OPTIMISTIC
TRANSFORMING CARE

Practitioner Letter of Intent template: Payment Only

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This Letter of Intent (LOI) states my agreement to participate with the Indiana University OPTIMISTIC project in response to the CMS Innovations Center and CMS Medicare-Medicaid Coordination Office funding opportunity: The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents - Payment Reform (CMS-1E1-16-001).

As an eligible provider in a nursing facility participating in this initiative, if approved by CMS, I understand I will be able to utilize new billing codes when caring for eligible long stay (greater than 100 days in the facility) residents in the facility when assessing an acute change in condition suspected to be one of the six target conditions of the initiative. These codes may be billed during the project period – October 1st 2016-October 1st 2020 with agreements renewed annually.

I agree to:

- Make the best available decisions for care for patients at all times regardless of payments received through the initiative;
- Participate in trainings related to this initiative, via the OPTIMISTIC Learning Community;
- Adhere to CMS requirements and qualifying criteria related to the billing codes, including use exclusively for the target population;
- Respond to requests from CMS or its contractors for the purposes of oversight, monitoring or evaluation , e.g. - participation in conference calls, data sharing, or chart reviews; and to
- Communicate promptly any changes to my information to OPTIMISTIC, e.g.- change of practice ownership, change in NPI number.

Please check the box below if applicable:

☐ I use an ONC-certified HER

☐ I use an electronic system for care planning or the creation and exchange of transition of care documents.

I attest that I have had an average panel of at least 7 long stay Medicare beneficiaries in the participating facility over the past 6 months. I am in good standing and have received no sanctions related to fraudulent billing in the past 3 years. I am committed to maintaining the above criteria throughout the initiative.

_____ _____ _____

Signature of practitioner Date Facility name

Practitioner Legal name			
Practitioner National Provider Identification (NPI) number			
Practitioner Tax Identification Number (TIN)			
Practitioner Email		**Practitioner Phone**	
Practitioner- # OPTIMISTIC eligible residents (min. 7 residents)			
*Name of Practice Group Administrator			
*Practice Group Administrator Email		*Practice Group Administrator Phone	

BOLD Denotes required fields

*If no practice group administrator, please include name of billing contact information