MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
2016 Hospital Appeals Settlement Call
MLN Connects National Provider Call
Moderator: Hazeline Roulac
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Hazeline Roulac. Thank you. You may begin.

Announcements and Introduction

Hazeline Roulac: Thank you, Holley.

Hello, everyone. Thank you for joining us today. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I am your moderator for this call. Welcome to this MLN Connects National Provider Call on the 2016 Hospital Appeals Settlement. MLN Connects Calls are part of the Medicare Learning Network®.

CMS has announced that we will again allow eligible providers to settle inpatient status claims currently under appeal using the Hospital Appeals Settlement process. Our subject matter experts will discuss the background, proposed settlement, and process. A question-and-answer session will follow the presentation.

Before we begin, I have a few announcements. There is a slide presentation for this call. You should have received a link to the presentation in your registration email. If you have not already done so, please view or download the presentation from the CMS website at go.cms.gov/npc – that's go.cms.gov/npc – and select today's call from the list. Click on the slide presentation under Call Materials.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website under Call Materials. You will receive an email when these are available.

At this time, it is my pleasure to turn the call over to Ronke Fabayo.

Presentation

Ronke Fabayo: Good afternoon, everyone.

This is Ronke Fabayo. I'm the Deputy Director for the Division of Medicare Debt Resolution. I'm going to go over the presenters for today. Today presenting – on this – in

this presentation – during this presentation, rather, is Tracy Richardson, the Deputy Director for the Financial Services Group in the Office of Financial Management, and also Casey Welzant, who is the Health Insurance Specialist in the Division of Medicare Debt Resolution. We thank you all for participating in the call again. Today, we're going to be discussing the background for the Hospital Appeals Settlement process, the 2016 process. We're going to go into the overview, the proposed settlement, the process overview, major changes from 2014, and then we're going to go into the questions-and-answer period.

With that said, I will turn it over to Tracy.

Background and Overview

Tracy Richardson: Good afternoon, everyone. Thank you all for joining us again. I am going to start with slide 5, talking a little bit about the background.

So, in August of 2014, CMS made available an administrative settlement process to eligible hospitals intended to alleviate administrative burden for all parties involved. Hospitals approved for participation who were willing to withdraw their pending eligible appeals received timely partial payment at 68 percent of the net allowable amount for the claims associated with those appeals. The deadline for hospitals to request participation was October 31st, 2014. Under the 2014 Hospitals Appeals Settlement process, CMS executed settlements with 2,022 hospitals representing approximately 300,046 claims. CMS paid approximately $1.47 billion to hospital providers that agreed to the settlement process.

Moving on to the overview on slide 6. Some providers, however, did not take advantage of this process the first time. The purpose of this call is to provide an overview of the process and answer some questions that the provider community has regarding this settlement opportunity. The specifics of the process will be discussed in upcoming slides presented by Casey Welzant.

Beginning December 1st, 2016, CMS will allow eligible providers to settle their inpatient status claims using and administrative settlement process similar to the process used to resolve such claims in 2014. CMS is making available this Administrative Agreement to eligible hospitals willing to withdraw their pending appeals in exchange for timely partial payment of 66 percent of the next allowable amount. CMS encourages hospital

providers with inpatient status claims currently in the appeals process at levels three or four or within the timeframe to take advantage of this process.

Moving on to slide 7, the proposed settlement. To give you an idea of some of the proposed settlement terms, CMS is proposing to make partial payment at 66 percent of the net payable amount of the denied inpatient claim. Hospitals must settle on all of their eligible claims to receive payment. They may not choose to settle some of their claims and not others. The hospital, then CMS, will sign the Administrative Agreement, after which the claims will be paid and the associated appeals will be dismissed. This settlement will serve as the final administrative and legal resolution of the eligible claims.

Moving on to slide 8, eligible providers. The facility type eligibility remains virtually unchanged from 2014 with the following facility types generally eligible to submit a settlement request—including acute care hospitals including those paid via Prospective Payment System, Periodic Interim Payment and Maryland waiver—along with critical access hospitals. We want to note here that, otherwise eligible providers may be excluded from this settlement process based on pending claims, False Claims Act cases, or other investigations.

The following facility types are not eligible to submit a settlement request—psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System, inpatient rehabilitation facilities, long-term care hospitals, cancer hospitals, and children's hospitals. I would also like to note that providers with claim appeals that do not meet the eligibility criteria for this settlement should check the OMHA website for information on the Settlement Conference Facilitation website.

Slide 9 on eligible claims. Claims that are eligible to be included in a provider's request – if the claim was not for items or services provided to the Medicare Part C enrollee; the claim was denied due to a patient status audit conducted by a Medicare contractor, a MAC, RAC, CERT, OIG, or ZPIC on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not, and the claim has a date of admission prior to October 1st, 2013; and as of the date the provider signs and submits their first Administrative Agreement with list of eligible claims, the appeal decision was still pending at the ALJ or the DAB, or the provider had not yet exhausted their appeal rights at the ALJ or the DAB levels. CMS has determined that there are no patient status

claim denial appeals at level one and level two with dates of admission prior to October 1st, 2013, eligible for the settlement and, therefore, it is not an eligible criteria in the 2016 process.

I will now turn it over to Casey Welzant to discuss the Hospital Appeals Settlement process in greater detail.

Hospital Appeals Settlement Process

Casey Welzant: Thank you, Tracy.

Hello, everyone. As Tracy stated, my name is Casey Welzant, and I will be going over the process for this Hospital Appeals Settlement. We are going to start on slide 10, that's proposed settlement initiation of the process.

If you are a facility that meets the eligible provider types and you have claims that meet the eligibility criteria that Tracy just went over, you are welcome to initiate the settlement process. In order to initiate the settlement process, hospitals should complete an Expression of Interest. This document can be found on our Hospital Appeals website, which is go.cms.gov/HASP2016. This link is case-sensitive. So, please be sure to capitalize the HASP.

Once the Expression of Interest is completed and signed by the hospital, it should be submitted to CMS at MedicareAppeals – and that's plural – Settlement@cms.hhs.gov. We ask that in the subject line of this email, you include the provider name, the six-digit provider number or PTAN, and the words "Expression of Interest." This will help CMS be able to be – more efficiently work these requests. CMS will start accepting Expressions of Interest on December 1st, 2016. And the last day to submit Expressions of Interest will be January 31st, 2017. This gives providers a 60-day window to initiate the process.

Moving on to slide 11. The next step in the process will be CMS generating the list of eligible claims. Once CMS receives the Expression of Interest, we will generate a list of potentially eligible claims for that hospital. If the hospitals meet the eligibility criteria and have eligible claims, CMS will email a copy of the Administrative Agreement, along with a spreadsheet listing claims that are potentially eligible. As previously mentioned, there is a chance that during this process, the hospital may be excluded from settlement

based on False Claims Act or other investigations. If this is the case, a hospital will be notified as soon as possible after we receive the Expression of Interest.

Next in the process, on slide 12, hospital validates list. The hospital will receive the Administrative Agreement and eligible claims spreadsheet from CMS. The hospital should review the claims listing spreadsheet for accuracy and verify that all eligible claims are included and only eligible claims are included. If the hospital is in agreement with claims listed on the spreadsheet, the hospital should sign the attached Administrative Agreement and send back to CMS by replying to the email in which they received the agreement or emailing us at MedicareAppealsSettlement@cms.hhs.gov within 15 calendar days from when they received the agreement.

If the hospital finds any discrepancies while reviewing the claims spreadsheet, they should complete an Eligibility Determination Request document. This document can be found on our Hospital Appeals website. This document allows providers to request to add other potentially eligible claims or remove claims they believe were added to the claims spreadsheet in error. This document should be sent to CMS within 15 calendar days from receipt of the Administrative Agreement from CMS.

Once CMS receives this Eligibility Determination Request, they will work with the hospital and the hospital's servicing Medicare Administrative Contractor, or MAC, to reach a consensus on the claims on the spreadsheet. Once a consensus is reached, the hospital should sign the Administrative Agreement and continue in the settlement process. If the hospital and CMS are unable to come to a consensus on the eligibility of the claims, the provider has the option to move forward with the claims that CMS has determined are eligible or they have the option to abandon the process and maintain their appeals for all the claims.

Whether the hospital is in agreement and sends back an Administrative Agreement or has discrepancies and sends in the Eligibility Determination Request, the hospital should be responding to CMS within 15 calendar days of receiving their Administrative Agreement and claims listing spreadsheet. If there are any problems in meeting this deadline, the hospital should let CMS know as soon as possible because if CMS does not receive any response from the hospital with 15 calendar days, the hospital will be considered to have abandoned the process.

Okay. We're moving on to slide 13. And this is finalizing the Administrative Agreement. So, once CMS receives the signed Administrative Agreement from the hospital, the hospital appeals included on their spreadsheet will be pended. This will be so they will not be worked as part of the appeals process until settlement is finalized. At this point, CMS will also countersign the Administrative Agreement. Once CMS signs the agreement, both the Administrative Agreement and the claims spreadsheet will be sent to the hospital's servicing MAC for processing, a final validation, and payment.

So, that will take us to slide 14. And this is payment and appeal dismissal. Payment for the settlement will be made within 180 days of CMS's signature on the Administrative Agreement. There will only be one payment made per hospital provider number. The hospital at this point should not seek additional payment from the Medicare beneficiary or collect any deductible or co-insurance amount. However, they may retain amounts already collected.

The appeals associated with settlement will be dismissed following the payment. There will be no additional Notice of Dismissal or Procedural Order of Dismissal. The Administrative Agreement, in this case, will serve as the Notice of Dismissal or Procedural Order of Dismissal.

So that's all I have for the process.

Major Changes from 2014 Process

We're going to move on to slide 15 and 16, and I would like to highlight some of the major changes that we have made in comparison to the hospital appeals process we offered in 2014. We really tried to institute changes from lessons learned and stakeholder feedback in order to make the process smoother and easier for all parties.

The first major change that we made is that providers will be submitting an Expression of Interest and CMS will then be generating the list of potentially eligible claim appeals instead of the provider having to generate this list. The next big change is that providers will be the ones validating the potentially eligible claims appeals compiled by CMS instead of the provider generating the list and CMS doing the validation. The third big change that we made is that providers will sign the Administrative Agreement when they agree that – when they agree to the claims list and they are committed to the settlement instead of signing the agreement first and then deciding whether to proceed

or abandon the process. The fourth big change is that the MACs will be pricing the claims included in the agreement after the agreement has been signed by both parties instead of pricing the claims up front. And the final big change is that we will not be doing the round one and round two with separate agreements and payments. In this hospital appeals process, there will only be one agreement and one payment.

Resources

I'll touch on resources really quick. The website we have listed there – it's go.cms.gov/HASP2016. And please remember that is case-sensitive. We have a lot of really useful information there. Especially helpful, we have an FAQ document, which is a combination of questions that we received from the 2014 process as well as some clarifications that we wanted to make on this process and some questions that we received in this time.

The CMS email address for submission is MedicareAppeals – again, that's plural – Settlement@cms.hhs.gov. And then, our email address for if there's any questions regarding this presentation or this process is MedicareSettlementFAQs – and FAQs is plural – @cms.hhs.gov.

Okay. That is all that I have. At this point, I will turn the presentation back over to Hazeline.

Keypad Polling

Hazeline Roulac: Thank you, Casey.

So, in just a moment, we will start the question-and-answer portion of our call. But before we do, we will pause to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. There will be a few moments of silence while we tabulate the results.

Holley, we're ready to start polling.

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two

and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Hazeline.

Question and Answer Session

Hazeline Roulac: Thank you, Holley.

So, before we begin taking your questions, our subject matter experts will address questions that were submitted by you during the registration process.

Ronke?

Ronke Fabayo: Thank you. Again, everyone, thank you for submitting the questions during the registration process. This is Ronke Fabayo again. Morris Plater and I are going to go through the questions that we received.

Morris Plater: During what time period can I submit an Expression of Interest?

Ronke Fabayo: Providers may submit an Expression of Interest from December 1st, 2016, through January 31st, 2017.

Morris Plater: When would providers receive payment under this settlement?

Ronke Fabayo: Providers should expect to receive payment within 180 days of CMS's signature on the Administrative Agreement.

Morris Plater: What if a provider doesn't agree with the claims list on the spreadsheet that CMS sends with the Settlement Agreement?

Ronke Fabayo: If the provider disagrees with the claims on the spreadsheet, the provider should submit an Eligibility Determination Request. The provider can use the Eligibility Determination Request spreadsheet to identify claims the provider believes are eligible but not included in CMS's generated list as well as to identify claims that were mistakenly included on CMS's list. The Eligibility Determination Request can be found at go.cms.gov/HASP2016.

The provider should complete and send the Eligibility Determination Request to CMS within 15 calendar days of receiving the CMS-generated claims list. The provider will have 30 days to work with CMS to come to an agreement. If an agreement cannot be reached, CMS makes the final eligibility determination. We remind providers that they can abandon the process if they choose to do so at any point before signing the Administrative Agreement.

Morris Plater: Under the 2014 Hospital Appeals Settlement process, providers experienced a great administrative burden with identifying eligible versus ineligible claims with the MACs. Should we expect that the level of burden this time around?

Ronke Fabayo: CMS has made a series of improvements to the process to reduce stakeholder burden and expedite the process. Casey went through and highlighted for you the changes that were made in regards to identifying claims – eligible claims under this 2016 process, CMS will generate the list of eligible claims for providers.

Morris Plater: Will the spreadsheet of eligible claims I receive from CMS include pricing information and the proposed payment amount?

Ronke Fabayo: The settlement amount will be 66 percent of the net paid/payable amount for each included claim. The spreadsheet will not contain price claims. Pricing will be done at effectuation.

Morris Plater: Eligibility—what level of appeals are included in the settlement?

Ronke Fabayo: Only appeals currently pending or appeals of providers that have not yet exhausted their appeal right at level three or four are included in the settlement. The date of service for eligible claims is prior to October 1st, 2013. CMS does not believe there are any eligible claims pending at levels one or two.

Morris Plater: Is there a minimum or maximum number of appeals required to participate in this process?

Ronke Fabayo: There is not a minimum or maximum number of claims to participate in this settlement. Providers must settle all claims meeting eligibility criteria.

Morris Plater: If the provider abandoned the process during the first Hospital Appeals Settlement in 2014, is the provider eligible to participate in the second Hospital Appeals Settlement?

Ronke Fabayo: Yes, as long as the provider has claims that meet the eligibility criteria and did not receive payment for those claims under the 2014 appeals settlement.

Morris Plater: If a provider participated and received payment in the first Hospital Appeals Settlement in 2014, can the provider submit claims that were not submitted for the first settlement?

Ronke Fabayo: If a provider participated in the first appeals settlement, all eligible claims should have been included. However, if the provider believes there are eligible claims still pending at level three or four, the provider may submit an Expression of Interest. Alternatively, the provider may wait for CMS to contact them directly if eligible claims are found.

Morris Plater: Will inpatient rehab claims be allowed in the settlement this time?

Ronke Fabayo: No. IRF claims are not eligible for this settlement. Please check OMHA's website for information on the Settlement Conference Facilitation process.

Morris Plater: Is a case eligible for settlement if it started out as a diagnosis-related group coding denial but during appeal review was denied for incorrect patient status?

Ronke Fabayo: Yes. In limited circumstances, DRG claims may be eligible for this settlement. DRG reviews conducted by the RAC and/or MAC medical review units resulting in claim denials are not eligible for settlement. However, if the MAC appeal unit modified the denial reason and later denied the claim based on patient status, the claim would then possibly be eligible for settlement.

Morris Plater: Are coding denials included in this settlement?

Ronke Fabayo: No, coding denials are not included in this settlement.

Morris Plater: Will settled claims continue to be denied in this system?

Ronke Fabayo: Yes, settled claims will remain denied in this system.

Morris Plater: Does this settlement include those pending appeals reviewed by CERT audit process? Will the settlement apply to only RAC cases or prepayed and CERT cases also in appeal?

Ronke Fabayo: It does not matter who initiated the claim denial or whether the claim denial was made on a pre-payment or post-payment. If a – if a hospital provider meets the eligibility criteria for patient status denial, all claim denials will be included.

Morris Plater: General question. Why is the percentage lower this time around? Last time, it was 68 percent. This time, you are offering 66 percent.

Ronke Fabayo: The 2014 Hospital Appeals Settlement was intended in part to alleviate the administrative burden of current appeals on both the provider and Medicare. For those providers who did not take advantage of the settlement in 2014, the Department of Health and Human Services had to incur administrative burdens for appeals that remained in the system.

Morris Plater: What is the net allowable amount and/or does this include amounts paid by patients and/or supplemental plans for deductible or coinsurance paid?

Ronke Fabayo: The net settlement amount is the bottom line of the claim after deductible and coinsurance.

Morris Plater: Will the settled IP discharges appear on the paid claims report or cost report settlement?

Ronke Fabayo: No. Total inpatient days will remain unchanged on the cost report. Settled claims remain denied in the system.

Morris Plater: Can a provider abandon the process after submitting an Expression of Interest?

Ronke Fabayo: Yes, a provider can abandon the process at any time before sending CMS a signed Administrative Agreement.

Morris Plater: At what point in the process will the appeals be pended?

Ronke Fabayo: Once CMS receives a sign Administrative Agreement from the provider, the provider's associated appeals will be pended.

Morris Plater: What additional information besides the claim number will be used for the matching of claims between providers and MACs to avoid discrepancies related to claim numbers?

Ronke Fabayo: The ALJ or DAB appeal number and date of service will also be included. A sample claims spreadsheet is available on the HASP 2016 – that's HASP 2016 – website for further reference.

Morris Plater: Since this is during the holiday season, does CMS count the holidays as part of our 15-day timeline?

Ronke Fabayo: Providers are welcome to submit an Expression of Interest from December 1st, 2016, through January 31st, 2017. CMS uses the calendar days to measure timeliness for the 15-day timeframe. If a provider experiences an issue with timeliness – excuse me – and needs additional time, please contact CMS via email as soon as possible. The provider should reply to the email correspondence from CMS containing the Administrative Agreement and claims spreadsheet regarding this issue. Please note, a provider that is not responsive during the 15-day timeframe will be considered to have abandoned the process. CMS will attempt to follow up with the provider before this happens.

Morris Plater: How does a provider abandon the settlement process?

Ronke Fabayo: The provider abandons this process after submitting an Expression of Interest by, one, not responding to CMS timely within 15 days after receiving the Administrative Agreement and list of eligible claims or, two, by not signing the

Administrative Agreement when received from CMS. It is the provider's discretion as to whether to abandon the settlement process. But we request that the provider notifies us by emailing us at the MedicareAppeals – that's plural – AppealsSettlement@cms.hhs.gov email address should the provider decide to abandon the process.

This now concludes the overview of the questions we received throughout the registration – or during the registration period.

Hazeline Roulac: Thank you.

So I want to thank our subject matter experts for addressing those questions. And thank you to everyone who submitted questions during the registration period.

We are ready to take your questions. I want to remind everyone that this call is being recorded and transcribed. Before asking your question, please give your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup or have more than one question, you may press star one to get back into the queue, and we'll address additional questions as time permits.

All right, Holley. We are ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

And our first question comes from the line of Jeff Reid.

Jeff Reid: I was wondering if this will impact any claims for bad debts for coinsurance and deductible that may still be outstanding for any of these years.

Benjamin Moll: Hello. This is Ben Moll. So, the claim will remain denied. So, the associated deductible and coinsurance will follow that. So, if you're referring to the Medicare cost report, that's the way that will be handled.

Operator: And our next question will come from the line of Ed Coyle.

Ed Coyle: Hello. Yes. I had a question about overlap. Your date of claims prior to October 1st of 2013 – is this overlapping the other ones so that the earlier 2014 settlements – that is a hospitals participated in that first round, they really wouldn't be getting any benefit from this second round? Is this really focused on those hospitals that did not participate the first time?

Amanda Burd: That is correct. The claim eligibility criteria remains the same and, therefore, hospitals who settled with us in 2014 – all of their eligible claims should have been removed. And this is Amanda.

Operator: Our next question will come from the line of Tracy Field.

Tracy Field: Hi. Thank you. I wondered, what is the availability of this settlement for providers whose claims are included – status amounts are included in an extrapolation overpayment calculation. Are those eligible for a settlement as well?

Hazeline Roulac: Just one moment.

Casey Welzant: So, extrapolation does get a little tricky with this settlement process. If a claim is involved in extrapolation, it doesn't necessarily make it not eligible for this process. But, the claim needed to be part of the sample. It can't be a part of what was extrapolated out. We have an FAQ on this on our website.

It's Question 10. So, the extrapolated universe of the claims are not eligible. And if a provider wishes to include extrapolated sample claims and have the extrapolation recalculated after settlement, the provider in that case is going to have to contact the OIG to request the recalculation of the sample because I know that it will affect that. And this is Casey. I'm sorry.

Operator: And our next question will come from the line of Lucy Ebel.

Lucy Ebel: Yes. Can you please explain again how you arrived to the 66-percent proposed settlement? Thank you.

Amanda Burd: Hi. Yes. This is Amanda. And the 66 percent came from – under the 2014 Hospital Appeals Settlement, it was intended in part to alleviate the administrative burden of the current appeals on both the provider and Medicare. For those providers who did not take advantage of the 2014 settlement, the Department of Health and Human Services had incurred additional administrative burdens for those appeals that remained in the system. Thank you.

Operator: And our next question will come from the line of Gail Vitale.

Gail Vitale: Yes. We have a few appeals both at the ALJ level and at the Department of Appeals Board level that we have requested dismissal letters on, extending as far back as August, we've requested that, but we've not received the actual dismissal letters or confirmation of our written request that was sent. How do we go about if we – you know, that appeal will come on as part of the eligibility determination? And would those be allowed to be dismissed from that if we could show proof that we've actually requested a dismissal quite a while ago and have not receive a response back?

Maria Ramirez: Hi. This is Maria Ramirez. Can you clarify why you are requesting dismissals of the ALJ and DAB level?

Gail Vitale: At the DAB level, it's because they've been out there for 4 years and we no longer wanted to pursue it. We wanted to do our Part B. We've – we had a few at the ALJ level that we have since reviewed and we feel we could – we actually would – they're a high-dollar level that we should – when we were billing Part B, we would actually get a significantly higher amount than 66 percent to rebill those.

And, so, we'd like to take that out of that process as well since they've been there for a while.

Maria Ramirez: Can you repeat your name? And is there a phone number?

Gail Vitale: Sure. It's Gail Vitale. I could send you an email. My phone is XXX-XXX-XXXX

Ronke Fabayo: Can you send the email and just address it for Maria? Can you send that email to the MedicareAppeals – the MedicareSettlement – excuse me – FAQs@cms.hhs.gov? Again, that is MedicareSettlementFAQs@cms.hhs.gov. And just attention it to for Maria – a question for Maria, and we'll get it to her.

Gail Vitale: Okay. Thank you.

Ronke Fabayo: Thank you.

Operator: Our next question will come from the line of Joshua Siebalt.

Joshua Siebalt: Hi. This is Joshua Siebalt from Steward Health Care. My question is basically – does this apply to outpatient claims? And if not, is there a plan to do something similar for outpatient claims in the future? Thank you.

Amanda Burd: The eligibility criteria for this settlement is focused on the inpatient status claims. And you can see the eligibility criteria there. You may want to check out the Office of Medicare Hearings and Appeals – their website regarding the Settlement Conference Facilitation pilot.

Operator: And our next question will come from the line of Karen McKenney.

Karen McKenney: Yes. Hi. Good afternoon. In the last settlement that was offered in 2014, CMS adjusted the dollar amount after the hospitals had signed off on the agreement. And I heard that some of the numbers dropped as low as 38 percent from the 68 percent. Is there – is the same process going to be applied this time? Is the number going to be all good after the agreement is signed off on?

Amanda Burd: Hi, Karen. This is Amanda. As we had discussed, the claims will actually be priced after the Settlement Agreement is signed.

Karen McKenney: Right. So, we are going to be signing – so, we will be signing it and then finding out the price after that time?

Amanda Burd: It is 66 percent of the net paid or payable amount.

Karen McKenney: So, that won't change?

Amanda Burd: It will be 66 percent of the net paid payable amount less the coinsurance and deductible. The settlement percentage is 66 percent. Thank you.

Operator: And our next question will come from the line of Rebecca Scott.

Rebecca Scott: Yes. When can we expect to get our list of eligible claims? Like what is the timeframe on that?

Amanda Burd: Again, you have between December 1st of 2016. through January 1st of 2017, to submit your Expression of Interest. We would hope to turn around those claim listings within 7 to 10 days of the receipt of the Expression of Interest.

Operator: And our next question will come from the line of Tanya Livdahl.

Tanya Livdahl: Hi. We may have found the answer, but my question was, is the 835 remit – will that be a separate remit or would that mixed in with our other lines of business that we're currently submitting today?

Hazeline Roulac: Thank you. One moment.

Amanda Burd: Thank you for your question, Tanya. This is Amanda. We will take that question back and either address it on our next call or provide and updated FAQ regarding whether there's a separate 835 remit.

Operator: Okay. And our next question will come from the line of Sandy Sholti.

Sandy, your line is open.

And our next question will come from the line of Tim Wolters.

Tim Wolters: Yes. I understand that we will not know the settlement amount when we sign the settlement agreement. What if there's a discrepancy in the settlement amount compared to what we cleared our records—what we're showing as the net payment?

Amanda Burd: Hi, Tim. This is Amanda. Could you clarify your question?

Tim Wolters: Well, we're going to get 66 percent of the net payment amount. What if when we get that payment, the net payment amount from our records is greater than

the net payment amount on which the 66 percent is based – there're – we have a difference in terms of the amount of payment that had been withheld from us compared to the records used to calculate the 66 percent?

Amanda Burd: Tim, you will be receiving as part of the process after the claim – after effectuation, you will be receiving a spreadsheet that has those amounts included on the spreadsheet. So you would have that for your reference.

Tim Wolters: Okay. And if there is a difference, will we be able to, you know, submit, you know, documentation of what would – of the actual withheld amount compared to what is shown in that spreadsheet? Or how will that – how would that work?

Amanda Burd: We will follow up on this part of the question on our next call, which will be on December the 12th. But, you – I will tell you that you will receive the documentation of what our records show as part of the payment process. But we will follow up with this with more detail in our FAQs or on the 12th.

Operator: And our next question will come from the line of Robert Tipton.

Robert Tipton: My hospital participated in the 2014 settlement years ago. And pretty much almost exclusively, what we have out there now are very, very old DRG-related claims. And it appears that there's no real intent to include DRGs. Can CMS tell us why – we've got some of these claims that have been sitting out there for years and there seems to be no increase in the ALJ's ability to get to them. Is there any rationale why DRGs wouldn't be included in this?

Connie Leonard: Hi. This is Connie Leonard. And the criteria for this trigger settlement is only the patient status reviews. And this is really – this settlement, as well as the first settlement, goes back to the clarification in the policy with the Two-Midnight. So, at this time, no, CMS does not have any plans to allow the DRG validation or coding type of reviews to be settled.

Operator: And our next question will come from the line of Hannah Baldwin.

Hannah Baldwin: Hi. Yes. Thank you. We're just wondering after – if a hospital does sign the agreement, how long does CMS have to actually countersign the agreement?

Amanda Burd: There – we would think that it would be signed within 7 to 10 days, and then payment would be made within 180 days of that signature. It will not be...

Hannah Baldwin: Okay. Thank you.

Amanda Burd: It will not be as long as last time between the two signatures.

Operator: And our next question will come from the line of Vickie Kunz.

Vickie Kunz: Yes. So, I'm ready the FAQ and my questions have actually been answered. So, thank you very much.

Operator: And our next question will come from the line of Shari Shafer.

Shari, your line is open.

Shari Shafer: Good morning.

Hazeline Roulac: Good morning. You can go ahead with your question.

Shari Shafer: One moment. We have a question.

(Unidentified male): Hi. I wanted to confirm when these claims were denied, we lost the days on the Medicare Cost reports for the appropriate years. We've got claims going back to 2009. So, does settling mean that those cost reports going back to 2009 will not be reopened and adjusted to reflect these settlements?

Benjamin Moll: This is Ben again. Yes, that is correct. Those cost reports will not be impacted primarily because those claims will remain denied. Thank you.

Operator: And our next question will come from the line of Kim Edleheit.

Kim Edleheit: Hi. This is Kim Edelheit. And my question is, due to the large backlog – number of backlog of appeals at the ALJ level, is there any talk of future settlements for claims with admin dates after October 1st, 2013?

Amanda Burd: This is Amanda. We would encourage providers to check out the resources that are available of the Office of Medicare Hearings and Appeals website regarding the Settlement Conference Facilitation. Thank you.

Operator: If you would like to ask a question, press star one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Our next question comes from the line of Diane Zimmerman.

Diane Zimmerman: Thank you for taking my call. I have a really quick question and then another one. So, what do you consider to be the point of – it says on page 9, as of the date the hospital submitted the initial agreement. Is that the Expression of Intent? Or of Interest.

Amanda Burd: Diane, this is Amanda. And in response to your question, that is when you submit the signed Administrative Agreement, the signed Settlement Administrative Agreement.

Diane Zimmerman: Okay. So, in the instance where we have had hearings that were held like 3 months and we still don't have decisions from the ALJ, were there – will there be some expedited decisions coming down so we know if we have a favorable or not? Because if we're waiting for a signed agreement, things can be in play.

So, I'm just concerned about something that may fall into that crossover time period.

Operator: And our next question will come from the line of Joanne Wetch.

Hazeline Roulac: Holley, we want to respond to that question.

Operator: Oh, I apologize. Go ahead.

Maria Ramirez: Hi. This is Maria Ramirez. And can you please send us an email, again, to my attention to the MedicareSettlementFAQs@cms.hhs.gov email address so that we can see what exactly it is that you have pending for what claims? And if you could include the appeal numbers, that would be very helpful.

(Unidentified female): Okay. Thank you. Holley, you can go ahead and put through the next question.

Operator: Thank you. All right. Your next question will come from Joanne Wetch.

Joanne Wetch: Hi. I have a question tagging on to a question I had submitted and gotten a response to on the Medicare Settlement FAQ line. And it was regarding hospitals that are in bankruptcy. I was told that bankruptcies are considered on a case-by-case basis. And I provided the PTAN number to see if we could determine in advance if this was an eligible hospital. And the response was, if they're actively involved within a bankruptcy, they cannot participate in settlement. So, how is that on a case-by-case basis and what are the guidelines for why bankrupt hospitals cannot participate in settlement if they're actively doing ALJ hearings?

Operator: And our next question will come from the line of ...

Hazeline Roulac: Holley, one moment. We're going to address that question. Just a second.

Amanda Burd: And I believe – this is Amanda. I believe we have your contact information from that question. And we'll reach – we can reach out to you to discussing your specifics.

Joanne Wetch: Okay. Thank you.

Operator: And our next question will come from the line of Swapna Sreenivasula.

Swapna Sreenivasula: Hi. My name is Swapna Sreenivasula from Prime Healthcare Services. So my question is when we are submitting our Expression of Interest – so, following the Expression of Interest, CMS will be sending us a spreadsheet listing claim. So if there are multiple NPIs associated with one PTAN, so will CMS include all possible NPIs associated with that PTAN? And, also, following to this question, will CMS also submit claims which are eligible – I mean, which were dismissed under Part A but were not rebilled by the provider under Part B? So, will CMS already determine that list of claims and included it when they are sending us the list?

Casey Welzant: So, for the first part of the question, if there are multiple NPIs, we're doing this on the provider – the PTAN level. So, if there's multiple NPIs for one PTAN, all of the NPIs associated with that PTAN will be listed on one spreadsheet.

For the second part of your question, the claims will be included as long as they meet the eligibility criteria that we've gone over. Thank you. And this is Casey.

Swapna Sreenivasula: Thank you.

Operator: And our next question will come from the line of Dr. Mauvareen Beverly.

Dr. Mauvareen Beverly: Hi. Just want to clarify that behavioral health cases in acute care hospital qualifies for the settlement as well?

Amanda Burd: This is Amanda. And eligibility criteria are listed in the slides and they go over the types of services, the types of claims. And an acute care hospital would be allowed to be included. And it was where – it was where the claim is denied based on patient status – so, if the treatment was reasonable and necessary but the setting and the inpatient status was not appropriate. Thank you.

Dr. Mauvareen Beverly: So, I'm – I'm not sure. Just clarify – so, an inpatient in a behavioral health service line within an acute care hospital – a claim that was denied for lack medical necessity for inpatient has been appealed – that case cannot be a part of the settlement or it can?

Hazeline Roulac: Just a moment, sir.

Amanda Burd: If you could send in that question to us so that we could look into it a little deeper. And that would be at MedicareSettlementFAQs@cms.hhs.gov. Again, MedicareSettlementFAQs@cms.hhs.gov.

Dr. Mauvareen Beverly: Thank you.

Amanda Burd: And an example would be helpful, like a kind of a – if you could step up through an example, that would be great – without PHI in it.

Dr. Mauvareen Beverly: Thank you.

Operator: And our next question will come from the line of Christina Lannom.

Christina Lannom: I have kind of two-fold or more of a question and then a statement. My understanding is that we'll get 66 percent of the Part A net allowable amount and the full amount of interest that was recouped when they recoup the Part A payment. Is that correct?

Hazeline Roulac: Ma'am, could you repeat your question, please?

Christina Lannom: Yes. My understanding is we'll get 66 percent of the Part A net allowable amount. But we would also get the full amount of interest that was recouped with the Part A payment recoupment. Is that correct?

Amanda Burd: As you'll see on our FAQ document on page 17 under Section G, Interest, question one, yes, any interest paid by the hospital after the claim was denied will be refunded. In addition, if the interest has accrued on the claim that has not been paid, the accrued interest will be adjusted to zero. Each claim will be adjusted and it will result in a one lump sum payment made to the hospital.

Christina Lannom: Okay. And I would also like to comment on the guy before about – a lot of these claims are purged from our MAC's system. So, if the – if we sign the agreement and then we find out the amount is different, we would like to know what is the provider's recourse at that point if our amounts are different than what the MAC is showing.

Amanda Burd: And like we had discussed with the other caller, we will take that back and discuss it. And we will update the FAQs and/or discuss it on our 12/12 call.

Christina Lannom: Okay. Thank you.

Operator: And our next question will come from the line of Omar Jaff.

Omar, your line's open.

And our next question will come from the line of Larry Carlton.

Larry Carlton: Yes. This is Larry Carlton with Community Health Systems. In the first round of settlement relative to facilities that are acquired/divested and the new owner steps into the shoes of the prior owner, i.e., has the same provider number, there was an occasion where both entities, the prior owner and the current owner, filed a request. I know that came up. And, effectively, I think the end result was that the current owner was responsible for submitting all the claims even under the prior owner's ownership and then the monies would be paid to the current owner and the folks had to basically determine which would go to – determine the amounts that each one would receive. I would think that still stands.

Casey Welzant: Hi, Larry. This is Casey. And that is the case. Whoever is the owner of the provider number is the one who we – should be receiving the Expression of Interest from. They are also the person who will be paid. So, if they have taken over another entity, it's – it's on them to figure out how they want to – between the two facilities, how they want to work out that payment.

Larry Carlton: Okay. Thank you. Could I – could I do one quick follow-up question? Really, it's maybe some insight on one of the earlier questions on the psych and the rehab claims, which I know to submit an example to you all – but, there are inpatient psych claims and inpatient DRG claims that are billed under the acute care provider number. In other words, they're not a distinct part unit. And the way we operated before was the distinct part units, the rehab and the psyches, relative to what you have now, I wouldn't submit those.

But if I did have an inpatient psych or rehab under the acute care setting which was billed under the acute care provider number and was denied such, I would think that I would still submit those. Just – that's my insight to that. But I know you asked for something to be submitted. But, I just thought I'd throw that in there. Thank you.

Casey Welzant: Larry, this is Casey again. I appreciate that. And you are correct with that obviously you guys won't, the facilities won't be submitting, we'll be claims this time. But those types of claims that are billed under the acute care hospital's number...

Larry Carlton: Right.

Casey Welzant: ... they will be eligible for settlement.

Larry Carlton: Thank you.

Casey Welzant: Thank you.

Operator: And our next question will come from the line of Richard Adamas.

Richard Adamas: Yes. Good afternoon. You had answered before that these claims – this settlement is only for patient status changes only and not DRG coding changes. Is there any future settlements for DRG coding changes? What should we do with our current inventory?

Amanda Burd: Again, we would encourage you to check out the website of the Office of Medicare Hearings and Appeals for information on their Settlement Conference Facilitation pilot. Thank you.

Operator: And our next question will come from the line of Marissa Barese.

Marissa Barese: Hi. Yes. I just want to clarify on slide 9, the eligible claims. The date of admission prior to 10/1/13 – are we only – as you only pulling those prior? Or is it going to be newer ones like ’14 and ’15 claims?

Amanda Burd: This settlement is only available for claims with a date of service prior to 10/1/2013. Thank you.

Marissa Barese: Thank you.

Operator: And our next question will come from the line of Julie Hunter.

Julie Hunter: Yes. I just needed some clarification on the Medicare bad debt reporting. We just wanted to know how the deductible and coinsurance amounts for Medicare bad debt reporting would be – what we should do as far as reporting those if they’ve already been reported on a closed cost report.

Benjamin Moll: So, the MACs would not be reopening if it did not meet that reopenable threshold.

So, in your example, assuming that those claims remained denied, just like any other threshold for reopening and prior to the MPR cost report, unless it meets that threshold, there would be no rationale or justification to reopen those cost reports.

Julie Hunter: Okay.

Benjamin Moll: This is Ben Moll.

Julie Hunter: Okay.

Operator: And our next question will come from the line of Lindsay Knox.

Lindsay Knox: Hi. Yes. If we received an unfavorable decision from the ALJ but we have not exhausted our appeals right on that decision, will that be considered part of the eligible claims?

Amanda Burd: Yes. This is Amanda. That claim appeal would be eligible for this process. Please note that it may not show up on your pending list. Those are very difficult for us to see.

It would be eligible. You may just have to add that in. And you could do that through the Eligibility Request Determination.

Lindsay Knox: Okay. But, that's as long as it's within the appeals timeline of that unfavorable decision. Correct?

Amanda Burd: Yes.

(Unidentified female): Correct.

Lindsay Knox: Okay. Thank you.

Operator: And our next question will come from the line of Karen Fisher.

Karen Fisher: Yes. Hi. I have – my question is, if we do decide to go with the settlement and we accept the amount – you guys accept the amount and the claims are closed, can you guys come back at any time and review those same claims again?

Amanda Burd: This is Amanda. And the claims remain denied in the Medicare system. So we do not review denied claims.

Operator: And our next question will come from the line of Ann-Marie Carducci.

Ann-Marie Carducci: Hi. My question is, if we have some discrepancies with the cases that are on the list that CMS provides to us, in the prior settlement, we had the option to bill to Part B. Will that still be an option with the 2016 settlement?

Maria Ramirez: Hi. This is Maria Ramirez. I believe you are referring to the 1455 billing opportunity that we offered prior to the Hospital Settlement process. And I don't think….

Ann-Marie Carducci: No. There was some – because before, the – in the first settlement, the hospital submitted the list. So we had some cases where there were discrepancies, and then we ultimately rebilled for Part B if CMS didn't agree that they were eligible for the settlement.

Casey Welzant: Hi. This is Casey. Yes. If CMS – if we're saying that that claims are not eligible and we're not coming to a consensus on those claims, so we're going to move forward with everything that we deem as eligible. If you want to and can rebill for these other claims that we haven't deemed are eligible, you're more than welcome to do that.

Ann-Marie Carducci: Okay. Thank you.

Operator: And our next question will come from the line of Kirsten Berg.

Kirsten Berg: Hi. This is Kirsten Berg from Amita Health. And I'm wondering if – when we submit our list for Expression of Interest, do you sort out the DRGs and the medical necessity and then give us back the list of just our medical necessity that's eligible?

Casey Welzant: Hi, Kirsten. This is Casey. So, in terms of the Expression of Interest, what's on that form– and this is what's different from last time. We basically just ask for a contact information, your PTAN, your NPI. And we don't ask for any claim or appeal-specific information. And that comes into us, and we are going to generate the list for you...

Kirsten Berg: Okay.

Casey Welzant: ... of all of the claims that we believe are eligible.

Kirsten Berg: Very good. Thank you.

Casey Welzant: You're welcome.

Operator: And our next question will come from the line of Kristin Metter.

Kristin Metter: Hi. What happens if you receive a dismissal from an ALJ or a DAB appeal and that dismissal notice is, let's say, 61 days – is 61 days later and you – that's when you sign your agreement. Is that claim still eligible or is it not eligible because it's not appealable? And this is in reference to the frequently asked questions on page …it's number 5.

Maria Ramirez: Hi. This is Maria Ramirez. And I believe, if I understood your question correctly, claims need to be eligible for appeals. And at day 61, that claim would be considered late or that request for appeal would be considered late. You have 60 days to file a request for a hearing, 60 days to file a request for a review with the DAB after the ALJ issues a decision.

Kristin Metter: Okay. Thank you.

Operator: And our next question will come from the Hackensack University Medical Center.

Marie Matthew: Hello. My name is Marie Matthew. I'm from Hackensack University Medical Center. I participated in the settlement in 2014. The discrepancy that I had last time – that's why I want to ask you the question – the claim number – the original claim number and the one you submitted seemed to be different. Can you explain why? I had a difficult time finding the case. So, when you are submitting – when we provide you the Intent of Interest, you're going to mail us the list. I just want to know what claim number are you going to use. Is it the original claim number that we received or are you going to give an updated, like they did last time? Because it was very confusing for me.

Casey Welzant: So, hi, this is Casey. We understand that there were a lot of discrepancies with the claim numbers last time. And I know that that was a big burden. So the numbers that – the claim numbers that we're using are going to be pulled from our appeals bodies. So whatever the claim number is listed at the ALJ or at the DAB, whatever they have in their appeal, that's the claim number that we're going to be using. But I think was touched on in one of the questions that somebody brought up. We're also going to be providing some other information to help us come to a consensus or identify the claim. We're going to be giving you –once we give you the eligibility claim, we're going to be giving you the dates of service and the ALJ appeal number. So, hopefully, that will help us all speak the same language with the claim number.

Marie Matthew: Okay, thank you.

Casey Welzant: And, hopefully, we can work this out between CMS hospitals and the MACs if we need to just try to come to one claim number.

Marie Matthew: Okay, thank you.

Casey Welzant: You're welcome.

Operator: Our next question will come from Rebecca Scott.

Rebecca Scott: Yes. On slide 9 for eligible claims number 7, when you talk about the Part B claims, billed claims, I guess, how are they included in the settlement? Because in your FAQs on page 21, number 5, it has one example. And then on page 11, number 28, it says no. So, we're just confused as to if claims that have been denied at ALJ level and when we send for a Part B inpatient rebilling, can we – and have not received payment, can we include those as eligible claims?

Amanda Burd: Could you repeat that last – this is Amanda. Could you repeat that last part of your question on the timing with the ALJ?

Rebecca Scott: Sure. Like if we've been through the ALJ process and the ALJ denies our appeal and we decide instead of taking it to the fourth level we're going to do the Part B inpatient rebill, we're just confused because in one part of the FAQs, it says no, you cannot include those if you've not received payment. And then on page 21, it says yes,

you can include those claims that you've not received payment on yet through Part B. So we're just confused as to whether all of those claims that we have sent for Part B rebilling but not been paid yet – if they will be eligible or not.

Amanda Burd: All right. The question would become are the claims in question still the Part A claims in question – the appeals – are they still within the timeframe to appeal to the next level?

Rebecca Scott: Okay.

Amanda Burd: Thank you.

Operator: And our next question will come from the line of Omar Jaff.

Omar Jaff: Hi. My question is, if I have a patient status appeal that is dismissed for late filing at the ALJ level, but I am still within the timeframe to request an appeal and ask to for the dismissal to be vacated, is that claim still eligible for the settlement?

Maria Ramirez: Hi. This is Maria. Again, if you – if your claim is still eligible for appeal to the DAB, that claim will be considered as eligible for settlement.

Omar Jaff: Thank you.

Maria Ramirez: If you can fulfill the other criteria, of course.

Hazeline Roulac: Okay. Thank you.

Operator: And our next question will come from the line of Virginia Davis.

Virginia Davis: Good afternoon. Thank you for taking our question. I do have a clarification that I'd like for – that you were going through the presentation. On page 9, eligible claims, I understand the date of admission has to be for these type of patient status claims 10/1/2013. I thought I heard a comment that you all had already reviewed these claims and everything that would be eligible is probably already at the ALJ level. Is that what I understood you to say?

Casey Welzant: Hi. This is Casey. Yes, that is correct.

Virginia Davis: Okay. I appreciate it. Thank you.

Operator: And our next question will come from the line of Emilee White.

Emilee White: If we have a claim that is due for a hearing during the time of the intent letter, are we allowed to include that claim on our settlement or on our request or would that – because the decision wouldn't have necessarily been made yet by the ALJ? Or should we just try to pull it back?

Maria Ramirez: Hi. This is Maria Ramirez. Again, as long as your claim is still eligible and you don't have a hearing – you – a hearing is schedule but it hasn't taken place, that claim would be deemed eligible for settlement.

Casey Welzant: But tell her this would be ...

Emilee White: So, this – okay. So, the hearing is schedule during the time of the initiation. So, that's why it's fuzzy.

Casey Welzant: Hi. This is Casey. So, that's – that's honestly – this is going to be your prerogative and your choice in the matter. Our deadline for what – where we're drawing the line is when you sign the Administrative Agreement. So that, obviously, is going to be dependent on when you submit an Expression of Interest. Obviously, we're going to try to turn around that claims listing spreadsheet in 7 to 10 days, and then you have 15 days. So, we're still looking – I mean, even if you do it on December 1st – about a month before we get a signed Administrative Agreement. And that's, again, when the line would be drawn. So, if you had a favorable decision or an unfavorable before that point, then obviously the claim couldn't be included. So, again, it's your prerogative. It's up to you and what works best for your facility.

Emilee White: Okay. Thank you.

Operator: And our next question will come from the line of Kevin Steck.

Kevin Steck: Yes, thank you for taking my call. The question I have is if the claims are denied, will that reduce the number of days to calculate graduate medical education reimbursement?

Benjamin Moll: Hello. This is Ben Moll. Just to make sure I understand, could you just repeat the question?

Kevin Steck: Yes. If the claims as part of the settlement are considered denied, then will that reduce the number of days – of Medicare days in calculating graduate Medical education reimbursement?

Benjamin Moll: Yes, because the days – because the claim is denied, those associated days or days of service will also remain denied. So…

Kevin Steck: Thank you.

Benjamin Moll: Okay.

Operator: And our next question will come from the line of Donna Seeley.

Donna Seeley: Our hospital participated in the 2014 68-percent settlement. And we recently, within the last couple of months, received demand letters for cases that occurred before 10/1 of ’13. And as we looked into them, they were not part of the settlement. And we were under the impression based on communication with our MAC that they were rescinded. So, would we be able to participate in this settlement this time around even though we did before?

Casey Welzant: Hi. This is Casey. I’m – I’m a little bit blurry on the question. Can you repeat it, please?

Donna Seeley: Okay. We had some old denials that were years old. And they were – they were closed back long before the settlement occurred because we were told that the denial was rescinded. So, when we pulled together our list of eligible cases for the settlement, these particular cases were not included because we didn’t know that they were denied any longer. So now, within the last couple of months, we received probably a dozen or so demand letters, which is the starting process for the first level of appeal on cases from 2012 or so. So these would be cases that were never – they never even went to first level appeal. They were – they were either at the discussion level and they never proceeded. It’s like they were kind of in a black hole.

Casey Welzant: Hi. This is Casey. It's actually – that's a very interesting question. I'd like to look at this. So can you please send that one into our MedicareSettlementFAQs@cms.hhs.gov?

Donna Seeley: Sure. Do you want me to include some examples?

Casey Welzant: That would be wonderful.

Donna Seeley: Okay. Okay, thank you.

Casey Welzant: Thank you.

Operator: And our next question is a follow-up question from Tracy Field.

Tracy Field: Hi. Just with regard to the bad debt and your comment – your earlier answer regarding there would not be – the MAC would not reopen settled cost reports for these claims. But, under the new 60-day repayment statute with identification of potential overpayment, are you saying that that's going to – this settlement process would trump that sort of as part of a settlement? And should we – can we get confirmation of that in writing somehow on an FAQ?

Benjamin Moll: Yes. This is Ben Moll again.

We'll actually clarify this in an FAQ. Actually, I have a note here to do that just because that was something the MPRing and reopening of MPRs and previously-settled cost reports is something that, I think, we need to address via an FAQ. So, if you would like to send your question in, we can add it to the FAQ.

Tracy Field: And with particular attention that, you know, we have a duty to investigate and we just want to make sure that we satisfy that so there's no allegation later that we have retained an overpayment.

Benjamin Moll: Yes, we understand that.

Tracy Field: Thank you.

Benjamin Moll: Sure.

Operator: Our next question is a follow up from Swapna Sreenivasula.

Swapna Sreenivasula: Hi. This is Swapna again from Prime Healthcare Services. So, I had a question regarding appeals which are going to be in pending process. So, once we submit our Expression of Interest and we receive eligible list of claims, so would those appeals be in pending process until the settlement process is completed? Let's say, for example, we are – during this process, you know, we are receiving a new ALJ hearing notice or there is an already-scheduled ALJ hearing coming up. So, are we required to notify OMHA about the settlement process and keep that hearing on hold and request to take it off from calendar until the process is completed?

Casey Welzant: Hi. This is Casey. This is – go ahead, Maria.

Maria Ramirez: Yes. I am sorry about that. So, you can as the ALJ for a continuance of the hearing so that you don't have to go through the hearing or have to show up to the hearing and actually explain to the ALJ that you are also in the settlement – the Hospital Settlement process with CMS. And, you know, the claims, most likely, will be pended from the system anyway so that you will – the ALJ will not be able to issue a decision on it while you're still in this settlement.

Go ahead, Casey.

Casey Welzant: And this Casey. And just to clarify – so, in this – and I don't know if you were a part of 2014. In 2014, we pended as soon as basically people said that they were interested. This time, we are waiting until there is the agreement so that – when we're receiving the signed Settlement Agreement. So, claims and appeals will continue to be worked until we receive in that signed Settlement Agreement that you are agreeing. And that's like the hard line date is when the provider is signing the Settlement Agreement and sending it to CMS – the eligibility criteria. So, again, it's your decision. And you can do what Maria said, that if you know that you have a hearing coming up, ask for continuance if you'd like to participate in the process. Otherwise, you know, you're more welcome to participate in your hearing and then just – that claim will not be included in the settlement.

Swapna Sreenivasula: Okay. Yes. That was my question because the last time, we had that confusion going on because we were participating in the settlement process but

OMHA was sending us notice of hearing. So every time we had to notify them that, okay, we are in the process of settlement. So until then, hearings were requested that they were taken off calendar. And then it took a while for those claims, again, to be put back on calendar again.

Casey Welzant: Correct. And that's – hopefully – and I went over the differences between 2014 and 2016. And that's one of those changes that we've made is that, hopefully, once we are pending the claims this time and we are receiving your signed Administrative Agreement, those are more than likely claims that are going to be settled so we won't have to worry about, you know, claims being – and appeals being pended when providers are choosing not to move forward with settlement or anything else.

Swapna Sreenivasula: Yes. Okay. Thank you so much.

Casey Welzant: Thank you.

Operator: And our next question will come from the line of Joanne Wetch.

Joanne Wetch: Hi. This tags on to that last question and I think you answered it. But, I just want to validate that I heard it correctly. So, if we have a hearing prior to the Expression of Interest or even after we submit an Expression of Interest and it is decided – it may or may not be decided before the Administrative Agreement is signed by the provider. If it is decided before the Administrative Agreement is signed and countersigned and it's unfavorable, then it would still be an eligible appeal for settlement. If it is decided between Expression of Interest and the signing of the Administrative Agreement as a favorable appeal, since the Administrative Agreement has not yet been signed, the provider should get the payment and any 935 interest, if applicable. Is that correct? Because I also saw claims caught up in 2014 in the middle where we'd get favorable responses yet they said, "Well, you are in the settlement process, so you can't be paid" once because the cases were stayed at the point that we – that we chose to participate.

Casey Welzant: You are correct. And that – again, it's a change that we made this time. Last time, the providers were sending the Administrative Agreement. And that was in lieu of the Expression of Interest. So, at that point, that is when the claims were pended. So, that was – again, that was the drop dead date then. But – so, if – and I know the process was a lot longer once you got your agreement in and that whole back and forth.

This time, where we're pending claims and everything, we're hoping that will be much more expedited. And what you said is correct, that if there is an unfavorable decision and it's still eligible to appeal to the next level, you 've not yet exhausted your appeal rights, that would be continue to be eligible for settlement. If you receive a favorable decision, no, that would not be eligible for settlement.

Joanne Wetch: Okay. Thank you. And thank you for taking that step because that will take a lot of confusion out from last time. So, much appreciation for that.

Casey Welzant: Thank you for the positive feedback.

Joanne Wetch: You're welcome.

Hazeline Roulac: Holley, we'll take one more question.

Operator: Okay. Our final question for the day will come from the line of Rebecca Scott.

Rebecca Scott: Yes. In followup to a previous question about the interest that would be paid back to us, is that going to be locked in with the 66 percent lump sum payment? Or will that be broken out into a different line so that we know that that's just interest that's being paid back to us? Or how would we be able to determine the difference?

Amanda Burd: Thank you, Rebecca. This is Amanda. You will receive one lump sum payment. There will be more information that's provided with the payment spreadsheet. But it will come across in one lump sum payment.

Rebecca Scott: Okay. So, we should – but, on the information that we get, it should tell us what amount is the interest. Is that correct?

Casey Welzant: Correct.

Rebecca Scott: Okay. Thank you.

Additional Information

Hazeline Roulac: Thank you.

So, unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address that's listed on slide 17 of the presentation. If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will place an announcement in the MLN Connects Provider eNews and you will receive and email when these resources are available.

On slide 20 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Also, as mentioned earlier, there will be an update call that will take place on Monday, December the 12th. Registration is now open for this call.

Again, my name is Hazeline Roulac. I would like to thank our presenter and thank you, our participants, for joining us today on this presentation of the 2016 Hospital Appeals Settlement.

Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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