



HOSPITAL APPEALS SETTLEMENT PROCESS

EXPRESSION OF INTEREST

To more quickly reduce the volume of inpatient status claims currently pending in the appeals process, CMS has created an administrative agreement to allow eligible hospitals willing to withdraw its pending appeals in exchange for timely partial payment. CMS encourages hospitals with inpatient status claims currently in the appeals process, with dates of admission prior to 10/01/2013, to make use of this administrative agreement mechanism to alleviate the administrative burden of current appeals on both the hospital and Medicare system.

The following facility types ARE ELIGIBLE to submit an Expression of Interest (EOI):

- Acute Care Hospitals, including those paid via Prospective Payment System (PPS), Periodic Interim Payments (PIP), and Maryland waiver; and
- Critical Access Hospitals

The following facility types are NOT eligible to submit an Expression of Interest request due to the inherent differences in their inpatient admission standards for claims with Dates of Admission prior to 10/1/2013:

- Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS);
- Inpatient Rehabilitation Facilities (IRFs);
- Long-Term Care Hospitals (LTCHs);
- Cancer hospitals; and
- Children's hospitals.

A full definition of each of these facility types can be found at §1886(d) or §1820(c) of the Social Security Act. This agreement applies to all eligible claims from eligible providers. For purposes of this agreement, "eligible claims" are defined as those meeting all elements of the following definition: 1) the claim was denied by any entity that conducted a review on behalf of CMS; 2) the claim was not for items or services furnished to a Medicare Part C enrollee; 3) the claim was denied based on an inappropriate setting determination, that is, on the basis that the service might have been reasonable and necessary, but treatment on an inpatient basis was not; 4) the first day of the admission was before October 1, 2013; 5) the Hospital timely appealed the denial; 6) as of the date of an executed Agreement submitted to CMS by the Hospital, the appeal decision was still pending at the Administrative Law Judge (ALJ) or the Medicare Appeals Council (Council) levels of review, or the Hospital had not yet exhausted its appeal rights at the ALJ or Council level; and 7) the Hospital did not receive payment for the service as a Part B claim. The hospital may not choose to settle some claims and continue to appeal others.

Certain hospitals may be excluded from this settlement opportunity based on pending False Claims Act litigation or investigations.

To formally request participation you may submit this completed form in PDF format to MedicareAppealsSettlement@cms.hhs.gov no later than **January 31, 2017**. CMS cannot accept electronic signatures at this time. Please scan your EOI, with original signature, into PDF format and then send it as an attachment.

You must not email any beneficiary personally identifiable information including beneficiary first or last names, beneficiary names represented by initials, beneficiary addresses, or truncated health insurance claim numbers (HICN). You must only provide the information requested in this EOI. Failure to protect beneficiaries' private data will result in rejection of your appeals from the settlement process.

For more information on the settlement process, please visit <http://go.cms.gov/HASP2016> or contact us at MedicareSettlementFAQs@cms.hhs.gov.

Appellant (Provider) Name:

Appellant point of contact (not necessary if represented)		Representative name (if applicable) (must be an individual)	
E-mail Address:		E-mail Address:	
Point of Contact Title (not necessary if represented)		Representative firm or business (if applicable)	
Address		Address	
City	State	Zip Code	
Phone Number (extension #, if any)	Fax Number	Phone Number (extension #, if any)	Fax Number

Medicare Part A Provider Transaction Access Number (PTAN) and corresponding National Provider Identifier (NPI). Please note there can only be one PTAN number per EOI. Multiple NPI's associated with one PTAN may be added on the same form.

Please **do not** handwrite PTAN or NPI numbers. If you need additional space, please attach in a separate document:

<u>PTAN</u>	<u>NPI</u>	<u>SERVICING MEDICARE ADMINISTRATIVE CONTRACTOR</u>

Indicate whether the appealed claims pending are pre-payment denials, post-payment denials, or both:

- Pre-Payment Post-Payment Both

Has the appellant filed for bankruptcy and/or is expected to file for bankruptcy in the future? If yes, the appellant is not eligible for settlement.

- YES NO

Did the appellant receive payment under the 2014 Hospital Appeals Settlement?

- YES NO

I am requesting that CMS initiate the settlement process for my appeals that are pending an Administrative Law Judge hearing or Medicare Appeals Council review. I understand that CMS will review the appeals that I have pending and determine, to the best of its ability, which appeals would be eligible, if any.

I understand that this EOI serves only to indicate my interest in entering into a settlement. It does not constitute acceptance of an offer to settle any appeal. I understand that the Centers for Medicare & Medicaid Services (CMS) are not obligated to enter into a settlement agreement with me. I understand that certain hospitals may be excluded from this process based on pending False Claims Act litigation or investigations. I also understand that any party, including CMS, may respectfully decline participation in the settlement process at any time before an Administrative Agreement is signed, for any reason, or for no reason. I further understand that once a list is provided to the appellant, the appellant has 15 days to respond in order to continue participation. If the appellant does not respond within 15 days after the receipt of generated appeals list, the appellant will be considered to have abandoned the process.

I am authorized to initiate the settlement process on behalf of the appellant identified above. I attest that the information provided in this EOI is true and correct to the best of my knowledge.

Appellant Signature	Appellant Printed Name	Date
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