS' determination with respect to the periods of time for which CMS determined that such individuals are not early retirees. Upon receiving that email, a sponsor may submit an appeal.

The amount of any reimbursement request is also intrinsically linked to CMS' determination regarding whether a given diagnosis, procedure, or other code that has been submitted as part of a claim in advance of a reimbursement request is an acceptable code under ERRP (i.e., is for a "health benefit," as defined by the ERRP statute, regulation and other ERRP guidance). Thus, we interpret the definition of "adverse reimbursement determination" in 45 CFR §149.500, to include such determinations. An adverse reimbursement determination on whether any code is acceptable is appealable, as follows. After a sponsor submits a Claim List in advance of a reimbursement request, CMS will examine the Claim List to identify any diagnosis, procedure, and other codes that are unacceptable for purposes of ERRP. CMS will then assemble and post on the ERRP secure website, or transmit mainframe to mainframe to the sponsor (depending on how the sponsor sent the Claim List) a response file. To the extent CMS has found any unacceptable codes, the response file will identify which codes and associated claims are unacceptable (which will cause the entire Claim List to be rejected). CMS will also send the sponsor an email notifying the sponsor of the availability of the response file, and the email will state that the sponsor has a right to appeal CMS' determination with respect to these codes. Upon receiving this email, the sponsor may submit an appeal.³

² For example, a sponsor may claim that, for the plan year in question, an individual satisfies the ERRP definition of an early retiree from January 1, 2011 through December 31, 2011. But CMS may determine that the individual is an early retiree from March 1, 2011, through December 31, 2011.

³ CMS has indicated in other guidance that for purposes of ERRP, CMS generally applies Medicare coverage standards. Based on those coverage standards, CMS has published several lists of procedure and diagnosis codes that CMS will presumptively reject when included by a sponsor in an ERRP Claim List. However, if a sponsor has evidence that any such code is acceptable under Medicare in at least one setting, it may appeal CMS' determination to reject the code. For more information on how Medicare coverage standards apply to ERRP, and to view the lists of excluded ERRP codes, see related materials at www.errp.gov

After a sponsor submits an actual reimbursement request, CMS will send the 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).

Most ERRP adverse reimbursement determinations will be made, and communicated to the plan sponsor, in the manner described previously in this guidance. However, there may be instances when an adverse reimbursement determination is made based on an audit or other type of review. In all such cases, the plan sponsor will receive an email informing it of the adverse reimbursement determination, describing the nature of and reasons for the adverse reimbursement determination, and informing the sponsor of its opportunity to submit an appeal. The procedure and timeframes described in this paper for submitting an appeal apply, regardless of how an adverse reimbursement determination is made and communicated.

The ERRP regulations state that a sponsor has 15 calendar days from the date of receipt of an adverse reimbursement determination to submit an appeal. 45 C.F.R. §500(e). The 15-calendar day period does not begin to run until the sponsor receives the relevant email that notifies the plan sponsor about the adverse reimbursement determination. That email will describe the 15 calendar-day time limit for submitting an appeal.

What determinations are not appealable?

Appealable determinations are ones that CMS makes based on the plan sponsor's submissions to CMS. A plan sponsor may not appeal a reimbursement determination on the ground that:

- It neglected to include a given item or service in its reimbursement request;
- It misstated data with respect to a given item or service; or
- CMS could not process an Early Retiree List, Summary Claim Data, a Claim List, or a reimbursement request due to the fact that it was not submitted in the correct manner or format.

These instances relate to the underlying data upon which CMS made a reimbursement determination and do not provide a basis for challenging CMS' determination based on the data submitted to CMS.

Furthermore, the ERRP statute and regulations do not permit plan sponsors to appeal CMS' determinations to deny an ERRP application, to refuse to accept an application for processing, or to terminate approval of an application. The denial of an application, the refusal to accept an application, or the termination of an application approval are related to whether a plan sponsor may participate in the program, not a determination about reimbursement for participating plan sponsors.

Lastly, if a reimbursement request is not honored based on the unavailability of ERRP funds, a plan sponsor may not appeal. 45 CFR §149.500(c).

What is the deadline for submitting a request for appeal?

A request for appeal must be submitted within 15 calendar days of receipt of an adverse reimbursement determination. 45 CFR § 149.500(e).

As noted previously in this guidance, an adverse reimbursement determination is considered received by a plan sponsor when it has received the applicable email notifying the plan sponsor of the adverse reimbursement determination. For example, if the sponsor receives the email on Tuesday, November 25th, the 15 calendar days would begin to run on the next full calendar day, or Wednesday, November 26th. So in this example, if the plan sponsor received the email about the adverse reimbursement determination on 9:58 AM on November 25, the first day that counts toward the 15 calendar days would be November 26. In this example, the plan sponsor's appeal would have to be submitted by 11:59 PM on Wednesday, December 10.

The term "calendar days" generally includes Saturdays, Sundays, and Federal holidays. Thus, in the example above, the appeal would have to be submitted by December 10, even though several days between November 25 and December 10 are Saturdays and Sundays, and even though Thursday, November 27, would be a Federal holiday (Thanksgiving). However, if the due date itself would otherwise fall on a Saturday, Sunday, or a Federal holiday⁴, the actual due date would be the following business day. These emails are considered sent from CMS' ERRP Center and received by the plan sponsor on the date listed in the "sent" line of the email's header. CMS considers an email successfully sent to, and received by, a plan sponsor if the email is sent and CMS does not receive a message in return stating that the email was undeliverable. Therefore it is critical that plan sponsors ensure that their Authorized Representative's (AR) and Account Manager's (AM) email addresses are up-to-date in the ERRP Secure Website. It is also critical that plan sponsors ensure that their organization's spam filters are adjusted to allow emails from CMS' ERRP Center⁵. If an adverse reimbursement determination email is sent to both the AR and AM and only one email is returned as undeliverable CMS considers the plan sponsor to have received the email and the 15 calendar days for filing an appeal will begin to run.

What information or documentation must be submitted in or with a request for appeal?

A request for appeal must specify the findings or conclusions with which the plan sponsor disagrees and the reason(s) for the disagreement(s). 45 C.F.R. § 149.520. In submitting a request for appeal, a plan sponsor should include all information and data necessary for the Board to evaluate the request and CMS to respond to the appeal, including a copy of the email notifying the plan sponsor about the adverse reimbursement determination, the amount of reimbursement at issue, the application ID number, plan year, information about the items and services at issue including dates of service, and information about the individuals to whom the

⁴ The Federal holidays are: New Year's Day, Martin Luther King, Jr. Day, Washington's Birthday, Memorial Day, 4th of July, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day.

⁵ For a list of "from" ERRP-related email addresses that should not be blocked, see the Contact Us page at www.errp.gov.

items or services were provided. Since the Board is independent of CMS, the plan sponsor should not assume that the Board would have information that the plan sponsor submitted to CMS, such as the plan sponsor's Claim List.

The plan sponsor may also submit supporting documentation not previously submitted to CMS. The plan sponsor should not submit any documentation that is related to individuals, items or services not previously included in the Early Retiree List or Claim List, to the extent the adverse reimbursement determination being appealed is directly related to the response files sent with respect to those lists. To the extent the adverse reimbursement determination being appealed is the calculation of a reimbursement determination itself (as opposed to the complete or partial rejection of an individual as an early retiree, or the rejection of a procedure code, diagnosis code, or other code) , the plan sponsor should not submit any documentation that is related to items or services not previously included in the reimbursement request at issue in the appeal (such as revised claims data) or that CMS has determined are reimbursable. Revised claims data would be handled through the reopening and/or disclosing of data inaccuracies processes ⁶.

The plan sponsor's supporting documentation may not include testimonial evidence, such as an affidavit or declaration, but the Board may permit the submission of testimonial evidence in exceptional circumstances.

If a plan sponsor cannot submit all supporting documentation in the request for appeal (for example, the documentation may not be available to a plan sponsor by the last date for submitting the request for appeal), the plan sponsor must note that additional documentation will be forthcoming and the date by which the sponsor will submit the additional documentation to the Board. The due date for submission of the additional documentation shall be no longer than 45 calendar days after the plan sponsor's receipt of the adverse determination unless the plan sponsor presents a valid reason for such an extension and the Board grants an extension. If the due date would otherwise fall on a Saturday, Sunday, or Federal Holiday, the due date will be the next business day. The plan sponsor must request any further extension in writing before the original due date for additional documentation. If the additional documentation is not submitted by the original due date (or extended due date, as applicable), the Board may decide the appeal without the additional documentation.

When submitting any supporting documentation after the 15-calendar day deadline for appeal, the plan sponsor must submit that documentation in a single follow-up submission. The plan sponsor may not submit any further supporting documentation except in response to a request by the Board.

All requests for appeal from a plan sponsor must be signed by either the AR or the AM identified on the plan sponsor's ERRP application and include both the AR's and the AM's telephone numbers and email addresses. Any supporting documentation submitted after the original request for appeal must be accompanied by a cover letter signed by the AR or the AM.

How and where should the plan sponsor submit the request for appeal and the supporting documentation?

⁶ See 45 C.F.R. §149.600, 45 C.F.R. §149.610. Also see guidance on these topics at www.errp.gov.

If a plan sponsor wishes to submit its request for appeal and/or supporting documentation electronically, the plan sponsor should call the Board at (202) 565-0208 as soon as possible before the applicable deadline to ascertain whether the Board is able to accept the submission electronically and to obtain any instructions for submission. Any electronic submissions must be made using the DAB web portal.

Unless electronic submission is authorized by the Board, requests for appeal and supporting documentation must be sent to the Board at the address below via the U.S. Postal Service or a commercial delivery service.

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Appellate Division
330 Independence Ave., S.W.
Cohen Building - Room G-644
Washington, D.C. 20201

Any protected health information, as defined by the Health Insurance Portability and Accountability Act regulations, must be submitted in compliance with all applicable privacy and security laws regardless of the means of submission.

The date of submission of a request for appeal that is not sent to the Board electronically is the postmark date, the date sent by registered or certified mail, or the date deposited with a commercial delivery service. The plan sponsor should retain a copy of the request for appeal and all supporting documentation.

Supporting documentation should be organized in a logical manner, consistent with the nature of the issues raised on appeal, and should be accompanied by an index of the documents.

The plan sponsor must send to CMS (at the address identified in the adverse reimbursement determination email) a copy of the request for appeal and any supporting documentation submitted with its request for appeal or in a follow-up submission to the Board, unless these documents are submitted electronically. If the plan sponsor submits its request for appeal electronically, then both parties should make all future submissions electronically and the Board will issue all documents electronically.

What happens next in the appeals process?

The Board will consider a request for appeal to be complete once the Board has received the request and all supporting documentation, or when the Board has received the request for appeal and has determined that no supporting documentation was submitted by either the original due date or the due date pursuant to an extension granted by the Board.

Once the Board receives any supporting documentation or the due date for submitting that documentation has passed, the Board will request a response from CMS with respect to any request for appeal that meets the requirements for a valid appeal CMS' response must be submitted within 60 days of its receipt of the Board's request unless a later date is set by the Board at CMS' request: otherwise the Board may rule on the appeal as filed. CMS must send a

copy of its response to the person who signed the request for appeal, unless the response is submitted electronically.

The Board may dismiss the request for appeal at any time if:

- The determination appealed is not an appealable determination, or
- The plan sponsor does not meet the requirements for submitting a request for appeal.

If the Board determines that further information is needed in order for it to issue a sound decision, it may take steps to develop the record.

The appeal process will not include an evidentiary hearing, and will include a telephonic oral conference only if the Board determines that it is necessary.

How will the Board make and issue its decision?

The regulation does not establish a time period for conducting and adjudicating appeals; however, the Board will attempt to make a prompt decision once it has received CMS' response to a request for appeal or after the completion of any further record development deemed necessary by the Board.

The Board may affirm, reverse or modify CMS' adverse determination. Each decision will be made by the Board Chair and/or one or more Board Members designated by the Board Chair.

The Board will send a copy of its decision in either PDF or Word format as an email attachment to the plan sponsor's AM and AR, and to CMS. If the request for appeal requests notification by letter instead of by email, a letter attaching a copy of the Board's decision will be sent to the plan sponsor's AM and a copy of the decision will be emailed to CMS.

The Board will rule on the merits of the appeal. If the Board determines that the plan sponsor has a right to additional reimbursement, CMS will make any additional payment owed, consistent with the Board's ruling, if funds are available. CMS may require the plan sponsor to submit a new reimbursement request if necessary in order to process the payment.

What is the effect of a Board decision?

Consistent with 45 C.F.R. §149.520(c) the Board's decision is final and binding unless CMS reopens and revises the determination pursuant to 45 C.F.R. § 149.610(a)(3). A reimbursement determination revised by a CMS-initiated reopening pursuant to 45 C.F.R. § 149.610 that is adverse to the plan sponsor may be appealed to the Board.

If the Board decision is either completely or partially in the plan sponsor's favor, the plan sponsor can expect to receive further guidance from CMS on the next steps.

If the funds appropriated for the ERRP are exhausted between the time a request for appeal is submitted and the date the Board notifies CMS of a decision requiring the reimbursement of funds, CMS will pend the reimbursement request. CMS will sequence successful appeals by the

date of notice of the Board's decision. If ERRP funds become available due to adjustments of other plan sponsors' reimbursements or for any other reason, CMS will reimburse the plan sponsor all or a portion of the amounts determined by the Board to be reimbursable, from any available funds, after the plan sponsor takes any necessary steps. Because funds might become available a significant amount of time after the Board has made a ruling, necessary steps may include CMS requesting that the plan sponsor submit current cost information or confirming that the cost information that CMS possesses is current. However, if there are no adjustments of other plan sponsors' reimbursement requests, or if program funds do not otherwise become available, the plan sponsor will not receive reimbursement, as ERRP funds are exhausted. 45 C.F.R. § 149.520(d).