HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM – EXHIBIT A

HOSPITAL ABATEMENT DISTRIBUTION CLAIM FORM DEADLINE: September 30, 2022

I. Claimant Information

Please provide the information in Section I below for the Claimant, which should be the same information provided in Section I of the Claim Form.

A. Name of Operating Entity:	
B. Federal Employer Identification Number:	____ – ________
C. Claimant Number: If you received a Claimant Number after you completed your Registration Form, check the box and provide that four-digit Claimant Number.	☐ ____

II. Hospital/Facility Information

Please provide the following information for the Acute Care hospital/facility owned and/or operated by the above referenced Claimant in Section I above for which a claim is filed. If there is more than one such Acute Care hospital/facility, please complete a separate Exhibit A for EACH Acute Care hospital/facility for which a claim is being filed.

A. Name of Hospital/Facility:			
B. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
C. Duration of Ownership:	Date Acquired/Opened	Date Sold/Closed	
D. Number of Staffed Beds:[1]			

[1] *The number of beds reported from a hospital's most recent Medicare cost report (W/S S-3, Part I, line 7 column 2). Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments,*

E. Claim Number: If you received a Claim Number after you completed your Registration Form, provide that seven-digit Claim Number.	_______

1. Has the Acute Care hospital/facility listed above, as of the date of this Claim Form Exhibit A, provided to the Ad Hoc Group of Hospitals or its agent, substantially all of the Requisite Claims Data relating thereto (as described in #20 herein) to the best of your knowledge?
   ___ Yes ___ No

2. Is the Acute Care hospital/facility listed above listed on the national registry of hospitals maintained by the American Hospital Directory®, as in effect on the Effective Date, and it (a) a non-federal acute care hospital, as defined by CMS, or (b) a non-federal hospital or hospital district that is required by law to provide inpatient acute care and/or fund the provision of inpatient acute care?
   __ Yes __ No

3. Service Area. Please list below the counties that the above-described Acute Care hospital/facility serves that represents at least 75% of the total annual admissions of its hospital/facility in 2021, the population of those counties and the percentage of the total population of those counties served by the hospital/facility. Attach any supporting documents that deemed to be helpful.

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nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."

4. For the Acute Care hospital/facility listed above, please provide the payor mix (% of payor payments to total of all payor payments) as follows:

   a. % Medicare _______%
   b. % Medicaid _______%
   c. % TRICARE _______%
   d. % Commercial, e.g., Blue Cross Blue Shield, other non-governmental payors _______%
   e. % Self-pay _______%
   f. % All Other Payors _______%
   g. Describe the name of each payor that comprises "All Other Payors" ____

      ____

5. Please provide the amounts of funding, if any, received by the Acute Care hospital/facility listed above for the period of January 1, 2009 through October 20, 2020 in each of the following areas:

   a. Grants $____
   b. Taxing authorities $____
   c. Health-care authorities$ ____
   d. State funded programs for indigent care $______________________________
   e. "Disproportionate Share"[2] $______________________________________
   f. Foundations/charities $____
   g. Others $____

[2] *Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients.*

6. List and describe with particularity, all Hospital Authorized Abatement Purposes instituted at the Acute Care hospital/facility listed above that are intended to treat, reduce, abate and prevent opioid addiction. Include in the description below the year(s) such program(s) began; whether they presently remain operational; and, the prospective end date for the program(s), if any. In addition, please provide the extent that any funding received, as described in No. 5 above, was used to pay for the abatement programs described herein.

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7. Prescribing practices:

    a. Did the Acute Care hospital/facility listed above, prescribe the following opioids: (i) Brand Name Medications: OxyContin®, Hysingla ER®, Butrans®, Dilaudid®, Ryzolt, MS Contin®, MSIR®, Palladone®, DHC Plus®, OxyIR®, or OxyFast®; and (ii) the following Generic Medications: oxycodone extended-release tablets, buprenorphine transdermal system, hydromorphone immediate-release tablets, hydromorphone oral solution, tramadol extended release tablets, morphine extended-release tablets, oxycodone immediate-release tablets, oxycodone and acetaminophen tablets (generic to Percocet®), hydrocodone and acetaminophen tablets (generic to Vicodin® or Norco)?___ Yes ___No.

    b. Did the Acute Care hospital/facility listed above provide pain management care in a pain management clinic during the period of January 1, 2009 through October 20, 2020? ___ Yes ___No.
    If yes, please provide the dates for which each of the pain management clinics were in operation.

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8. Is the Acute Care hospital/facility listed above a "safety net" hospital as defined in the CARES ACT?[3] ___ Yes ___No.

    a. If yes, please provide proof of such designation.

9. Is the Acute Care hospital/facility listed above a tertiary referral center? (A hospital provides tertiary healthcare if it provides "*care of a highly technical and specialized nature, in a medical center, usually one affiliated with a university, for patients with unusually severe, complex, or uncommon health problems.*" See Flegel, Ken, Tertiary Hospitals Must Provide General Care (March 3, 2015), Nat'l Ctr. for Biotechnology Information, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4347764).
    ___ Yes ___No.

10. Does the Acute Care hospital/facility listed above perform screening brief intervention referral to treatment ("SBIRT") in the emergency department? _____ Yes _____ No.

11. Does the Acute Care hospital/facility listed above equip emergency departments to treat acute withdrawal and initiate treatment for OUD with medications, including buprenorphine, suboxone, and subutex, etc.? ___Yes ___ No.

12. Does the Acute Care hospital/facility listed above make discharge planning and post-discharge care coordination mandatory for patients with OUD? ___Yes ___No.

13. Does the Acute Care hospital/facility listed above provide bridge programs to encourage access to treatment for patients with OUD? ___ Yes ___ No.

14. Does the Acute Care hospital/facility listed above participate in community efforts to provide OUD treatment to others in the community, such as those in jails, or other detention facilities? ___ Yes ___ No.

15. Does the Acute Care hospital/facility listed above provide transportation to OUD treatment facilities? __Yes ___No.

16. Does the Acute Care hospital/facility listed above implement needle exchange in the hospital or an adjacent clinic and/or provide on-site medication-assisted treatment ("MAT") services? ___Yes ___No.

17. Does the Acute Care hospital/facility listed above use telemedicine, telehealth, and/or teleconsulting to support treatment and to support "spoke" entities? ___Yes ___No.

[3] *A "safety net" hospital has (a) a Medicare Disproportionate Patient Percentage (DPP) of 20.2% or greater; (b) annual uncompensated care (UCC) of at least $25,000 per bed; and (c) profit margin of 3.0% or less.*

18. Does the Acute Care hospital/facility listed above perform heart valve replacements?
___ Yes ___ No.

    a. If yes, please provide the percentage of all heart valve replacements performed that are secondary to opioid addiction. __________%

19. Does the Acute Care hospital/facility listed above have a Neonatal Intensive Care Unit ("NICU") that treats babies with Neonatal Abstinence Syndrome ("NAS")?
___ Yes ___ No.

    a. If yes, does the hospital/facility have a dedicated NAS NICU? ___ Yes ___ No

    b. If yes, does the hospital/facility provide obstetric and perinatal services to treat mothers with OUD? ____Yes ___ No

20. For all inpatient and outpatient discharges during the period January 1, 2009 through October 20, 2020, from the Acute Care hospital/facility listed above, please provide to the SFTP the following data in CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File to be used in connection with the calculation of financial damages. **An example of the data formatting is set forth in Exhibit C**. **This data should be in a separate CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File for each Hospital Opioid Claim**. Physician office visits and non-acute care visits should **NOT** be included in data provided.

    For the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File, please include in the file name the name of the Hospital Opioid Claim, City and State where located and Date Range of Data Provided, for example, PhoenixGeneral-Phoenix-AZ-Jan09-Dec12.csv. If more than one file is provided due to size limitations, each file name will be the same with only the date range of the data provided changing for example, PhoenixGeneral-Phoenix-AZ-Jan13-Dec20.csv

    It is important to note, and as further described below, that the following data for each visit/discharge will need to be repeated on each row corresponding to each different ICD diagnosis code (except for ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority). The data for the ICD diagnosis codes, ICD diagnosis code descriptions and ICD diagnosis code priorities for each visit/discharge will therefore be unique to each row. For example, if a visit has 18 ICD diagnosis codes, there would be 18 rows/lines for that visit/discharge with each line containing a different ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority. For all other data fields, such as Patient Medical Record Number, Date of Discharge, etc., this data will be the same, and thus repeated, on all 18 rows/lines for that visit/discharge.

    To the extent the hospital/facility listed above utilizes a coding system for any columns/data fields, please provide an index to explain the contents of any column/data

field to the SFTP provided by the Trustee. For example, the Patient Type data provided includes a 1, 2, or 3 and these respective contents are 1=Inpatient, 2=Outpatient, 3=Emergency.

Please also ensure that all columns/data fields that may contain commas are updated so that such columns/data fields are placed in quotations when populating the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File. The columns/data fields that often contain commas include, but are not limited to, Attending Physician Name, DRG and ICD Diagnosis Code Descriptions.

Once the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File is prepared, **please review the data VERY CAREFULLY** to confirm the data in each column contains the applicable data for that respective column's data field description. For example, payment amounts (Total Payments) should not be shown in the DRG Code column/data field, ICD Diagnosis Code column/data field should not be blank or designated null for a patient visit without an explanation, etc. This will require, that in conducting your review that you "reality test" your data before submission to ensure that it does not contain obvious errors and inconsistencies. **After submission of the Registration Form, each Claimant will be provided a SFTP by the Trustee to upload an executed BAA (as described in #4 of the Claim Form), and then upload this Requisite Claims Data to the SFTP.**

Requisite Claims Data		
Column	**Data Fields**	**Definitions and Clarifications**
a.	**Name**	Name of hospital/facility for which data is provided.
b.	**Address**	Address of hospital/facility for which data is provided.
c.	**City**	City of hospital/facility for which data is provided.
d.	**State**	State of hospital/facility for which data is provided.
e.	**Zip**	Zip of hospital/facility for which data is provided.
f.	**CMS Certification Number**	Center for Medicare & Medicaid Services Certification Number – Formerly known as the Medicare Provider Number. This should be a six-digit Medicare certification number for which the data is provided.

g.	**Patient Medical Record #**	
h.	**Patient Account #**	
i.	**Payor Financial Class Description**	e.g., Blue Cross, Medicaid, Self Pay, etc.
j.	**Patient Type**	e.g., Inpatient or Outpatient. Hospital related clinics or physician office visits should NOT be included in data provided.
k.	**Custom Patient Type**	e.g., Inpatient Psych, Outpatient Single Visit, Surgery, Lab, etc. Hospital related clinics or physician office visits should NOT be included in data provided.
l.	**Date of Admission**	
m.	**Date of Discharge**	
n.	**Length of Stay (days)**	
o.	**Admission Type Description**	e.g., Emergency, Reservation, Reference Lab, etc.
p.	**Discharge Disposition Description**	e.g., Discharge Home, Nursing Home, Expired, etc.
q.	**Patient Date of Birth**	
r.	**Patient Age at Discharge**	
s.	**Patient Gender**	
t.	**Patient Race**	
u.	**Patient City**	
v.	**Patient State**	
w.	**Patient Zip Code**	

x.	**Attending Physician Name**	
y.	**Total Charges**	
z.	**Total Payments**	Total Payments should only contain actual payments received (e.g., insurance/self-pay). It should NOT include adjustments, bad debt, write-offs or contractual adjustments.
aa.	**DRG Code**	Diagnosis Related Group (DRG) code for each inpatient visit/discharge.
ab.	**DRG Code Description**	DRG Code description for the above DRG Code.
ac.	**All ICD Diagnosis Code**	All International Classification of Disease (ICD) diagnosis codes (ICD-9 or ICD-10, as applicable) associated with each patient visit/discharge. Note: In most instances there should be multiple ICD codes for a patient visit/discharge. Each of these ICD Diagnosis Codes related to each patient's visit should NOT be listed in multiple columns but rather each ICD Code should be listed in the same single column with each ICD Code shown on separate rows within the same single column. See Exhibit C.
ad.	**ICD Diagnosis Code Descriptions**	ICD Diagnosis Code descriptions for the above ICD Diagnosis Codes.
ae.	**ICD Diagnosis Code Priority**	Indicate whether each ICD Diagnosis Code is a Primary, Secondary, Tertiary, etc. diagnosis. These categories must be expressed in terms of a numerical code such as 1=Primary, 2=Secondary, 3=Tertiary, etc.
af.	**Mom's MRN - If applicable**	This field pertains only to Hospital Opioid Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a birth mother, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a baby, then this field should contain the mother's MRN so that there can be a mother/baby link associated therewith.

ag.	**Baby's MRN - If applicable**	This field pertains only to Hospital Opioid Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a baby, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a birth mother, then this field should contain the Baby's MRN so that there can be a mother/baby link associated therewith.

I certify that I am authorized to sign this Claim Form Exhibit A and I understand that an authorized signature on this Claim Form Exhibit A serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Your typed signature and submission of this Claim Form will have the same force and effect as if you signed the Claim Form on paper, which you may do alternatively.

Signature: ____

Executed on date: (MM/DD/YYYY) _________________________________

Print the name of the person who is completing and signing this Claim Form Exhibit A.

Name (First, Middle, Last): ____

Title: ____

Hospital: ____

Address: ____

____

Contact phone: (________) – ________ – ______________

Email: ____