STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM**
**Nursing Home Transmittal No. 227**
**May 13, 2010**

To: Nursing Home Administrators

From: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure appropriate staff members in your organization are informed of the content of this transmittal

Re: **Adjustments to September 1, 2002 to May 12, 2010 Contribution of Care Claims**

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Due to the resolution in a case entitled *Smith v. Colmers*, DHMH will be adjusting up to $16 million in previous long term care claims that did not properly take into consideration the recipients' contribution to care. Providers may be entitled to an adjustment of the reimbursement you received for services you provided to Medicaid long term care recipients between September 1, 2002 and May 12, 2010.

## I. The Cost Settlement Process

### A. Background

In July 2008, nursing home providers received a subpoena from the *Smith* plaintiffs asking for information about the services they provided to Medicaid LTC recipients since September 1, 2002. Providers that responded to the subpoena provided claims data showing the amount of pre-eligibility medical expenses (PEME) that recipients incurred and that remained unpaid after the recipients became eligible for Medical Assistance. DHMH has agreed to recalculate the recipients' contributions of care to take these unpaid PEME into consideration. Providers will be allowed to submit adjustments to prior claims based upon the data provided in response to the subpoena. Claim adjustments will not be permitted if the PEME amount:

- is associated with a recipient who (1) was correctly categorized as eligible for Supplemental Security Income (SSI) and (2) had no post-eligibility income other than SSI;

- exceeds the lesser of (1) the total cost of care contribution obligation determined by DHMH, the Secretary, or their designees for that recipient; or (2) that amount a class member actually paid as his or her cost of care contribution; and

- is based upon an incorrect eligibility or admissions date of the class member into the nursing home, provided that the provider will be permitted to correct any clerical error (e.g., correcting a "1905" admit date to "2005 ").

Plaintiffs' counsel and DHMH have reviewed all of the data providers submitted in response to the subpoena to identify which data meet the above criteria.

**B. Submitting Claim Adjustments**

Providers must submit by June 25, 2010 a claim adjustment for post-eligibility long term care provided between September 1, 2002 and May 12, 2010. Providers must submit the claim adjustments by email to smithcolmers@dhmh.state.md.us.

No claim adjustments will be accepted that are greater than the amount reported by the providers in response to the subpoena. A provider that did not respond to the subpoena cannot submit a claim adjustment. Copies of the claim adjustment form are available at www.MarylandPEMESettlement.com. If you would like, Zuckerman Spaeder, the *Smith* plaintiffs' counsel, can help prepare or review a claim.

All claim adjustments must:

1. Use the reason adjustment code of "SC" for each recipient claim identified; and

2. Be accompanied by a signed declaration that is specifically related to these claims. Providers are encouraged to carefully review and understand the declaration before submitting a claim adjustment. Enclosed is the form of provider declaration. **(Attachment 1)** Copies of the declaration are also available at www.MarylandPEMESettlement.com. The signed declarations should be scanned and be attached to the email submitting the claim adjustment.

If the claim adjustment form and scanned provider declaration are too voluminous to be emailed, they should be sent to:

*Smith v. Colmers* Prior Claim Adjustment Submission
c/o Marlene Bush
Department of Health and Mental Hygiene
Medical Assistance Claim Adjustments
Room: SS-18
201 W. Preston Street
Baltimore, MD 21201

### C. DHMH Review and Payment of Claim Adjustments

DHMH will review all of the submitted claim adjustments. DHMH will then submit to CMS up to $16 million in claim adjustments over the course of three fiscal years that it determines will have the greatest likelihood of receiving federal matching funds. DHMH has the exclusive right to decide (1) which claim adjustments to submit to CMS to receive federal matching funds and (2) which additional claim adjustments to submit to CMS to receive federal matching funds should any of the claims DHMH submitted to CMS in the previous fiscal year be disapproved by DHMH or disallowed by CMS. Therefore, although all long term care providers may submit claim adjustments to DHMH, **DHMH will only choose a portion of these claims in fiscal years 2011 – 2013 to submit to CMS and will only reimburse those providers whose claims DHMH submitted and were approved by CMS**.

The reimbursement will be in the form of a paper check mailed to the provider's address on record in MMIS with a special reason adjustment code (SC) identified on the check.

### D. Zuckerman Spaeder Escrow Account

The plaintiffs' counsel established an escrow account for all of the claim adjustment reimbursement. Providers who receive reimbursement for claim adjustments must ***immediately*** remit and deposit ***all*** of the reimbursement to the escrow account.

Providers who deposit the paper checks into their bank accounts must immediately electronically transfer the funds to:

Name: Escrow Account for the Benefit of Certain MA Program Long-Term Care Recipients
Bank: BB&T
Account #: 0005162783469
ABA Routing #: 054001547
Escrow Agent: Zuckerman Spaeder LLP

Providers who do not deposit the paper checks must endorse the checks to "Escrow Account for the Benefit of Certain MA Program Long-Term Care Recipients" and mail the endorsed checks to:

Escrow Account for the Benefit of Certain MA Program Long-Term Care Recipients
c/o Zuckerman Spaeder LLP
100 East Pratt Street
Suite 2440
Baltimore, MD 21202-1031
Attention: William Meyer

### E. Disbursements from the Escrow Account

The escrow agent will disburse funds from the escrow account within 30 days of the escrow account receiving at least 75% of all nursing facility reimbursements paid by DHMH in a fiscal year under this cost settlement. The escrow agent will disburse funds in the following order:

1. To pay for attorneys' fees and costs;
2. To reimburse those class members that directly paid for their care and submitted claims; and
3. To all of the providers who participate in the cost settlement and submitted claims to DHMH.

The amount that each provider will receive is the proportional amount of what that provider submitted in claim adjustments to the total amount of claim adjustments submitted by all providers that meet the criteria outlined in I.A above. For example, in Fiscal Year 2012 when DHMH will submit $4 million in claims to CMS, if there are $1 million in attorneys' fees and costs and class member claims, and if Provider A submitted 10% of all the claim adjustments that meet the criteria and were submitted by DHMH, then the escrow agent will disburse $300,000 to Provider A in Fiscal Year 2012 ($3,000,000 x 0.10).

If you have questions about forwarding claim adjustments to or receiving disbursements from the escrow account, please contact William Meyer, Zuckerman Spaeder, LLP (410) 332-1240.

### F. Use of Reimbursement Disbursed from Escrow Account

Providers must apply the amount of reimbursement they receive from the escrow account to the account of each class member associated with the claim adjustments they submitted to DHMH as follows:

1. First, to any class member post-eligibility debt owed to the provider, and
2. Second, any remaining balance to any class member pre-eligibility debt owed to the provider.

Questions about claims submissions should be submitted to Charlotte Krueger, Deputy Director of Operations, (410) 767-3382.

## II. Auditing of Claim Adjustments

### A. General Right to Audit and Auditing Guidelines

DHMH and its designee and CMS retain the right to audit the claim adjustments that DHMH submits to CMS. If DHMH did not submit a claim adjustment to CMS, then that claim adjustment will not be audited.

For these specific claim adjustments related to recalculating the recipients' contribution to care, DHMH will only use the audit protocols enclosed **(Attachment 2)** and also available at www.MarylandPEMESettlement.com. Although CMS has agreed to the audit protocols, DHMH and plaintiffs' counsel have agreed that DHMH will use all of the audit protocols except item 10(b)(ii), which would exclude claims for eligibility dates prior to April 1, 2009 for expenses incurred more than 90 days prior to MA eligibility ("90-Day Claims").

### B. What Happens to Claims Denied or Disallowed by an Audit

If DHMH identifies a claim adjustment that was reimbursed that should not have been, DHMH will notify the provider who submitted the claim and reconcile the claim with other reimbursement available to all long-term care providers in that fiscal year. **Because providers proportionally share the reimbursement for the claim adjustments, they also proportionally share the amount to repay DHMH for the claims that should not have been paid.** For example, Provider A submitted a $1 million claim adjustment, DHMH reimbursed Provider A $1 million, Provider A forwarded the $1 million to the escrow account, and the escrow agent disbursed $500,000 to Provider A, and $250,000 to each of Providers B and C. DHMH audits the $1 million claim adjustment and determines it should not have been paid. DHMH will reconcile $500,000 from Provider A's future reimbursement, and $250,000 from each of Providers B and C's future reimbursement.

Providers may contest any reconciliation under COMAR 10.01.09.

DHMH has agreed to reimburse up to $16 million in claim adjustments to recalculate contributions to care for September 1, 2002 through May 12, 2010. If DHMH or CMS denies or disallows a claim adjustment, DHMH will submit additional claim adjustments so that the total reimbursement paid under the resolution is approximately $16 million. If DHMH determines there are an insufficient number of additional claims to submit to CMS that have a great likelihood of receiving federal matching funds, DHMH will submit 90-Day Claims to CMS, even though the 90-Day Claims may not generate federal matching funds.

DHMH will use its best efforts to contest all claims that CMS disallows to the extent it is practicable and DHMH believes has a reasonable basis for success.

Questions about the auditing procedures should be directed to Jim Miller, Deputy Director, Management/Program Analysis, (410) 767-5427.

## III. Regulation Changes

DHMH will shortly promulgate regulations clarifying how it will treat PEME. The regulations will clarify that PEME:

1. Are unpaid medical or remedial expense incurred prior to eligibility during a "period under consideration" (as that term is defined in COMAR 10.09.24.04J) of an application that has lapsed, whatever the reason;

2. Are only used to determine a Medical Assistance or community-based waiver recipient's contributions towards the cost of care post-eligibility;
3. Are limited to the three months prior to the month of application; and
4. Cannot have not been paid for by any third party, including a family member or an insurer, and cannot be not required to be paid for by any third party, such as an insurer.

Attachments
SJT/mlb

cc: Charles Lehman
Charlotte Krueger
Jim Miller
William Meyer, Zuckerman Spaeder LLP
Maryland Chapter of the National Academy of Elder Law Attorneys
Long Term Care Assistance Project for the Legal Aid Bureau, Inc.
Office of Administrative Hearings
Board of Review
All local departments of social services and local health departments
Nursing Home Liaison Committee

# PROVIDER DECLARATION AND CERTIFICATION

In connection with (a) a Cost Settlement Protocol (the "Protocol") executed by DHMH of Health & Mental Hygiene (the "Department") and a certified class of long-term Medicaid recipients (the "Class") to resolve a class action commenced on or about August 9, 2005 in the Circuit Court for Baltimore City (the "Court") by the Class against the Secretary and DHMH and captioned "Eunice Smith et al. v. John Colmers et al." (Case No. 24-C-05-007421 OG) (the "Class Action"); and (b) a Remand Order entered in the Class Action on _____ __, 2010 (the "Remand Date"), the long-term care provider identified on the signature page hereto (the "Provider") declares and certifies as follows:

1. Capitalized terms not defined herein shall have the same meanings ascribed to them in the Protocol.

2. The gross prior claim adjustment (the "Claim") the Provider submits hereby to DHMH is being submitted pursuant to the terms of the Protocol and the Remand Order.

3. The amount of the Claim is a true and accurate amount of incurred, pre-eligibility expenses for medical or remedial care (including necessary medical or remedial care recognized under Maryland State law) (hereafter "PEME") provided by the Provider to Maryland Medical Assistance program recipients that were not paid for by any third party.

4. The Provider has the Accounts Receivable Journal, Patient Register, or equivalent data (the "Register") for each resident listed on the Claim, and

a. the Register reflects the period from the initial date of admission through the date of death or final discharge from facility (as applicable), and the total charges and payments for same time period for each listed resident;

b. the charges for PEME as reflected in the Register were calculated using standard billing rates; and

c. the Provider will retain and preserve the Register for six (6) years;

5. In order to implement the cost settlement process set forth in paragraph 13 of the Protocol, the Provider agrees:

a. to immediately remit and deposit all reimbursement received from DHMH of all or any portion of the Claim to the PEME Escrow Account, as established pursuant to the Protocol;

b. to accept the amount of the Provider PEME Reimbursement disbursed by the Escrow Agent as described in paragraph 13.3.5 of the Protocol as full payment of the Claim

and to release and forever discharge any claim against DHMH for further reimbursement of any PEME associated with a Class Member, now existing or having ever existed from the beginning of time to the Remand Date;

c. that the Escrow Agent shall make disbursements from the PEME Escrow Account to the Class Attorneys of Attorney's Fees in accordance with paragraph 12.1 of the Protocol; and

d. that the Escrow Agent shall make disbursements from the PEME Escrow Account for payment of Class Member Refund Claims, as set forth in paragraph 12.2 of the Protocol.

6. Timely after receipt of the Provider PEME Reimbursement, the Provider shall, at the Provider's sole election, either (i) pay each Class Member associated with the Provider PEME Claim, or (ii) apply to the account of each Class Member associated with the Provider PEME Claim, the amount of the Provider PEME Reimbursement for amounts of uncompensated care not otherwise paid by DHMH to the Provider for that amount of service, provided that no payments to or application of this money shall be made to any Class Member to the extent that the Class Member received a Class Member Refund Claim.

7. The Provider agrees that the Provider's sole recourse in contesting (i) any determination by DHMH about the Claim, (ii) any Disapproved PEME Claim or (iii) any withhold from future Medical Assistance claims pursuant to paragraph 13 of the Protocol is through the Nursing Home Appeal Board pursuant to COMAR 10.01.09. The Provider agrees that it may not seek any other recourse against DHMH or the Secretary for any matter related to the Protocol.

8. The Provider, for itself and its owners, directors, officers, employees, agents, successors, and assigns (collectively, the "Provider Releasors"), agree to forever discharge, acquit, and release members of the Class, and all of their respective past, present, and future heirs, assigns, representatives, executors, administrators, successors, trustees, and fiduciaries, in their individual and representative capacities, from any and all actions, causes of actions, obligations, costs, expenses, damages, losses, claims, liabilities, suits, debts, reckonings, demands, and benefits (including attorneys' fees and costs actually incurred), of whatever character, in law or in equity, known or unknown, suspected or unsuspected, matured or unmatured, for the payment of PEME, now existing or having ever existed from the beginning of time to the Remand Date.

9. The Provider Releasors, agree to forever discharge, acquit, and release the Escrow Agent from all from any and all actions, causes of actions, obligations, costs, expenses, damages, losses, claims, liabilities, suits, debts, reckonings, demands, and benefits (including attorneys' fees and costs actually incurred), of whatever character, in law or in equity, known or unknown, suspected or unsuspected, matured or unmatured, relating to administration of, or disbursements

from, the Escrow Account, with the exception of a claim seeking a disbursement required pursuant to paragraph 13.3.5 of the Protocol.

10. The Provider Releasors agree to forever discharge, acquit, and release DHMH and the Secretary from all from any and all actions, causes of actions, obligations, costs, expenses, damages, losses, claims, liabilities, suits, debts, reckonings, demands, and benefits (including attorneys' fees and costs actually incurred), of whatever character, in law or in equity, known or unknown, suspected or unsuspected, matured or unmatured, relating to (i) the timeliness of submitting Provider PEME Claims to CMS, with the exception of DHMH's obligation to annually submit Provider PEME Claims to CMS pursuant to paragraph 13.1.6 of the Protocol; (ii) any reimbursement for any Provider PEME Claim DHMH does not submit to CMS under its exclusive authority to determine which Provider PEME Claims to submit under paragraph 13.1.7 of the Protocol; (iii) any disbursements from or Provider PEME Reimbursement paid from the PEME Escrow Account; (iv) the actions, omission or performance of the Escrow Agent in making disbursements from the PEME Escrow Account; and (v) any matter related to the formation, operation or performance of the PEME Escrow Account.

11. The Provider Releasors agree that if during the term of this Protocol the Provider engages in any change of ownership transaction with a different corporate entity (the "Third Party"), either through an asset purchase, equity purchase, or bankruptcy proceeding, the Provider shall require that in any such transaction and as a condition of consummating such transaction that the Third Party shall agree and acknowledge that, upon consummation of the transaction effecting the change of ownership, (i) DHMH may submit the Provider's PEME Claim to CMS in accordance with the provisions of paragraph 13.1 of the Protocol; (ii) the Third Party assumes liability, jointly and severally with the Provider, for the Provider's Provider PEME Reimbursement and Provider PEME Disapproval; and (iii) the Provider's Provider PEME Disapproval may be withheld from the payment of claims submitted by the Third Party to DHMH.

12. The Provider Releasors agree that if during the term of this Protocol the Provider becomes bankrupt, (i) DHMH may submit the Provider's PEME Claim to CMS in accordance with the provisions of paragraph 13.1 of the Protocol; and (ii) the Provider shall not be entitled to Provider PEME Reimbursement after such date of bankruptcy and the Escrow Agent shall distribute the Provider's Provider PEME Reimbursement that accrues after such date of bankruptcy in accordance with paragraph 11.5 of the Protocol. For purposes of this paragraph, other than in connection with a change of ownership as defined in paragraph 11 above, "bankrupt" shall be deemed to occur at the earliest of the time when (i) the Provider files a petition in bankruptcy; (ii) the Provider voluntarily takes advantage of any bankruptcy or insolvency law; (iii) the Provider files any petition or application for the appointment of a receiver or trustee; (iv) a petition or answer is filed proposing the adjudication of the Provider as bankrupt or seeking the appointment of a receiver or trustee for the Provider, and the Provider either consents to the filing thereof, or such petition or answerer is not discharged or denied prior to the expiration of 60 days from the date of such filing; or (v) the Provider dissolves or commences winding up.

13. The Provider acknowledges, recognizes, and consents to the exclusive jurisdiction of the Court over all matters related to the Class Action and enforcement and administration of the Protocol, and the Provider consents to the consolidation of any cause of action, claim, suit or proceeding that the Provider may initiate in relation thereto with the Class Action. In the event that an action is brought against the Provider in order to enforce the provisions of paragraph 5(a) herein, Provider agrees that the Court may award reasonable attorney's fees and costs to the prevailing party.

I solemnly affirm under the penalties of perjury that the contents of the foregoing Provider Declaration and Certification are true to the best of my knowledge, information, and belief.

Executed this ___ day of _____, 2010

Provider Name:_____

_____
Signature

_____
Printed Name

_____
Title

Smith v. Colmers
Determination of Allowable PEME Claim Amounts

Objectives:

A. Determine length of time class members resided in nursing home prior to Medicaid eligibility.
B. Determine total charges incurred prior to Medicaid eligibility for each class member.
C. Determine an allowable claim amount for each class member and for each nursing facility, in accordance with the terms of the settlement agreement.

Procedures:

1. Review the issues and unusual items noted from prefield testing and the internal control evaluation. Pay particular attention to any control weakness concerns related to management's ability to properly account for Accounts Receivable and/or Patient Census. Summarize the issues that may impact the testing to be performed in this module. As necessary, modify testing approaches to ensure that all identified concerns will be addressed during testing performed in this program module.

2. Obtain a listing of claims included in the Smith v. Colmers lawsuit. Verify that each claim is valid for further consideration: Use worksheet template XXXXXX.xls for this testing and reject as unallowable the following claims:

   - claims for SSI recipients who only received payments that are not considered income in the posteligibility process
   - claims for nursing home expenses incurred while the recipient was eligible for Medicaid,
   - claims for which either the admission date or the eligibility date are invalid, and
   - claims for services provided in public nursing homes which are submitted more than two years after the calendar quarter in which the services were provided.

3. Compare dates of Medicaid eligibility reported by MMIS data and provider census data to the date reported on the class list. If there is a discrepancy between dates, MMIS data will prevail.

4. Obtain the DHMH 1189A or other approved census forms for the time periods in which each class member resided in the facility. Determine the time period each class member resided in the facility prior to Medicaid eligibility.

5. Obtain the Accounts Receivable journal or Patient Register for each resident listed as a class member. The register should cover the period from the initial date of admission through the date of death or final discharge from facility and indicate total charges and payments for same time period.

6. Obtain schedule of standard billing rates applicable to each year in which a class member resided in the facility.

7. Review the Patient Register to verify that the charges in the Patient Register were calculated using proper standard billing rates.

8. Determine the total charges applicable to the period of time between the date of admission and the date on which Medicaid eligibility became effective. Utilize verified patient census information and standard billing rates to make this determination.

9. Review patient register for sources of payment other than Maryland Medicaid. Payments could come from other insurance sources, private payors, or through liquidation of a class member's estate.

10. Determine allowable claim under the terms of the settlement agreement:

    a. For those claims with Medicaid eligibility dates prior to April 1, 2004, allowable claim is calculated as the lower of the following:
        i. Total reported PEME,
        ii. Total verified nursing home charges incurred prior to Medicaid eligibility minus any payments for these charges, as verified in Step 9, or
        iii. The difference between the amount of Patient Contributions to Care per month as calculated originally and as corrected multiplied by the number of months, or part thereof, that the resident remained in the facility after eligibility.

    b. For those claims with Medicaid eligibility dates on or after April 1, 2004, allowable claim is calculated as the lower of the following:
        i. Total reported PEME,
        ii. Total verified nursing home charges incurred 90 days prior to Medicaid eligibility minus any payments for these charges, as verified in Step 9, or
        iii. The difference between the amount of Patient Contributions to Care per month as calculated originally and as corrected multiplied by the number of months, or part thereof, that the resident remained in the facility after eligibility.

11. Multiply the allowable claim amount determined in Step 10 by the applicable percentage in the settlement agreement.

CONCLUSION

12. After completing this module, document claims amounts for each class member and a total for each nursing facility. If any significant issues were noted during the performance of these procedures, prepare a memo and include in the work paper file.

13. Calculate the Federal Medical Assistance Percentage at 50%.