

## SETTLEMENT AGREEMENT

In this Settlement Agreement (“Agreement”), dated as of December \_\_\_\_, 2019, it is hereby agreed by and between the Connecticut Hospital Association (“CHA”), the CHA’s member hospitals identified on Exhibit 1 (the “Hospitals” or a “Hospital”), and the State of Connecticut (the “State”), including, but not limited to, the Connecticut Office of Policy and Management (“OPM”), the Connecticut Department of Social Services (“DSS”) and the Connecticut Department of Revenue Services (“DRS”) (all collectively referred to as the “Parties” and individually as a “Party”) as follows:

**WHEREAS**, certain hospitals subject to the tax set forth in Chapter 211a of the Connecticut General Statutes (the “First Hospital User Fee”) and CHA (referred to collectively as the “Plaintiffs”) filed petitions for declaratory ruling with DSS and DRS on or about November 30, 2015, challenging the constitutionality and legality of the First Hospital User Fee;

**WHEREAS**, on September 22, 2016, DSS and DRS issued a joint declaratory ruling in response to the Plaintiffs’ petition upholding the constitutionality and legality of the First Hospital User Fee;

**WHEREAS**, on November 1, 2016, the Plaintiffs appealed the joint declaratory ruling (the “Hospital Appeal”) to the Tax and Administrative Appeals Session of the Superior Court of the Judicial District of New Britain (the “Court”), which is entitled The Connecticut Hospital Association, et al. v. Connecticut Department of Social Services, et al., No. HHB-CV16-6035321-S;

**WHEREAS**, certain Hospitals subject to the First Hospital User Fee filed claims for refund of the First Hospital User Fee paid for calendar quarters occurring during the period July 1, 2012 through September 30, 2015 (“First Set of Claims for Refund”) with the Commissioner

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of Revenue Services (“Commissioner of DRS”) challenging the constitutionality and legality of the First Hospital User Fee as well as the scope of services subject to the User Fee;

**WHEREAS**, the Commissioner of DRS disallowed the Hospitals’ First Set of Claims for Refund by the issuance of Notices of Proposed Disallowance;

**WHEREAS**, the Hospitals protested the Commissioner of DRS’ disallowance of their First Set of Claims for Refund (“First Protests”) to the Appellate Division of DRS;

**WHEREAS**, while the Hospitals’ First Protests were pending before the DRS’ Appellate Division, certain Hospitals withdrew their Protests intending to resolve various disputes with the State;

**WHEREAS**, the balance of the Hospitals’ First Protests remain pending before the DRS’ Appellate Division;

**WHEREAS**, certain Hospitals subject to the First Hospital User Fee filed claims for refund of the First Hospital User Fee paid for calendar quarters occurring during the period October 1, 2015 through June 30, 2017 with the Commissioner of DRS (“Second Set of Claims for Refund”) challenging the constitutionality and legality of the First Hospital User Fee as well as the scope of services subject to the User Fee;

**WHEREAS**, the Commissioner of DRS disallowed the Hospitals’ Second Set of Claims for Refund by the issuance of Notices of Proposed Disallowance;

**WHEREAS**, the Hospitals protested the Commissioner of DRS’ disallowance of their Second Set of Claims for Refund to the DRS’ Appellate Division (“Second Protests”);

**WHEREAS**, the Hospitals’ Second Protests remain pending before the DRS’ Appellate Division;

**WHEREAS**, Exhibit 2 of the Agreement contains an exhaustive listing of the Hospitals' First and Second Protests pending before the DRS' Appellate Division (referred to collectively as the "Outstanding Claims for Refund");

**WHEREAS**, certain Hospitals filed rehearing requests pursuant to Conn. Gen. Stat. § 17b-238 with DSS, in which the Hospitals challenged the adequacy, validity and legality of various Medicaid rates and other Medicaid payments, failures to pay, and other decisions by the Commissioner of Social Services ("Commissioner of DSS") for various years (referred to collectively as the "Hospital Rate Appeals");

**WHEREAS**, the Hospital Rate Appeals for inpatient hospital services for (i) October 1, 2013 through December 31, 2014 and (ii) January 1, 2015 through December 31, 2016; outpatient hospital services for SFYs 2013, 2014, and 2015; and DSS's 2016 decision not to refund the direct coding improvement withhold from inpatient hospital rates covering the period January 1, 2015 through December 31, 2015, were consolidated for rate rehearing and contested case hearings were held by a DSS Hearing Officer and remain pending before the DSS Hearing Officer, as further proceedings were stayed pending settlement discussions (referred to collectively as the "First Set of Hospital Rate Appeals");

**WHEREAS**, there are additional Hospital Rate Appeals other than the First Set of Hospital Rate Appeals related to Medicaid rates, other Medicaid payments, purported rate rehearing requests regarding the First Hospital User Fee, and certain decisions by the DSS Commissioner, for which administrative hearings have not yet commenced (referred to collectively as the "Remaining Set of Hospital Rate Appeals");

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**WHEREAS**, intending to resolve various disputes with the State, certain Hospitals withdrew Hospital Rate Appeals related to Medicaid rates and other Medicaid payments effective for certain time periods;

**WHEREAS**, in order to avoid further administrative expenses and the uncertainty and expense of litigation, and to provide certainty to the Hospitals and the State regarding the First Hospital User Fee, the Second Hospital User Fee, and Medicaid payments during the Term of the Agreement, the Parties desire and agree to resolve the Hospitals Appeal, the Hospital Rate Appeals (both the First Set of Hospital Rate Appeals and the Remaining Set of Hospital Rate Appeals), and the Outstanding Claims for Refund as part of a comprehensive settlement of the disputed issues;

**WHEREAS**, the terms of the Agreement are premised upon payment and user fee structures that are permissible in accordance with current Federal Requirements as of the First Effective Date, the State's ability to leverage federal funding in accordance with the current Federal Requirements as of the First Effective Date, the receipt by the Hospitals of the rate increases and supplemental payments, and the limitation on taxation described in the Agreement;

**WHEREAS**, the Parties desire to settle these actions on terms and conditions fair and just to all Parties, and all Parties acknowledge that the Agreement provides significant financial benefit to both the State and the Hospitals;

**WHEREAS**, the Parties enter into the Agreement acknowledging, as set forth herein in paragraph 59, that if Federal Requirements or other circumstances specified herein related to health care provider taxes or the Medicaid program negatively affect the State's ability to meet its obligations under the Agreement, including payment to the Hospitals of the rate increases and

supplemental payments as set forth in Sections VII and VIII of the Agreement, then the Parties will meet and confer in accordance with Section XII of the Agreement.

**NOW, THEREFORE, IT IS HEREBY AGREED** by and between the Parties, as follows:

**I. General Recitals**

1. The Parties believe that resolving these matters through this negotiated Agreement is in the best interests of all Parties in order to: (i) settle and compromise disputed claims brought by CHA and the Hospitals that carry significant financial exposure and expense for the State and entail continued expense for CHA and the Hospitals; (ii) assist in providing financial stability to the State's current revenue structure during the Term of the Agreement by establishing Second Hospital User Fee revenues for the State over the Term of the Agreement; (iii) provide predictability and fiscal stability for the Hospitals with respect to the Second Hospital User Fee obligations as well as Medicaid supplemental payments and rate increases over the Term of the Agreement; (iv) continue significant financial benefit to the State by allowing it to access federal funds to fund the state's Medicaid program and provide significant benefit to the Hospitals by enabling the use of federal funds for the State to pay, and the Hospitals to receive, the Medicaid supplemental payments and rate increases described in the Agreement; and (v) enable a collaborative working relationship between the Hospitals and the State to work together to improve overall health outcomes and patient experience, reduce unnecessary costs, and ensure access to health care services for Connecticut residents.

2. The Parties enter into the Agreement solely in consideration of the mutual promises contained herein. The State agrees and acknowledges that the terms of the Agreement vest in CHA and the Hospitals enforceable contract rights, that CHA and the Hospitals would not

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have entered into the Agreement and compromised their claims against DRS and DSS absent the promise of and vesting of those contractual rights (including the provisions herein for the enforcement of those rights and the waiver of sovereign immunity as a defense to enforcement), that those rights are intended to provide predictability and financial stability for both the State and the Hospitals, and that the obligations and duties of the State as set forth in the Agreement for the entire Term of the Agreement have been agreed to by the State notwithstanding any fiscal impact on the State or any constituent part of the State, either at present or in any future period, even if that fiscal impact is not presently known or foreseeable, subject to the provisions of the Agreement that allow modification of the State's obligations set forth herein.

3. The Parties acknowledge that the Attorney General has determined that the Agreement requires legislative approval pursuant to Conn. Gen. Stat. § 3-125a.

4. Upon the Second Effective Date and the State's satisfaction of all of the Taxpayers' Refunds required by Section III of the Agreement (paragraph 10), CHA and the Hospitals release any and all claims that were raised, or could have been raised, on or before the Second Effective Date arising from the imposition, calculation, or collection of the First Hospital User Fee and the Second Hospital User Fee.

5. Upon the Second Effective Date and the State's satisfaction of all of the applicable one-time payments required by Section VI of the Agreement (paragraphs 31 through 37), CHA and the Hospitals release any and all claims that were raised, or could have been raised, on or before the Second Effective Date arising from Medicaid payments to the Hospitals and the determination of the components of Medicaid payments to the Hospitals and purported claims against DSS regarding the First Hospital User Fee, including, but not limited to, all claims

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set forth in the First Set of Hospital Rate Appeals and the Remaining Set of Hospital Rate Appeals.

6. The Agreement may not be used or raised affirmatively or defensively by any Party in a future judicial, administrative, or arbitration proceeding, if any, provided that any Party herein may use the Agreement where said future proceeding is barred by or otherwise subject to the terms of the Agreement or in connection with any subsequent proceeding brought to enforce the Agreement or to remedy an impairment of the Agreement.

7. The Parties intend the Agreement to be legally binding on the Parties, their successors and assigns and enforceable by the Court. The Parties understand and agree, as more specifically set out in paragraph 61 of the Agreement, that until such time as the Term of the Agreement has expired and the Parties have complied with all of the Agreement's terms and obligations, the Court's jurisdiction will continue for the purpose of enforcing, as necessary, the obligations of the Parties under the Agreement.

8. In entering the Agreement, DSS and DRS expressly do not admit liability, or violation of the law, as to any claims raised or which could have been raised by the Hospitals or CHA pertinent to events giving rise to the actions commenced or issues raised by the Hospitals and CHA prior to the Second Effective Date. The Agreement is limited to the issues identified herein and shall not constitute an admission of any kind by any of the Parties regarding any issue of fact or law involved in the matters identified in the Agreement.

## **II. Definitions**

9. The following definitions apply to the Agreement:

a. "Amendment Standard" means the requirement, to the extent feasible, that any changes or modifications to the terms of the Agreement that are ordered by a court impact each

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of the individual Hospitals and the State proportionately with, and in a manner that most closely aligns with, the benefits, obligations, and financial impacts on the Parties contemplated under the original terms of the Agreement, within the constraints necessary to ensure compliance with Federal Requirements and resolution of any and all Compliance Issues.

b. “CBSA” means a Core-Based Statistical Area delineated by the U.S. Office of Management and Budget that was used by CMS to calculate and assign wage index values to hospitals for purposes of Medicare based on the applicable standards in effect as of the First Effective Date.

c. “CHA” means the Connecticut Hospital Association, or any successor organization, its officers, administrators, staff, and employees.

d. “CMS” means the U.S. Centers for Medicare and Medicaid Services or any successor agency, its officers, administrators, staff, and employees.

e. “CMS Approvals” means CMS approval of all of the Tax Waiver and Medicaid State Plan Amendments necessary for the State to implement the Agreement.

f. “Commissioner of DRS” means the Commissioner of Revenue Services including the Commissioner’s successors and assigns.

g. “Commissioner of DSS” means the Commissioner of Social Services including the Commissioner’s successors and assigns.

h. “Compliance Issues” means one or more of the following: (i) the State determines based upon a good-faith analysis, which shall be shared in writing with CHA and the Hospitals, that the provision of Medicaid payments to Hospitals or the Second Hospital User Fee no longer complies with Federal Requirements, including, but not limited to, when compliance requires a change in the base year or tax rate of the Second Hospital User Fee or to the supplemental pools



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and distribution criteria, (ii) CMS, a court, or other authorized federal agency has determined in writing that one or more provisions of the legislation adopted by the State in Exhibit 4 or one or more of the required actions to be taken by the State set forth in the Agreement do not comply with Federal Requirements, (iii) CMS, a court, or other authorized federal agency has nullified or rescinded in writing one or more of the CMS Approvals, or (iv) the State is required to make payments above the UPL using state-only funds as set forth in paragraph 54 of the Agreement.

i. “Downside Risk” means any payment arrangement that includes one or more of the following situations in which a Hospital (i) may be required to pay a penalty for, or return a portion of, Medicaid expenditures above aggregate cost or utilization targets, (ii) is subject to a reduction in fee-for-service claims paid, or (iii) is subject to a downward update to its fee-for-service or supplemental payments.

j. “DRS” means the State of Connecticut Department of Revenue Services, or any successor agency, its officers, administrators, staff, and employees.

k. “DSS” means the State of Connecticut Department of Social Services, or any successor agency, its officers, administrators, staff, and employees.

l. “Federal Requirements” means, as applicable, any combination of federal statutes, regulations, administrative orders, court orders, or any written guidance, policy, or other document from a federal agency that is binding on the State;

m. “FFP” or “Federal Financial Participation” means the federal Medicaid matching funds provided to state Medicaid programs in accordance with 42 U.S.C. § 1396b.

n. “FFY” or “Federal Fiscal Year” means the federal fiscal year that begins October 1<sup>st</sup> and ends September 30<sup>th</sup> of each year.

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o. “First Effective Date” means the date by which (i) the Parties have signed the Agreement; (ii) the Agreement is approved or deemed to be approved by the General Assembly; and (iii) legislation as set forth in Exhibit 4 to the Agreement, enacting the provisions of the Agreement, is passed by the General Assembly and signed into law by the Governor.

p. “First Hospital User Fee” means the tax set forth in Chapter 211a of the Connecticut General Statutes that was imposed on the net patient revenue of hospitals during the period July 1, 2011 through June 30, 2017.

q. “Hospital” means each licensed short-term general hospital listed on Exhibit 1 to the Agreement, including any successors or assigns to the Hospital that are also licensed short-term general hospitals, but excluding any entity other than the Hospital.

r. “Medicaid State Plan Amendment” means an amendment to the State’s Medicaid State Plan submitted by the State and approved by CMS pursuant to 42 C.F.R. Part 430, Subpart B.

s. “OPM” means the State of Connecticut Office of Policy and Management, or any successor agency, its officers, administrators, staff, and employees.

t. “Outstanding Claims for Refund” means Hospitals’ protests of the Commissioner of DRS’ denial of their claims for refund of First Hospital User Fee currently pending before the DRS’ Appellate Division, a listing of which is set forth in Exhibit 2 of the Agreement.

u. “Second Effective Date” means the date upon which both of the following have occurred: (i) the State has received the CMS Approvals and (ii) the Court has entered the Agreement as an order of the Court as set forth in paragraph 61.

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v. “Second Hospital User Fee” means the tax set forth in Chapter 211c of the Connecticut General Statutes that is imposed on the net revenue from provision of inpatient and outpatient hospital services beginning July 1, 2017.

w. “SFY” or “State Fiscal Year” means the state fiscal year that begins July 1<sup>st</sup> and ends June 30<sup>th</sup> of each year.

x. “State” means the State of Connecticut, including its officers, offices, departments, and agencies, including, but not limited to, OPM, DRS, and DSS.

y. “State Financial Impact” means an increase in the State’s costs of its payment obligations or loss of Second Hospital User Fee revenue under the Agreement, which is caused by one or more Compliance Issues.

z. “Taxpayers” means Hospitals with Outstanding Claims for Refund pending before the DRS, a listing of which is set forth in Exhibit 2 of the Agreement.

aa. “Tax Waiver” means a waiver requested by DSS from CMS pursuant to 42 C.F.R. § 433.72.

ab. “Term of the Agreement” means the duration of the Agreement, which spans from the First Effective Date of the Agreement through June 30, 2026.

ac. “Termination Notice” means a written notice sent by the State to CHA and the Hospitals that sets forth that the State is exercising its option to terminate the Agreement under paragraph 53 or 60 and the effective date of such termination.

ad. “Upper Payment Limit” or “UPL” means the limit on aggregate Medicaid payment to specified groups of facilities for which FFP is available, in accordance with 42 C.F.R. §§ 447.72 and 447.321, as applicable.

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ae. “Upside Only” means any payment arrangement that (i) pays an amount in addition to the fee-for-service payment provided for in Sections VII and VIII of the Agreement; (ii) is not Downside Risk, (iii) includes one or more types of financial incentives to encourage improved performance on one or more of patient experience, quality, and cost, and (iv) does not require a hospital to return to the State any excess Medicaid expenditures above specified total cost of care targets.

### **III. Settlement of Outstanding Claims for Refund of First Hospital User Fee**

10. Allocation of Settlement Amount. The Commissioner of DRS agrees to refund, and the Taxpayers agree to accept, the aggregate sum of Seventy Million Dollars (\$70,000,000) in full satisfaction of the Taxpayers’ Outstanding Claims for Refund (“Settlement Refund Amount”). The parties further agree that the Settlement Refund Amount shall be allocated among the Taxpayers and paid by the Commissioner of DRS in the manner set forth in subparagraphs a. through c. below.

a. The Settlement Refund Amount shall be allocated among the Taxpayers as follows:

(i) As set forth in Exhibit 2, each Taxpayer shall be refunded the amount they claimed as an “Overbreadth Amount” in their Outstanding Claims for Refund for the calendar quarters occurring during the period October 1, 2015 through June 30, 2017. The aggregate amount attributable to these periods is \$32,846,220; and

(ii) As set forth in Exhibit 2, each Taxpayer shall be refunded an allocable share of the balance of the Settlement Refund Amount based on the amount they have claimed as an “Overbreadth Amount” in their Outstanding Claims for Refund for the calendar

quarters occurring during the period July 1, 2012 through September 30, 2015. The aggregate amount attributable to these periods is \$37,153,780.

b. The parties agree that Exhibit 2 contains a true and accurate listing of the amount of refund each Taxpayer has agreed to accept and the DRS has agreed to pay to fully resolve and satisfy the Taxpayers' Outstanding Claims for Refund ("Taxpayers' Refunds").

c. The DRS will process the Taxpayers' Refunds diligently and will pay said Refunds to the Taxpayers on or before forty-five (45) days after the Second Effective Date.

11. Waiver of Confidentiality Afforded by Conn. Gen. Stat. § 12-15. The Taxpayers authorize the public disclosure of all return information included in the Agreement and the attachments thereto by the Commissioners of DRS and DSS.

a. For purposes of this section, the term "return information" has the same meaning as "return information" has in Conn. Gen. Stat. § 12-15(h).

b. The Taxpayers acknowledge that they are waiving the protections normally afforded by the provisions of Conn. Gen. Stat. § 12-15 with respect to all return information contained in the Agreement and the attachments thereto.

c. Each Taxpayer specifically acknowledges that the return information contained in the Agreement and the attachments thereto shall be disclosed to the other Taxpayers and parties to the Agreement as well as their respective representatives.

d. The Taxpayers specifically acknowledge that the return information contained in the Agreement and the attachments thereto shall be disclosed to the General Assembly, filed with the Court, and accessible to the general public.

e. The Taxpayers specifically acknowledge that the return information contained in the Agreement and the attachments thereto shall be disclosed to CMS.

**IV. Second Hospital User Fee for SFY 2020 through SFY 2026**

12. Subject to the enactment of the legislation attached hereto as Exhibit 4 by the General Assembly and the provisions of paragraph 17, the Parties agree that the Second Hospital User Fee will collect the following amounts each year, exclusive of any applicable penalty and interest that may be incurred by an individual Hospital:

SFY 2020 – \$890 Million
SFY 2021 – \$882 Million
SFY 2022 through SFY 2025 – \$850 Million each year
SFY 2026 – \$820 Million

13. Base Year. Subject to the enactment of the legislation attached hereto as Exhibit 4 by the General Assembly, the Parties agree that the Second Hospital User Fee shall be calculated by using each Hospital’s audited net revenue for fiscal year 2016 as the base year (“2016 base year”).

14. With respect to the 2016 base year, the Hospitals further affirm (i) each Hospital’s inpatient and outpatient net revenue identified on Exhibit 2 is a true and accurate representation of their audited net revenue for fiscal year 2016 and (ii) that it is appropriate and proper to use said information to calculate the amount of the Second Hospital User Fee due from each Hospital in accordance with the legislation attached hereto as Exhibit 4. The Parties accept the amounts set forth in Exhibit 2 and there shall be no changes to those amounts subsequent to the Parties’ signing of the Agreement subject to paragraph 59.

15. Absent any Hospital dissolutions and subject to paragraphs 18 through 22 of the Agreement, the Parties agree that the total audited net revenue for fiscal year 2016 attributable to inpatient hospital services and outpatient hospital services of all Hospitals that are required to pay the Second Hospital User Fee is as follows:

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SFY in which the Second Hospital User Fee is Imposed	Total 2016 Base Year Revenue from Inpatient Hospital Services	Total 2016 Base Year Revenue from Outpatient Hospital Service
2020	\$5,097,820,197	\$4,829,859,399
2021 through 2026	\$5,097,820,197	\$4,903,127,133

16. Effective Rate of Second Hospital User Fee. Subject to paragraphs 18 through 22 of the Agreement as well as to the enactment of the legislation attached hereto as Exhibit 4 by the General Assembly, the Parties agree that the effective tax rates of the Second Hospital User Fee will be as follows:

SFY in which the Second Hospital User Fee is Imposed	Inpatient User Fee Effective Rate	Outpatient User Fee Effective Rate
2020	6%	12.0942%
2021	6%	11.7503%
2022 through 2025	6%	11.0976%
2026	6%	10.4858%

17. Mergers, Acquisitions, and Dissolutions. Subject to the enactment of the legislation attached hereto as Exhibit 4, the Parties agree that if a Hospital or Hospitals subject to the Second Hospital User Fee merge, consolidate, are acquired, or otherwise reorganize such that one or more Hospitals that are parties to such merger, consolidation or acquisition do not continue to maintain a separate short-term general hospital license, the surviving Hospital, or any newly created merger entity, shall assume and be liable for the total Second Hospital User Fee owed by the merging, consolidating or reorganizing hospitals, including any outstanding liabilities from periods prior to such merger, consolidation or reorganization that were due and owing during the Term of the Agreement.

18. Subject to the enactment of the legislation attached hereto as Exhibit 4, if a Hospital ceases to operate as a hospital for any reason other than a merger, acquisition,

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consolidation, or reorganization, during the SFY in which the Hospital dissolves or ceases to operate, the State will not collect any amount from the Hospital that would have arisen from the Second Hospital User Fee after its dissolution or termination of operations. In the next succeeding SFY after the Hospital dissolves or ceases to operate and each subsequent SFY covered by the Agreement, the total audited net revenue for fiscal year 2016 shall be reduced by the said Hospital's net revenue and the effective rate of the Second Hospital User Fee shall be adjusted to ensure that the amount collected from all surviving Hospitals is equal to the amounts set forth in paragraph 12.

19. Should a Hospital file a request for any application required by law to dissolve or cease to operate during the Term of the Agreement, the Hospital is required to simultaneously send a copy of such request to the Commissioners of DRS and DSS. Prior to the end of the first quarter of the next succeeding SFY after a Hospital dissolves or ceases to operate, the DRS shall give the Hospitals subject to the Second Hospital User Fee notice of the dissolution or termination of operations of said Hospital and the corresponding reduction to the total audited net revenue for fiscal year 2016 as well as the change in effective rate(s) of the Second Hospital User Fee for the remaining Term of the Agreement. Nothing herein shall in any way alter any other legal obligation a Hospital has when dissolving, ceasing to operate, acquiring another Hospital(s), merging, consolidating, or otherwise reorganizing.

20. Reconciliation of Second Hospital User Fee Payments for SFY 2020. Subject to the enactment of the legislation attached hereto as Exhibit 4, the payment each Hospital made for the period ending September 30, 2019 shall be considered an estimated payment and applied against the amount of the Second Hospital User Fee due from each Hospital for SFY 2020. Each



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Hospital shall pay the remaining balance due for SFY 2020 in three equal payments, which shall be due on January 31, 2020, April 30, 2020, and July 31, 2020, respectively.

21. Exemptions from the Second Hospital User Fee. Subject to the enactment of the legislation attached hereto as Exhibit 4 by the General Assembly and approval of the Tax Waiver, the Parties agree to the following exemptions from the Second Hospital User Fee:

a. For SFY 2020, financially distressed hospitals as defined in the legislation attached hereto as Exhibit 4 shall be exempt from the Second Hospital User Fee imposed on net revenue for the provision of outpatient hospital services; and

b. For SFY 2021 through SFY 2026, sole community hospitals as defined in the legislation attached hereto as Exhibit 4 shall be exempt from the Second Hospital User Fee imposed on net revenue for the provision of outpatient hospital services.

22. As set forth in Chapter 211c, to the extent CMS determines any Hospital identified in subparagraphs a. or b. of paragraph 21 is not exempt from the Second Hospital User Fee, each said Hospital shall not be exempt from the Second Hospital User Fee imposed on net revenue for the provision of outpatient hospital services.

a. Upon receipt of such determination from CMS, the total audited net revenue for fiscal year 2016 shall be increased by the said Hospital's net revenue and the effective rate(s) of the Second Hospital User Fee shall be adjusted to ensure that the amount collected from all Hospitals is equal to the amounts set forth in paragraph 12.

b. Upon receipt of CMS's determination, the DRS shall give the Hospitals subject to the Second Hospital User Fee notice of the repeal of the exemption for said Hospital and the corresponding increase to the total audited net revenue for fiscal year 2016 as well as the change in effective rate(s) of the Second Hospital User Fee for the remaining Term of the

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Agreement. The notice shall be given prior to the end of the calendar quarter next succeeding the date of CMS's determination. If said determination is made mid-SFY, the adjusted audited net revenue for fiscal year 2016 as well as the change in effective rate of the Second Hospital User Fee shall be prorated to take into account the amount of Second Hospital User Fee already paid during said SFY.

c. Upon receipt of such determination, the payment terms of the Agreement shall be modified to closely align proportionately with the aggregate net financial impact of the Agreement and the benefits and obligations arising from the Agreement on each Hospital and on the State as contemplated under the terms of the Agreement, within the constraints necessary to ensure federal compliance and obtain necessary federal approvals.

23. Nothing herein shall affect a Hospital's ability to request an extension of time to pay any Second Hospital User Fee under Conn. Gen. Stat. § 12-263s.

24. If a Hospital timely files its Second Hospital User Fee return, accurately reports on said return its net revenue as attested to in Exhibit 2 of the Agreement, and pays the amount of Second Hospital User Fee it is required by law to pay, DRS will not initiate an audit, examination or a reassessment of said Hospital related to the First Hospital User Fee or the Second Hospital User Fee for each period during the Term of the Agreement the Hospital so files, reports, and pays, except for audits, examinations or reassessments based on claims asserting arithmetical, clerical or similar errors in calculating the applicable User Fee pursuant to the formula set forth in Conn. Gen. Stat. § 12-263p, as amended by the legislation set forth in Exhibit 4. Except as provided in this paragraph, nothing in the Agreement shall impact or otherwise limit the Commissioner of DRS's authority under Conn. Gen. Stat. §§ 12-263s through 12-263u or any taxpayer rights under Chapter 211c of the Connecticut General Statutes.

**V. Limitation on Taxation of Hospitals**

25. Subject to the enactment of the legislation attached hereto as Exhibit 4 by the General Assembly, during the Term of the Agreement, the State will not: (i) impose any new health care related tax or fee as defined in 42 U.S.C. § 1396b(w) on the net revenue of the Hospitals from inpatient and outpatient services or modify the Second Hospital User Fee except as provided for herein; (ii) impose any new tax on Hospitals or amend any taxes to which the Hospitals are already subject, except as provided in paragraphs 26 and 27 of the Agreement; or (iii) repeal or modify any tax exemptions available to Hospitals as of the First Effective Date of the Agreement, including those available to Hospitals under Chapters 203, 208, 219, and 221 of the Connecticut General Statutes.

26. Subject to paragraph 25, nothing in the Agreement shall preclude the State from enacting any new tax or from amending any tax, which are not health care related taxes or fees as defined in 42 U.S.C. § 1396b(w), to which the Hospitals may be subject provided that no more than fifteen per cent (15%) of the total tax imposed under the new or amended law is due from the Hospitals. Nothing in this agreement shall preclude CHA or the Hospitals from opposing in any manner any tax except as provided in paragraph 29.

27. Nothing in the Agreement shall preclude the State from enacting any legislation that would modify the provisions of the Second Hospital User Fee in a manner that does not affect the Hospitals that are Parties to the Agreement and that does not affect the State's ability to implement the Agreement, such as modifying one or more of the exemptions that apply only to hospitals other than the Hospitals that are Parties to the Agreement. If the State adopts a provider tax on hospitals that are not among the Parties to the Agreement and such adoption reduces the amount of funds available under the UPL for Hospitals that are Parties to the

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Agreement, such reduction shall be borne by the State and shall not adversely affect the amounts received by the Hospitals under the Agreement. Accordingly, any reduction in the amount of funds available under the UPL due to the State's adoption of a provider tax on hospitals that are not among the Parties to the Agreement shall have no adverse impact to the Hospitals on the calculations and discussions referenced in paragraph 54 of the Agreement.

28. With the exception of paragraph 25, nothing in the Agreement shall preclude the amendment or modification of sections 12-263i or 12-263r of the Connecticut General Statutes.

29. During the Term of the Agreement, for SFYs ending prior to July 1, 2026, the Hospitals and CHA will not offer, raise, submit, support, or otherwise endorse any legislative proposal that would repeal or modify the Second Hospital User Fee as set forth in the legislation attached hereto as Exhibit 4 in its entirety or decrease the amount of the Second Hospital User Fee to be collected under paragraph 12 of the Agreement. Notwithstanding the foregoing restriction on the Hospitals and CHA, CHA and its member hospitals shall not be prohibited from representing and advocating on behalf of any hospital or non-hospital affiliate of a CHA member hospital that is not among the Parties to the Agreement related to any proposal to impose a provider tax on such hospital or non-hospital affiliate, or for any other reason.

30. Subject to the enactment of the legislation attached hereto as Exhibit 4 by the General Assembly, to enforce the provisions of paragraph 25, the CHA and the Hospitals may move in the Court as provided in Section XIII, and the Court is authorized in the event it finds a breach of this Section V, to declare that the State has breached the Agreement, to enjoin the State and any appropriate official or agency of the State from implementing and administering the tax law enacted contrary to the Agreement, and to award monetary or other remedial relief against

the State that puts the Hospitals in the same financial position they would have been absent the breach. The Court may issue interim or temporary relief as provided in Section XIII.

**VI. One-Time Payments to Certain Hospitals**

31. DSS shall make one-time payments to certain Hospitals in accordance with paragraphs 32 through 37 below. The maximum total amount of the one-time payments described in this section is no more than \$9.3 million. The schedule of all one-time payments by hospital is detailed in Exhibit 5. The payments described in this section of the Agreement are one-time payments only. Nothing in this section shall be construed as an admission of liability by the State regarding any of the issues related to any of the one-time payments, and no adjustments will be made to any of the payment methodologies referenced in this section.

32. One-Time Payments Not Contingent on FFP. DSS shall make the one-time payments described in this section of the Agreement in the full amounts described herein regardless of whether the State receives FFP for such payments. Nothing in the Agreement shall prevent DSS from seeking FFP for any one-time payment(s) described herein for which DSS determines that such payment is anticipated to be eligible for FFP.

33. Timing. DSS shall make the one-time payments described in this section of the Agreement on or before forty-five (45) days after the Second Effective Date.

34. Emergency Department Physicians' Services. For each Hospital that (i) received Medicaid payment for emergency department physicians' services without separate Medicaid payment made for emergency department services to applicable physician group(s) prior to January 1, 2019 and (ii) appealed the lack of payment for emergency department physicians' services on the same day as an inpatient admission for dates of service from January 1, 2015 through June 30, 2016, DSS shall make one-time payments set forth in Exhibit 5 totaling

## Hospital Settlement Agreement

approximately \$3.4 million to such Hospitals as calculated for each Hospital by multiplying \$91.07 by the number of emergency department admissions for that Hospital from January 1, 2015 through June 30, 2016.

35. SFY 2019 Small Hospital Pool. DSS shall pay additional amounts for the SFY 2019 small hospital supplemental payment pool to redistribute the funds that were previously not paid due to the acquisition of Charlotte Hungerford Hospital by Hartford HealthCare, which is approximately \$3.0 million total.

36. Graduate Medical Education (GME). DSS shall pay applicable Hospitals the amounts set forth in Exhibit 5 related to the disputed phase-in of GME costs factored into the inpatient hospital diagnosis-related group (DRG) payment system, which totals approximately \$1.7 million.

37. Disproportionate Share Hospital (DSH). DSS shall pay Day Kimball Hospital \$1,106,338 as set forth in Exhibit 5 related to disputed DSH claims. Said payments shall be in full satisfaction of said claims.

### **VII. Medicaid Rate Payments to Hospitals – Annual Rate Increases**

38. Description of Increase. Effective for dates of service on and after January 1, 2020 and each January 1st thereafter during the Term of the Agreement, DSS shall increase annually the following Medicaid rates payable to Hospitals described in paragraph 40 and, as applicable, subparagraph (b) of paragraph 41: (i) the inpatient hospital all-patient refined (APR)-DRG base rate by two percent (2%), (ii) the 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 two percent (2%), (iii) the outpatient hospital ambulatory payment classification (APC) conversion factor by two and two-tenths percent

## Hospital Settlement Agreement

(2.2%), and (iv) the revenue center codes listed on the hospital outpatient flat fee schedule by two and two-tenths percent (2.2%). The rate increases set forth in this paragraph shall apply only to those rates specifically enumerated in this paragraph and shall not apply to any other rates or components thereof. Each annual increase shall be applied to the rates in effect for the calendar year that is just ending. The rate increases set forth in this paragraph are detailed on Exhibit 3.

39. Timing of Implementation. Even if the Second Effective Date occurs after January 1, 2020, DSS shall begin paying the rate increase described in paragraph 38 in a timely manner and in accordance with the dates of service described in paragraph 38.

40. Underlying Payment Methodologies.

Except as otherwise provided in paragraphs 41, 59, and 60, during the Term of the Agreement: (i) the State shall not repeal, reduce or otherwise remove the rate increases set forth in paragraph 38, and appropriations for any payments to Hospitals based on such rates shall not be subject to rescissions or holdbacks, (ii) the State shall continue to set Medicaid rates for inpatient and outpatient hospital services applicable to the Hospitals in accordance with the rate setting rules and methodologies established in the Medicaid State Plan and in effect as of the effective date of the legislation set forth in Exhibit 4 and which shall also incorporate the provisions of paragraph 41 and the provisions of the Medicaid State Plan, and (iii) the State shall not make reductions to such rates other than in accordance with those methodologies.

41. Wage Index Values and Initial Discounted DRG Base Rate and APC Conversion Factor.

a. Effective for dates of service from January 1, 2020 through June 30, 2026, the Medicaid APR-DRG and APC payment methodologies shall use the following wage index

## Hospital Settlement Agreement

values: (i) 1.2563 for Hospitals located in CBSA 14860 and (ii) 1.2538 for all Hospitals not located in CBSA 14860.

b. Prior to the application of the relevant rate increase set forth in paragraph 38, effective for dates of service from January 1, 2020 through December 31, 2020: (i) the discounted Medicaid APR-DRG base rate shall be \$6,924.58 and (ii) the discounted Medicaid APC conversion factor shall be \$75.46.

### **VIII. Medicaid Supplemental Payments to Hospitals**

42. For the Term of the Agreement, subject to paragraphs 54, 59, and 60, DSS shall make Medicaid supplemental payments to the Hospitals in accordance with paragraphs 43 through 47.

43. For SFY 2020 and SFY 2021, DSS shall make Medicaid supplemental payments to the Hospitals that total \$548.3 million each SFY. The amount per Hospital is set forth in Exhibit 6.

44. For SFY 2022 through SFY 2026, DSS shall make Medicaid supplemental payments to the Hospitals that total \$568.3 million each SFY. The amount per Hospital is set forth in Exhibit 6.

45. During the Term of the Agreement, the State shall appropriate both the state and federal share of supplemental payments in DSS' budget, and supplemental payments shall not be subject to rescissions or holdbacks.

46. Timing of Payments. During the Term of the Agreement, DSS shall make supplemental payments to the Hospitals on or before the last day of the first month of each calendar quarter, except for the following:



## Hospital Settlement Agreement

a. Not later than thirty (30) days after the First Effective Date of the Agreement, DSS shall make payment adjustments to reconcile the quarterly supplemental payment due to each Hospital pursuant to Exhibit 6 for the quarter ending September 30, 2019 with the amounts already paid to the Hospital for such quarter as interim payments, which shall ensure, that after accounting for such payment adjustments, the actual supplemental payments made to each Hospital for the quarter ending September 30, 2019 shall be the amounts due to each Hospital pursuant to Exhibit 6;

b. Any supplemental payments other than those described in subparagraph (a) of this paragraph that are scheduled to be made before the First Effective Date in accordance with this paragraph shall be made not later than thirty (30) days after the First Effective Date of the Agreement;

c. Any supplemental payments scheduled to be made after the First Effective Date but prior to the Second Effective Date shall be paid as scheduled, even if such supplemental payment due date occurs prior to the Second Effective Date.

47. If a Hospital is merged or consolidated with or acquired by another Hospital such that the Hospital does not continue to maintain a separate short-term general hospital license, then the supplemental payments that would have been paid to the Hospital that no longer maintains such license shall instead be paid to the surviving Hospital starting with the first calendar quarter that begins on or after the effective date of the merger, consolidation or acquisition. If a Hospital ceases to operate or otherwise terminates licensed short-term general hospital services, then the supplemental payments that would have been paid to such Hospital shall not be made to any other Hospital for the remainder of the SFY in which the Hospital ceased operations or otherwise terminated licensed short-term general hospital services.

Effective with the beginning of the SFY occurring after the Hospital ceases to operate or otherwise terminates licensed short-term general hospital services, the supplemental payments that would have been made to said Hospital will be redistributed to all other Hospitals in accordance with the distribution methodology for each applicable supplemental payment pool set forth in Exhibit 6.

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

48. The Parties agree to work together to implement payment and care delivery strategies that will (i) improve Medicaid and Children’s Health Insurance Program (CHIP) member outcomes and care experiences; (ii) improve the overall coordination, quality and efficiency of care, particularly with respect to behavioral health; and (iii) reduce unnecessary utilization and costs.

49. DSS shall consult with, and provide opportunity for meaningful input from, CHA and the Hospitals to identify payment reform initiatives aimed at meeting the goals set out in paragraph 48 and to establish the elements of each such payment reform initiative prior to implementation.

50. Nothing in the Agreement shall preclude any Hospital from voluntarily choosing to participate in any payment reform initiative developed by DSS. During the Term of the Agreement, DSS shall not require any Hospital to participate in any Medicaid payment system that includes Downside Risk. During SFY 2020 through SFY 2022, DSS may provide each Hospital with relevant data and technical assistance to assist each Hospital in preparing to participate in any new Medicaid payment models described in this paragraph. Not sooner than July 1, 2022, provided that the consultation described in paragraph 49 has occurred, nothing in the Agreement shall preclude DSS from implementing Upside-Only payment arrangements.

51. DSS shall ensure that all such initiatives comply with applicable state statutes and regulations and Federal Requirements, including, but not limited to, seeking appropriate public input and stakeholder input and obtaining necessary federal approvals. Nothing in the Agreement shall preclude CHA and the Hospitals from participating in any process for public and stakeholder input or engaging in advocacy regarding any proposed legislation or regulations related to the initiatives developed pursuant to this section.

**X. Other Provisions Concerning Payments to Hospitals**

52. Rate Appeal Legislation. The State will not enact any legislation to repeal or limit in any way Conn. Gen. Stat. § 17b-238(b), unless and only to the extent any modifications to such procedures are specifically required in order to comply with Federal Requirements. CHA and the Hospitals shall not seek the enactment of any legislation to modify Conn. Gen. Stat. § 17b-238(b).

53. Federal Approvals and Federal Compliance.

a. As soon as practicable after the First Effective Date, DSS shall submit revised versions of Medicaid State Plan Amendments (SPAs) 19-0017 and 19-0018, initial versions of new SPAs necessary to implement the rate increases set forth in paragraph 38, and the revised Tax Waiver necessary to implement the provisions of the Agreement for the Term of the Agreement.

b. DSS agrees to pursue approval of applicable SPAs and the Tax Waiver diligently and to provide regular updates to CHA regarding the status of CMS review and to consult with CHA on an ongoing basis regarding any potential adjustments to the methodologies specified in the Agreement as necessary to obtain and maintain federal approvals. As soon as practicable: (i) after DSS receives each of the CMS Approvals, DSS shall provide a copy of each

## Hospital Settlement Agreement

such CMS Approval to CHA, (ii) after DSS has received all of the initial CMS Approvals necessary for the State to meet its obligations under the Agreement, then DSS shall provide written notice thereof to CHA, and (iii) after such notice has been issued, the Parties shall jointly move the Court to enter the Agreement as an order of the Court pursuant to paragraph 59.

c. If one or more of the CMS Approvals are denied or the Second Effective Date does not otherwise occur prior to June 30, 2020 or such later date as agreed to in writing by the Parties, then: (i) DSS shall provide written notice thereof to all Parties as soon as possible, but not later than ten (10) days after DSS determines that any such condition has been met and (ii) not later than ten (10) days after such notice is sent, the State and CHA will meet to determine if any steps can be taken to address the issues identified in the notice. The Parties may adjust any of the terms of the Agreement by mutual agreement, which shall be executed in writing and signed by all Parties as a formal amendment of, or addendum to, the Agreement. If any changes negotiated by the Parties in accordance with this subparagraph require legislation to be enacted by the General Assembly in order to be implemented or need to be presented and approved by, or deemed approved by, the General Assembly pursuant to Conn. Gen. Stat. § 3-125a, the Parties shall diligently work together to propose necessary legislation, pursue its adoption, or present such changes for approval to the General Assembly pursuant to Conn. Gen. Stat. § 3-125a. If the Parties are unable to reach agreement on making adjustments to the terms of the Agreement within thirty (30) days after DSS sends the notice pursuant to this subparagraph but not later than July 30, 2020 unless the Parties extend such timeframe by mutual agreement, then the Agreement shall terminate.

54. Upper Payment Limit (UPL). If for any SFY during the Term of the Agreement, total Medicaid payments made to non-governmental hospitals exceeds either the

## Hospital Settlement Agreement

inpatient hospital UPL, the outpatient hospital UPL, or both, then, except as otherwise provided in this paragraph, the State shall make the payments to Hospitals as required by the Agreement above the UPL using state-only funds to the extent required in accordance with paragraph 59.

a. For any SFY during the Term of the Agreement, if the total inpatient payments to non-governmental hospitals exceed the UPL but there is still room under the outpatient UPL, then, in order to minimize or eliminate the amount of payments over UPL, prior to making any payments using state-only funds to the extent required by paragraph 59, subject to federal approval, the Parties shall meet and develop a plan to reduce the aggregate amount of funds allocated to the general inpatient pool or other inpatient supplemental payment pool(s) and increase the general outpatient pool or other outpatient supplemental payment pool(s) by the same aggregate dollar amount, which shall be the lesser of the amount over the inpatient UPL or the room under the outpatient UPL.

b. For any SFY during the Term of the Agreement, if the total outpatient payments to non-governmental hospitals exceed the UPL but there is still room under the inpatient UPL, then, in order to minimize or eliminate the amount of payments over UPL, prior to making any payments using state-only funds to the extent required by paragraph 59, subject to federal approval, the Parties shall meet and develop a plan to reduce the aggregate amount of funds allocated to the general outpatient pool or other outpatient supplemental payment pool(s) and increase the general inpatient pool or other inpatient supplemental payment pool(s) by the same aggregate dollar amount, which shall be the lesser of the amount over the outpatient UPL or the room under the inpatient UPL.

c. DSS shall provide CHA and the Hospitals with copies of all UPL filings related to the Hospitals, including, but not limited to, any initial filings, subsequent filings or amendments, and all correspondence with CMS related to such UPL filings.

d. If the Parties reach mutual agreement to adjust the allocation of supplemental payment pool(s) pursuant to subparagraph (a) or (b), then such adjustments shall be executed in writing and signed by all Parties as a formal amendment of, or addendum to, the Agreement. If the Parties are unable to reach mutual agreement pursuant to subparagraphs (a) or (b) of this paragraph, then the provisions of paragraph 59 shall govern.

**XI. Withdrawals and Future Appeals**

55. Withdrawal of Outstanding Claims for Refund. Each Taxpayer shall file a withdrawal of its Outstanding Claims for Refund within ten (10) business days following receipt of the Refund due to the Taxpayer as identified in Exhibit 2. If a Taxpayer is not entitled to a Refund under the Agreement, the DRS shall issue each said Taxpayer a notice upon issuance of all Refunds identified on Exhibit 2, and each said Taxpayer shall file a withdrawal of its Outstanding Claims for Refund within ten (10) business days following the date of said notice. Upon filing of the withdrawal, the Outstanding Claims for Refund will, subject to any termination of the Agreement by the State and reinstatement of claims in accordance with paragraph 60, be fully and finally terminated, including all the issues raised therein. Said withdrawal may be effectuated through the issuance of a letter to the Commissioner of DRS.

56. Limitation on Additional Claims for Refund. The Hospitals shall not file any claims for refund for any period covered by the Agreement with respect to the First Hospital User Fee or the Second Hospital User Fee, except that a Hospital may file a claim for refund of the Second Hospital User Fee for any period occurring during the Term of the Agreement based

on claims of arithmetical, clerical or other similar errors, in calculating the amount of the Second Hospital User Fee imposed on the Hospital making such claim.

57. Withdrawal of Hearings Requested Pursuant to Conn. Gen. Stat. § 17b-238. In regards to the Hospital Rate Appeals (both the First Set of Hospital Rate Appeals and the Remaining Set of Hospital Rate Appeals), each Hospital shall file a withdrawal of all of its rehearing requests filed pursuant to Conn. Gen. Stat. § 17b-238(b) for such First Set of Hospital Rate Appeals, the Remaining Set of Hospital Appeals, and all other rehearing requests raising claims released under paragraph 5 within ten (10) business days following written notice of receipt of all of the one-time payments due to applicable Hospitals pursuant to Section VI of the Agreement (paragraphs 31-37). DSS shall issue written notice to all of the Hospitals after it has issued all of the one-time payments due to applicable Hospitals. Upon filing of the withdrawals, the rehearing requests filed pursuant to Conn. Gen. Stat. § 17b-238(b) will, subject to any termination of the Agreement by the State and reinstatement of claims in accordance with paragraph 60, be fully and finally terminated, with prejudice, including any issues raised or that could have been raised therein. Said withdrawals may be effectuated through the issuance of a letter to the Commissioner of DSS. If, for any reason, a withdrawal is not filed for any rehearing request that is within the First Set of Hospital Rate Appeals or the Remaining Set of Hospital Rate Appeals, or otherwise raising claims released under paragraph 5, then by signing the Agreement, each of the Hospitals agree that as of ten (10) business days following receipt of the DSS notice that it has issued all of the one-time payments due to applicable Hospitals, all such rehearing requests with respect to that Hospital shall, subject to any termination of the Agreement by the State in accordance with paragraph 60, be fully and finally terminated, with

prejudice, including any issues raised or that could have been raised therein, to the same full force and effect as if a withdrawal had been filed.

58. Except solely with respect to new initiatives undertaken pursuant to Section IX of the Agreement, the Hospitals and CHA shall not file any requests for rehearing pursuant to Conn. Gen. Stat. § 17b-238(b), any state or federal action, any petition for declaratory ruling, or other petitions or similar filings with any state or federal agency related to any issues covered by the Agreement, including, but not limited to, supplemental payments to Hospitals, Medicaid rate payments to Hospitals, one-time payments to Hospitals, the First Hospital User Fee, or the Second Hospital User Fee. The Hospitals may file rehearing requests pursuant to Conn. Gen. Stat. § 17b-238(b) based only on (i) claims of arithmetical, clerical or other similar errors, or based on factual errors unrelated to the underlying payment methodology or such methodology's aggregate level of funding, in calculating Medicaid rates or Medicaid supplemental payments covered by the Agreement to an individual hospital or (ii) claims regarding matters not covered by the Agreement.

## **XII. State Financial Impact**

59. The Parties expressly recognize and acknowledge that the financial terms of the Agreement are predicated on the State's ability to access federal funds in accordance with and based upon the Federal Requirements in effect on the Second Effective Date and the receipt by the Hospitals of the rate increases and supplemental payments and the limitation on taxation described in the Agreement. Therefore, this paragraph describes actions to be taken after the Second Effective Date if there are Compliance Issues.

a. In the event that one or more Compliance Issues occurs after the Second Effective Date which, in the State's judgment, results in a State Financial Impact, the State may provide



## Hospital Settlement Agreement

written notice thereof to the Hospitals and CHA as soon as practicable, but not later than fifteen (15) days after the State makes said determination. Not later than fifteen (15) days after such notice is sent, the Parties' representatives shall meet and negotiate in good faith to develop and implement changes to the Agreement to address and, to the extent feasible, mitigate the impact of the Compliance Issues. To the extent only that the Parties are unable to agree upon revisions to the Agreement after the applicable meet-and-confer process described in this paragraph, the State shall absorb any State Financial Impact of up to \$50 million in any SFY due to Compliance Issues. Any agreement reached by the Parties shall be in writing and signed by all Parties and shall constitute an addendum to the Agreement with the same force and effect as if it were fully set forth in the Agreement, including enforceability under Section XIII of the Agreement.

b. If any changes negotiated by the Parties in accordance with subparagraph (a) of this paragraph require legislation to be enacted by the General Assembly in order to be implemented or need to be presented and approved by, or deemed approved by, the General Assembly pursuant to Conn. Gen. Stat. § 3-125a, the Parties shall diligently work together to propose necessary legislation, pursue its adoption, or present such changes for approval to the General Assembly pursuant to Conn. Gen. Stat. § 3-125a.

c. If, after meeting and negotiating in accordance with subparagraph (a) of this paragraph, the Parties are unable to reach an agreement with respect to one or more Compliance Issues that have resulted in a cumulative State Financial Impact of greater than \$50 million in any SFY, the State may file a motion with the Court for modification of any of the terms of the Agreement (hereinafter, a "Motion for Modification") pursuant to the procedures set forth herein. The Court's authority to modify the Agreement shall be limited to modifications that address a State Financial Impact of greater than \$50 million, but less than or equal to \$100 million, in any

and all applicable SFYs. If CHA has disputed in writing whether a Federal Requirement has resulted in a cumulative State Financial Impact of greater than \$50 million in any SFY, prior to filing a motion with the Court pursuant to this subparagraph, the State shall make a good-faith effort to seek written clarification from CMS. A Motion for Modification shall include a detailed description of the State's proposed adjustments to the Agreement, including how said adjustments conform to the Amendment Standard. All Parties shall have an opportunity, consistent with court procedures, to file motions, submit evidence, and, where applicable, request a hearing on contested matters. The Parties will seek to expedite resolution of such Motion for Modification without undue delay and to request, to the extent permitted by the Court, that the Motion for Modification be deemed a privileged matter. A final decision issued by the Court under this section shall be subject to appeal. The Court may, in accordance with law, issue interim or temporary relief pending a final decision, including relief designed to avoid the loss of federal funds, avoid federal penalties, secure temporary compliance with Federal Requirements, or avoid the loss of state revenue. Any order granting a Motion for Modification in whole or in part shall, to the extent feasible, modify the Agreement to achieve the Amendment Standard.

60. State's Option to Terminate Agreement.

a. If one or more Compliance Issues occurs which result in a cumulative State Financial Impact of greater than \$100 million in any SFY, after completing the meet-and-confer process in accordance with subparagraph (a) of paragraph 59, the State may terminate the Agreement in accordance with this paragraph. If the State elects to terminate the Agreement pursuant to this paragraph, the State shall issue a Termination Notice to CHA and the Hospitals. If CHA has disputed in writing whether a Federal Requirement has resulted in a cumulative State Financial Impact of greater than \$100 million in any SFY, prior to issuing a Termination Notice

## Hospital Settlement Agreement

pursuant to this subparagraph, the State shall make a good-faith effort to seek written clarification from CMS, unless the State has already made a good-faith effort to seek written clarification from CMS to the extent required pursuant to paragraph 59.

b. Immediately upon provision of such Termination Notice, the Parties' rights and obligations under the Agreement shall terminate and shall be null and void, except to the extent otherwise specifically provided by this paragraph. Notwithstanding any other provision of the Agreement, including, but not limited to, the releases set forth in paragraphs 4 and 5, if the State issues a Termination Notice, CHA and the Hospitals shall be entitled to reinstate the Hospital Appeal, the Hospital Rate Appeals (both the First Set of Hospital Rate Appeals and the Remaining Set of Hospital Rate Appeals), and the Outstanding Claims for Refund. Any claims reinstated pursuant to this paragraph shall not include interest or penalties attributable to the period from the First Effective Date through the date of the State's termination of the Agreement. The State's liability with respect to any claim reinstated under this paragraph shall be reduced by the amount of the State's performance of the Agreement as set forth in Exhibit 7. Upon termination of the Agreement, the State shall have the ability to assert any and all defenses to reinstated claims. All such proceedings shall remain subject to all applicable procedures, including rights for review and appeal.

c. Notwithstanding the foregoing, if the State elects not to exercise the option to terminate the Agreement in accordance with this paragraph, the State may, after completing the meet-and-confer process set forth in subparagraph (a) of paragraph 59, file a Motion for Modification, provided that the Court's authority to modify the Agreement if the State files the Motion for Modification shall be limited to modifications that address a cumulative State Financial Impact of greater than \$50 million, but less than or equal to \$100 million in any and all applicable SFYs.

**XIII. Enforcement**

61. Upon execution of the Agreement by all Parties, approval or deemed approval of the Agreement by the Connecticut General Assembly pursuant to Conn. Gen. Stat. §3-125a, enactment of legislation attached as Exhibit 4, and the State's receipt of the CMS Approvals as detailed in paragraph 53, the Parties shall submit the Agreement, attached to a joint motion seeking an order of approval of the Agreement, to the Court, Docket No. HHB-CV 16-6035321-S. The Parties agree that the Court shall have jurisdiction to adjudicate such motion. The Parties further agree that the Court shall retain jurisdiction to enforce the Agreement until the Term of the Agreement expires and the Parties have complied with all of the Agreement's terms and obligations or the State exercises the option to terminate the Agreement under paragraph 60, except that if the Agreement is terminated by the State pursuant to paragraph 60, the Court shall retain jurisdiction over the reinstated Declaratory Ruling Appeal, Docket No. HHB-CV16-6035321-S. Once the Term of the Agreement has expired and the Parties have carried out all terms and obligations under the Agreement, the Parties shall file a stipulation that the terms and obligations under the Agreement have been met.

62. Subject to paragraph 63 and including, but not limited to, the circumstances described in paragraph 30, nothing herein shall preclude the Parties from moving in the Court for enforcement or modification of the Agreement based upon a showing of material non-compliance with the requirements of the Agreement by any Party. Pursuant to the legislation set forth in Exhibit 4, sovereign immunity shall not be a defense in any proceeding to enforce or modify the Agreement. The Parties agree to cooperate in taking all steps necessary to expedite resolution of such motion without undue delay and to have it scheduled, to the extent permitted by the Court, as a privileged matter. The Parties agree that the Hospitals will be irreparably

harmful in the event of the State's failure to provide any payments owed to the Hospitals under the Agreement or in the event of a breach of paragraph 25. The Court shall be authorized, in accordance with law, to issue interim or temporary relief pending a final decision. The Parties agree that any final order issued by the Court under this section shall be subject to appeal.

63. Prior to moving for enforcement or modification of the Agreement, any Party shall first provide fifteen (15) days' written notice to all Parties detailing the factual basis for the claimed non-compliance. The Parties shall then meet to discuss and to attempt to resolve in good faith any claimed non-compliance no later than fifteen (15) days after the provision of the written notice required by this paragraph before filing any such motion for enforcement or modification of the Agreement. In the event that the motion for enforcement or modification is filed by CHA or any or all of the Hospitals because DSS has failed to pay scheduled Medicaid payments to any or all of the Hospitals when the scheduled supplemental payments are due to be paid, or in the event that CHA and the Hospitals claimed that the State breached paragraph 25, the moving Party or Parties may proceed immediately to file a motion with the Court pursuant to paragraph 62.

**XIV. Miscellaneous**

64. Collections. Nothing in the Agreement shall impact or otherwise limit the DRS' ability to collect from a delinquent Hospital the amounts due and owing for any period covered by the Term of the Agreement by any means the DRS is currently authorized or may become authorized by law to pursue, including, but not limited to, its collections authority under Chapters 202, 211c, and 906 of the Connecticut General Statutes.

## Hospital Settlement Agreement

65. Technical Changes. Nothing in the Agreement shall preclude the State and CHA from mutually agreeing to pursue technical changes to any provisions of the Connecticut General Statutes necessary to implement the Agreement.

66. Payment Audits. Nothing in the Agreement shall impact or otherwise limit DSS' ability to audit and recover from a Hospital, pursuant to all applicable authority, including, but not limited to, Conn. Gen. Stat. § 17b-99, any payments or portions thereof (which would include overpayments), including payments for dates of service that predate or may overlap with any portion of the Term of the Agreement, except for the one-time payments pursuant to Section VI of the Agreement. Nothing in the Agreement shall impact or otherwise limit the ability of a Hospital to exercise all rights afforded to it under Conn. Gen. Stat. § 17b-99, or any other applicable authority, in the event of such an audit, including the right to appeal any audit findings and recoupments.

67. Meetings of the Parties. The Parties may designate authorized representatives for participation in any meetings pursuant to the Agreement. The Agreement shall not be construed to require the participation of the General Assembly or representatives of said body.

68. Modification. The Parties agree that the Agreement shall not be modified except by mutual agreement of the Parties or as ordered by a court with jurisdiction over the Agreement. Any mutually agreed amendment or modification by the Parties shall not be binding unless executed in writing and signed by all Parties as a formal amendment of, or addendum to, the Agreement.

69. Exhibits/Entire Understanding. The exhibits attached to the Agreement are incorporated into and made part of the Agreement as if fully set forth herein. The Agreement

## Hospital Settlement Agreement

embodies the entire agreement between the Parties with respect to the subject matter of the Agreement.

70. Authority. Each of the Parties to the Agreement hereby represents and warrants that it has the legal authority to enter into the Agreement and that the person executing the Agreement on behalf of the Party is authorized to do so.

71. Counterparts. The Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and all of which, when taken together, shall constitute one and the same instrument. The Parties hereby consent to the use of electronic signatures in connection with the execution of the Agreement, and further agree that electronic signatures to the Agreement shall be legally binding with the same force and effect as manually executed signatures.

Hospital Settlement Agreement

ACCEPTED AND AGREED BY:  
State of Connecticut

BY: \_\_\_\_\_  
Ned Lamont  
Governor

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Department of Social Services

BY: \_\_\_\_\_  
Deidre S. Gifford  
Commissioner of Social Services

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Office of Policy and Management

BY: \_\_\_\_\_  
Melissa McCaw  
Secretary, Office of Policy and  
Management

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Department of Revenue Services

BY: \_\_\_\_\_  
Scott D. Jackson  
Commissioner of Revenue Services

DATE: \_\_\_\_\_



Hospital Settlement Agreement

ACCEPTED AND AGREED BY:  
Connecticut Hospital Association

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Lawrence + Memorial Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Manchester Memorial Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
MidState Medical Center

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Milford Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Norwalk Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Rockville General Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Saint Francis Hospital & Medical  
Center

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

Hospital Settlement Agreement

ACCEPTED AND AGREED BY:  
Saint Mary's Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
St. Vincent's Medical Center

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Stamford Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Waterbury Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Windham Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
The William W. Backus Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Bridgeport Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Bristol Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

Hospital Settlement Agreement

ACCEPTED AND AGREED BY:  
The Hospital of Central Connecticut

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Danbury Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Day Kimball Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Greenwich Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Griffin Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Hartford Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
The Charlotte Hungerford Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Yale-New Haven Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

Hospital Settlement Agreement

ACCEPTED AND AGREED BY:  
Sharon Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Johnson Memorial Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
The Hospital of Saint Raphael

By: Yale-New Haven Hospital

\_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
New Milford Hospital

By: Danbury Hospital

\_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_

ACCEPTED AND AGREED BY:  
Middlesex Hospital

BY: \_\_\_\_\_  
Name:  
Title:

DATE: \_\_\_\_\_