Overview of the Hospital Settlement Agreement

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Issue

Provide an overview of the hospital settlement agreement.

The Office of Legislative Research is not authorized to provide legal opinions and this report should not be considered one.

Summary

This report provides a bulleted summary of the major provisions of the proposed settlement agreement for *The Connecticut Hospital Association, et al.* v. *Connecticut Department of Social Services, et al.*, (No. HHB-CV16-6035321-S) and a brief history of the underlying dispute. Many of the agreement's provisions are contingent on the General Assembly enacting implementing legislation, included as Exhibit 4 in the agreement; an OLR analysis of the bill will be made available on our website in advance of the special session.

The agreement's provisions are tied to two effective dates: (1) the date by which the parties have signed the agreement, it is approved or deemed approved by the General Assembly, and the implementing legislation is enacted (i.e., "first effective date") and (2) the date by which the state has received federal approval of all of the tax waiver and Medicaid State Plan Amendments necessary for the agreement's implementation and the court has approved the agreement (i.e., the "second effective date"). It runs through June 30, 2026.

I. & II. General Framework for the Agreement and Definitions

- Provides the agreement's stated purposes and intentions, including that the parties intend the agreement to be legally binding and enforceable by the court
- Defines the agreement's terms

III. Hospital User Fee Refund

- Requires a $70 million hospital user fee (i.e., hospital provider tax) refund to the hospitals; allocates the refunds to each hospital based on the amount they claimed as an "overbreadth amount" in their pending refund claims filed with the Department of Revenue Services (DRS) (must be paid within 45 days after the second effective date)
- Requires the hospitals with pending tax refund claims to authorize the public disclosure of the tax return information contained in the agreement

IV. Hospital User Fee Changes

Rates and Base

- Reduces the total amount of revenue to be collected from the "second hospital user fee" (i.e., the tax on inpatient and outpatient hospital services beginning July 1, 2017) from $900 million to:
    - $890 million for FY 20
    - $882 million for FY 21
    - $850 million per year for FYs 22–25
    - $820 million for FY 26
- Sets the base for calculating the user fee as each hospital's audited FY 16 net revenue (see Exhibit 2)
- Sets the effective user fee rates as follows:

FY	Effective User Fee Rates	
	Inpatient Hospital Services	Outpatient Hospital Services
20	6%	12.0942%
21		11.7503
22-25		11.0976
26		10.4858

- Provides that if a hospital or hospitals merge, consolidate, are acquired, or otherwise reorganize, the surviving hospital or newly created entity is liable for the total user fee owed by the merging, consolidating, or reorganizing hospitals, including any outstanding liabilities from prior periods

- Provides that if a hospital ceases to operate for any reason other than a merger, acquisition, consolidation, or reorganization, the user fee amount due from each hospital must be recalculated in the following fiscal year to ensure that the total amount of revenue from all surviving hospitals equals the totals listed above
- Requires the payment hospitals made for the first quarter of FY 20 to be considered an estimated payment and applied against the amount due for FY 20 under the amended tax; they must pay the remaining balance due in three equal payments

Exemptions

- For FY 20, requires "financially distressed hospitals" to be exempt from the outpatient services portion of the user fee (the implementing legislation defines a financially distressed hospital as one that experienced an average net loss of more than 5% of aggregate revenue from October 1, 2011, through September 30, 2016)
- For FYs 21 through 26, requires "sole community hospitals" to be exempt from the outpatient services portion of the user fee (under the implementing legislation and federal law, a hospital is a "sole community hospital" if it is more than 35 miles from similar hospitals or located in a rural area and meets one of several other conditions)
- Provides that financially distressed or sole community hospitals are not exempt from the outpatient services portion of the user fee if the Centers for Medicare and Medicaid Services (CMS) denies the exemption; if so, the fee must be recalculated to ensure that the total amount collected from all hospitals equals the totals listed above

User Fee Audits

- Provides that if a hospital timely files its second hospital user fee return, accurately reports its net revenue on the return, and pays the legally required amount, DRS will not initiate an audit, examination, or reassessment of the hospital, except for audits based on math or clerical errors

V. Limitation on Taxing Hospitals

- Over the agreement's term, prohibits the state from:
    - imposing any new health care related tax or fee on hospital net revenue from inpatient and outpatient services or changing the second hospital user fee, except as allowed under the agreement
    - imposing any new tax on hospitals or amending any taxes to which hospitals are already subject, except as described below
    - repealing or changing any tax exemptions available to hospitals, including property tax, corporation business tax, sales and use tax, and motor vehicle fuels tax exemptions

- Allows the state to enact a new tax or amend a tax to which hospitals may be subject as long as (1) the tax is not a health care related tax or fee and (2) no more than 15% of the total tax imposed is due from hospitals
- Allows the state to change the second hospital user fee as long as the changes do not affect the (1) hospitals that are parties to the agreement and (2) state's ability to implement the agreement
    - Provides that the agreement does not preclude the state from amending or changing the ambulatory surgical centers gross receipts tax or nursing home and intermediate care facility resident day user fees
- Restricts the hospitals and the Connecticut Hospital Association (CHA) from supporting or endorsing legislative proposals to repeal or change the second hospital user fee

VI. One-Time Payments to Certain Hospitals

- Requires the Department of Social Services (DSS) to make one-time payments to certain hospitals, totaling no more than $9.3 million (see Exhibit 5) to resolve claims concerning:
    - emergency department physicians' services (1/1/15–6/30/16)
    - small hospital pool additional fund distribution due to a merger (7/1/18–6/30/19)
    - phase-in of graduate medical education costs
    - a disproportionate share hospital (DSH) payment
- Allows DSS to seek federal financial participation (FFP) for any one-time payment, however specifies the full payments (1) are not contingent on FFP receipt and (2) must be paid within 45 days after the second effective date

VII. Medicaid Rate Payments to Hospitals – Annual Rate Increases

- For dates of service on and after January 1, 2020, through June 30, 2026, requires DSS to annually increase the following Medicaid rates payable to hospitals each January 1 (see Exhibit 3):
    - inpatient hospital all-patient refined-diagnosis related groups (APR-DRG) base rate by 2%
    - inpatient hospital behavioral health per diem rate, inpatient psychiatric services and rehabilitation per diem rates, and inpatient behavioral health child discharge delay per diem rate, each by 2%
    - outpatient hospital ambulatory payment classification (APC) conversion factor by 2.2%
    - revenue center codes listed on the hospital outpatient flat fee schedule by 2.2%
- Prior to applying these rate increases, establishes the following initial discounted rate factors effective for dates of service from January 1, 2020, through December 31, 2020:

  - discounted Medicaid APR-DRG base rate: $6,924.58
  - discounted Medicaid APC conversion factor: $75.46
- Except under specified conditions related to federal compliance or reimbursement:
  - Prohibits the state from repealing, reducing, or otherwise removing the rate increases, and exempts appropriations for these rate-based payments from rescissions or holdbacks
  - Prohibits the state from reducing other inpatient and outpatient rates unless made in accordance with the rate setting rules and methodologies in the state Medicaid plan, as amended by the agreement and implementing legislation
  - Effective for dates of service from January 1, 2020, through June 30, 2026, establishes the following wage index values for use in the Medicaid APR-DRG and APC payment methodologies:
    - 1.2563 for hospitals located in the Bridgeport-Stamford-Norwalk statistical area
    - 1.2538 for all other hospitals

VIII. Medicaid Supplemental Payments to Hospitals

- Requires DSS to make Medicaid supplemental payments to the hospitals (see Exhibit 6) totaling:
  - $548.3 million each year for FYs 2020 and 2021
  - $568.3 million each year for FYs 2022 through 2026
- Requires the state to appropriate both the state and federal share of supplemental payments in the DSS's budget, and specifies that these payments are not subject to rescissions or holdbacks
- Requires payments to be made on or before the last day of the first month of each calendar quarter, except for the following:
  - Within 30 days after the agreement's first effective date, DSS must make:
    - payment adjustments to reconcile the quarterly supplemental payment for the quarter ending September 30, 2019, with the amounts already paid to the hospital
    - any other supplemental payments that are scheduled to be made before the first effective date
  - Any supplemental payments scheduled to be made after the first effective date but prior to the second effective date must be paid as scheduled
- Redirects supplemental payments from a hospital that does not continue to maintain a separate short-term general hospital license due to a merger, consolidation or acquisition, to

the surviving hospital starting with the first calendar quarter that begins on or after the effective date of the transaction

- Redistributes supplemental payments that would have been paid to a hospital that ceases to operate or otherwise terminates licensed short-term general hospital services to all other hospitals in accordance with the distribution methodology for each applicable supplemental payment pool (see Exhibit 6) beginning the following fiscal year

IX. Value-Based Payments to Hospitals and Other Quality of Care Initiatives Related to Hospitals

- Directs the state and hospitals to work together to implement value-based payment and care delivery strategies particularly for behavioral health
- Requires DSS to consult with, and provide opportunity for meaningful input from, CHA and the hospitals in identifying and developing these payment reform initiatives
- Prohibits DSS from requiring hospitals to participate in any Medicaid payment system that includes "downside risk" (i.e., financial penalties for hospitals failing to meet goals) during the agreement term, however does not preclude any hospital from voluntarily choosing to participate in any such system
- Allows DSS to implement "upside-only" payment arrangements (i.e., financial incentives for improved performance) beginning July 1, 2022, provided that the department has already consulted with the hospitals as required
- Allows CHA and the hospitals to participate in any process for public and stakeholder input or engage in advocacy regarding any proposed legislation or regulations related to the development of these initiatives

X. Other Provisions Concerning Payments to Hospitals

- Prohibits the state from enacting legislation to repeal or limit CGS § 17b-238(b) (i.e., rate appeal process), unless required for federal compliance; similarly prohibits CHA and the hospitals from seeking such legislation
- Requires DSS, as soon as practicable after the first effective date, to submit for federal approval revised and initial versions of Medicaid State Plan Amendments (SPAs) to implement the agreement's provisions and provide regular status updates to CHA
- Requires the parties to jointly seek court approval of the settlement after receiving the CMS approvals
- If one or more of the CMS approvals are denied or the second effective date does not occur before June 30, 2020, (or a later date as agreed to in writing by the parties), then the state and CHA must meet to determine if the agreement can be adjusted to address the issues identified

    - If these negotiated changes require legislation, requires the parties to diligently work together to propose necessary legislation, pursue its adoption, or present such changes for approval to the General Assembly
    - Terminates the agreement if the parties are unable to agree on adjusting the terms
- If for any fiscal year during the agreement term,
    - total Medicaid payments made to non-governmental hospitals exceed either the inpatient or outpatient hospital Upper Payment Limit (UPL) or both, the state must make the payments to hospitals as required using state-only funds
    - total inpatient payments to non-governmental hospitals exceed the UPL but there is still room under the outpatient UPL, or vice versa, then prior to making any payments using state-only funds to the extent required above and subject to federal approval, the parties must meet and develop a plan to redistribute the allocated funds to minimize or eliminate payments over the UPL
- DSS must provide CHA and the hospitals with copies of all related UPL filings, including any initial filings, subsequent filings or amendments, and all associated CMS correspondence

XI. Withdrawals and Future Appeals

- Requires the hospitals, within specified timeframes after receiving their agreed-upon tax refunds and one-time payments, to withdraw their outstanding (1) claims for refunds and (2) requests for hospital rate appeal hearings
- Limits the hospitals from filing certain claims or requests for rehearing for issues covered by the agreement, with specified exceptions (e.g., clerical errors)

XII. State Financial Impact and Option to Terminate the Agreement

- Recognizes that the settlement agreement's financial terms are based upon (1) the state's ability to access federal funds and (2) the hospitals' receipt of Medicaid rate increases, supplemental payments, and taxation limitation from the state as described in the agreement
- Establishes methods for the parties to meet and negotiate changes to the agreement to solve compliance issues (e.g., changes in federal funding requirements) resulting in (1) increased state costs for its payment obligations or (2) loss of hospital user fee revenue to the state (i.e., state financial impact)
- Specifies resolution methods in the event that parties cannot agree on how to resolve compliance issues, based upon the amount of the state financial impact, as described below

Methods for Resolving Agreement Compliance Issues Absent Party Agreement	
Amount of State Financial Impact in a FY	***Resolution Method***
Up to $50 million	State must absorb the impact
Greater than $50 million and up to $100 million	State may file a motion to have the court modify the agreement
Greater than $100 million	State may terminate the agreement

- Allows CHA and the hospitals to reinstate their appeals and refund claims after the state issues a notice of agreement termination

XIII. Enforcement

- Requires the parties to submit the agreement for court approval after the legislature has approved it and enacted the implementing legislation and the state has received the CMS approvals
- Gives the New Britain Superior Court jurisdiction to enforce the agreement until it expires after June 30, 2026, and all parties agree that its terms have been fulfilled
- Allows parties to move to enforce or modify the agreement in court if another party is not complying with its terms

XIV. Miscellaneous

Collections and Audits

- Affirms DRS's statutory authority to collect delinquent amounts due from hospitals while the agreement is in effect
- Affirms DSS's authority to audit hospitals and recover payments from dates before or during the agreement's term, except for the one-time payments described above
- Affirms hospitals' statutory rights relating to audits and appeals of audit findings

Technical Changes

- Allows the state and CHA to agree to pursue technical statutory changes needed to implement the agreement

Party Meetings and Authority

- Allows the parties to choose their own representatives to participate in meetings about the agreement; participation from the legislature or its members is not required
- Specifies that, by entering the agreement, the parties are signifying that they have the legal authority to do so

Agreement Modification, Exhibits, and Counterparts

- Specifies that the parties must mutually agree in writing to modify the agreement and must modify it if the court orders
- Specifies that Exhibits 1–7 are part of the settlement agreement and the settlement agreement represents the entire agreement between the parties
- Allows the parties to (1) use electronic signatures to enter into the agreement and (2) execute the agreement using a number of separate instruments

Background

Hospital Provider Tax

In 2011, the legislature enacted a hospital provider tax to help finance the state's Medicaid program. In FY 12, the first year the tax applied, the state appropriated Medicaid supplemental payments to hospitals that were greater than their total tax assessed, resulting in additional federal matching funds for the state and a net gain to hospitals. For each of the following FYs, however (FYs 13–19), hospitals received less back from the state in supplemental payments than their total tax assessed.

Affected hospitals, along with CHA, decided in 2015 to file petitions with DSS and DRS challenging the tax's constitutionality and legality. The following year, these agencies jointly ruled that the hospital tax was constitutional and legal. The hospitals and CHA appealed the agencies' ruling in Superior Court in November 2016. Additionally, certain hospitals filed two rounds of refund claims with DRS for hospital provider taxes paid in FYs 13–17. DRS denied both sets of refund claims.

Currently, the hospitals' lawsuit challenging the constitutionality and legality of the tax remains pending in Superior Court. Also, their two rounds of refund claims for provider taxes paid remain pending before DRS' Appellate Division.

Medicaid Rate Appeals

In 2016, certain hospitals filed a request with DSS for a rehearing challenging the adequacy, validity, and legality of Medicaid rates and other Medicaid payments decided by the DSS commissioner.

Currently, DSS has not yet begun administrative hearings on Medicaid rate appeals; they remain pending before a DSS hearing officer pending settlement discussion.

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