

MEMORANDUM

TO: Member Nursing Homes

FROM: Continuing Care Leadership Coalition
Greater New York Health Care Facilities Association
Healthcare Association of New York State
LeadingAge New York
New York State Health Facilities Association
Southern New York Association

DATE: December 24, 2014

SUBJECT: **ACTION NEEDED: Universal Settlement of Litigation and Rate Appeals**

ROUTE TO: Administrator, Owner, Director of Finance

ABSTRACT: Information on universal settlement of nursing home appeals/litigation. Facility responses are due by Jan. 9, 2015.

Introduction

After several months of negotiations, a group of attorneys representing provider associations and individual facilities in Medicaid reimbursement challenges has reached agreement with the State of New York on a proposed settlement of nearly all Medicaid rate appeals and lawsuits (the “Universal Settlement” or “US”). Under the broad parameters of the US agreement, the State would make payments totaling \$850 million over a five-year period in exchange for universal agreement among nursing homes to surrender their rights to pursue most pending Medicaid rate lawsuits and appeals and certain future rights to challenge Medicaid reimbursement.

To determine whether there is “universal” agreement to the US, each facility is being asked to expeditiously review the summary included herein, the legal terms of the agreement (the “Term Sheet”), its own settlement payments, and its pending rate appeals and litigation. Following this review, a representative of each facility is asked to complete an on-line response form (accessible [here](#)) indicating whether or not the facility is interested in participating in the settlement. **The deadline for completing the response form is Jan. 9, 2015. Given that the overall response will dictate whether the US can proceed, the above-named associations (the “Associations”) respectfully urge their members to respond within this timeframe.**

The Associations recognize that the relatively short timeframe given for responding may be difficult to accommodate, given the time of year and relative complexity of assessing facility interest in participation. For its part, the State is interested in obtaining a timely response so that the US can be reflected in State budget planning. Accordingly, the Associations are committed to

assisting member facilities through issuance of written guidance, conducting educational programming and working with counsels on outreach efforts.

The following items are available to assist each facility in making a decision about US participation:

1. The US overview summary provided in this document;
2. The US Term Sheet approved by the State (Attachment A);
3. The Associations' summary of the Term Sheet provisions (Attachment B);
4. A listing of your facility's payments under the US (see body of e-mail); and
5. DOH-generated master lists of pending rate appeals and lawsuits (Attachments C & D).

The Associations will be hosting a webinar for all nursing homes on the Universal Settlement on Monday, Dec. 29, 2014 from 3:00-5:00 p.m. Facilities' accounting/auditing firms are invited to participate as well. No advance registration is required but we recommend that providers follow the link prior to the event to ensure your computer has the appropriate players.

To participate in the webinar, follow the link below and enter the event number and password:
<https://hanys.webex.com/hanys/onstage/g.php?MTID=e6bca830c0cda37f645d65846f81889bb>

Event number: 715 050 098

Event password: Settle1

To participate by phone, please use the phone number and code:

For Audio Only: 1-866-469-3239

Access code: 715 050 098

The session will provide an overview of the US including the Term Sheet provisions, the facility payments, recommended facility actions, and next steps in the process. Time will be allotted to address participant questions. The webinar will be recorded and made available to all facilities, as well as auditing/accounting firms and law firms, shortly thereafter. As needed, follow-up education and/or materials may be offered to provide further clarifications.

Universal Settlement Payments

Provided that all terms of the US agreement are met, the State will pay to current facility operators (and in some cases former operators) or the operator's attorney (if one is designated to represent the operator), up to a total of \$170 million in funds annually per State fiscal year for 5 fiscal years beginning as soon as State Fiscal Year (FY) 2014-15 which ends March 31, 2015. The total amount of funds that can be paid under the US agreement over the 5-year period is \$850 million, less: (a) any offsets of liabilities owed to the State; and (b) all amounts allocated to any proposed distributee that does not participate in the US agreement.

Each facility has been given access to its own schedule of payments under the settlement. DOH has also provided the Associations with a facility-specific listing of currently outstanding liabilities to the State (e.g., rate overpayments, unpaid assessments). Under the terms of the US agreement, the State will be permitted to offset up to 70 percent of the first settlement installment payment against outstanding liabilities and up to 100 percent of the next four installments. Member facilities interested in obtaining their liability amounts should contact their Association representative.

Your facility's allocation may be subject to the claims of former owners. If your facility changed ownership during the affected period - particularly recently - the former owner may have outstanding claims/appeals that are also being settled. You should immediately resolve any such issues with the former owner of your facilities.

The payment amount for each facility was determined by a formula that allocates total funding of up to \$850 million paid in five equal annual installments of \$170 million to all eligible facilities (NOTE: Non-Medicaid facilities and specialty facilities/units with discrete Medicaid rates are ineligible to participate in the settlement). The allocation formula is based on the following factors:

1. The transition to statewide pricing and the positive/negative facility-specific impacts created thereby;
2. Negotiated settlements of specific lawsuits pending against the State relating to various Medicaid reimbursement issues involving rate periods prior to 2012;
3. Negotiated settlements of certain pending rate appeals relating to various Medicaid reimbursement issues involving rate periods prior to 2012;
4. A guaranteed minimum benefit to each facility of the greater of approximately \$225,000 or 4.5% of the facility's estimated annual operating revenue, taking into account all other amounts payable to the facility under the first three factors above; and
5. A reserve up to \$10 million allocated for settlements of specific rate appeals that would otherwise be included in the settlement. An industry-appointed master would allocate funds, based on the merits of each case or appeal, to those facilities that are: (1) eligible to receive funding under the guaranteed minimum benefit (see #4 above); and (2) willing to give up their rights to the guaranteed minimum benefit funding to participate in this process.

Facility payment amounts are not subject to appeal or revision. They represent pre-determined settlement amounts offered to each facility in exchange for giving up current and future rights to specific rate appeals and lawsuits. In addition, the payment amounts under the US are not subject to audit by the Office of the Medicaid Inspector General (OMIG). Subject to approval by the Centers for Medicare & Medicaid Services (CMS), these payments will be made directly by the State to distributee facilities and certain prior owners (or their designated attorneys) and not through Medicaid managed care plan payments.

The State has agreed to fund the annual distribution of US payments (i.e., up to \$170 million in total) from the following sources:

1. \$50 million in resources otherwise set aside for Medicaid rate litigation;
2. \$50 million out of the \$80 million annual cap on Medicaid rate appeals processing (leaving \$30 million per year to address appeals not included in the settlement); and
3. \$70 million, which represents half of the amounts collected from continuing the 0.8 percent assessment that was instituted in 2011 (the remaining \$70 million is supposed to be added to the Medicaid rates, once CMS approval is received).

Included and Excluded Appeals

Under the terms of the US, a participating facility will be required to withdraw all pending and possible future Medicaid rate appeals and litigation related to the following issues in exchange for its settlement payments. In other words, the settlement **includes** claims related to:

- The reimbursement methodologies in place before Statewide pricing (i.e., prior to Jan. 1, 2012);
- The Wage Equalization Factor (WEF);
- Medicare Part B offset appeals and any associated reconciliation audits;
- Reserved bed day reimbursement;
- Trend factor “banking” adjustments;
- Case-mix index adjustments related to any reimbursement methodology in place prior to Jan. 1, 2012;
- Medicaid rebasing issues, including hold harmless claims and the \$210 million “scaleback” adjustment;
- The Medicaid global spending cap; and
- All other pending and future rate appeals related to operating and/or capital per diem rates prior to Jan. 1, 2012, unless specifically excluded below.

The following matters are **excluded** under the agreement (i.e., a facility will not be required to give up its rights to pursue these appeals/lawsuits). However, each participating facility must identify any of its appeals or lawsuits in these categories to DOH at the time the facility executes the settlement documents, and DOH must agree that they are excluded from US:

- Adult day health care rate appeals;
- Rate appeals for initial processing of 12 month cost reports for eligible rebasings;
- Capital component appeals for rate periods beginning on and after Jan. 1, 2012;
- Capital component appeals for rate periods prior to Jan. 1, 2012 related to: (1) changes in bed capacity; (2) changes in ownership; (3) interim and approved project costs; (4) Medicaid Allowable Transfer Price (MATP); (5) new facilities; and (6) refinancings;
- Cash receipts assessment add-on reconciliations;
- Initial rate appeals for facility consolidations;
- Negotiated Medicaid rate settlements signed by a distributee and DOH prior to the effective date of the settlement agreement awaiting final approval;
- Rate appeals for initial base year operations;
- Rate appeals related to dropped services;
- Rate appeals and lawsuits brought by specialty facilities and discretely reimbursed specialty units (i.e., AIDS, TBI, neurobehavioral, ventilator and pediatric);
- Rate appeals and/or lawsuits filed subsequent to Jan. 1, 2012 that challenge the statewide pricing methodology, except those that relate to: (1) the WEF; (2) Medicare Part B offsets and any associated reconciliation audits; (3) reserved bed day reimbursement; (4) Medicaid rebasing issues, including hold harmless claims and the \$210 million “scaleback” adjustment; and (5) legally compelling DOH to process a rate appeal within a certain timeframe;
- Computational (i.e., strictly mathematical) errors made by DOH; and
- Medicaid rate litigation and the settlement thereof associated with the Medicaid base price reduction adjustment.

Next Steps

Presuming that a sufficient percentage of facilities respond favorably to the settlement terms, such that the State is prepared to consider the US truly “universal” and proceed, there are still a number of things that need to happen before the US is in place and payments begin to flow:

- Each facility participating in the US will have to sign and return to the State a settlement agreement and release, accepting the terms of the US and releasing the State from liability. The terms of the settlement agreement and release have not yet been drafted, and will need to be approved by the State and the facility attorneys participating in the US before they are distributed to facilities for signature. It is anticipated that facilities that have changed ownership will have to provide settlement agreements and releases from both the former and the current owners.
- As described more fully in the Term Sheet, in order for a facility to retain its rights to continue with appeals and litigation that are excluded from the US, the facility must submit to DOH, before or together with its settlement agreement, a list specifically identifying each of the excluded appeals and litigation. DOH must then agree that these items are excluded from the US.
- The US is subject to approval by CMS. The State expects to submit the US to CMS expeditiously but, as always, CMS's timing cannot be predicted. It is possible that CMS may raise questions or concerns that require the State to respond.
- Once all these steps have been completed, DOH may submit the first payments under the US to the Division of the Budget to be paid by the State in the ordinary course. For payment to be made by March 31, 2015, the last day of the 2014-2015 state fiscal year, the cutoff date for submission to the Division of the Budget is usually sometime in mid-February. Clearly, this is an extremely tight timetable, and is contingent on very rapid facility responses.

Ultimately, each individual facility will need to estimate the value of any outstanding rate appeals, as well as any litigation it is party to, for the matters included in the settlement, and compare those amounts to the net benefit, if any, it would receive from the settlement. Consultations with boards, CPAs, attorneys, etc. may all be prudent given an individual facility's appeals and litigation status.

If you have questions in the meantime, please contact your association representative as follows:

Continuing Care Leadership Coalition: Scott Amrhein (Amrhein@cclcnny.org) or Gabriel Oberfield (goberfield@cclcnny.org) or 212-506-5409

Greater New York Health Care Facilities Association: Michael Balboni (mineolapol@gmail.com) or Mary Gracey-White (mgwhite@gnyhcfa.org) or 212 643-2828

Healthcare Association of New York State: Christina Gahan (cgahan@hanys.org), 518-431-7771

LeadingAge New York: Darius Kirstein (dkirstein@leadingageny.org) or Dan Heim (dheim@leadingageny.org) or 518-867-8383

New York State Health Facilities Association: Carl Pucci (cpucci@nyshfa.org) or Stephen Hanse (shanse@nyshfa.org) or 518-462-4800

Southern New York Association: Matthew Schneck (mschneck@snya.org), or Helen Lantry (hlantry@snya.org) or 212-425-5050