

Financial Guidance

UPDATED INFO

See yellow highlights for updated content from previous published version.

Background

Accelerated/Advance Payments

Accelerated and Advance Medicare payments provide emergency funding and addresses cash flow issues based on historical payments when there is disruption in claims submission and/or claims processing. These expedited payments are typically offered in natural disasters to accelerate cash flow to the impacted health care providers

To qualify for Accelerated or Advance Medicare payments, the provider or supplier must:

1. Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form,
2. Not be in bankruptcy,
3. Not be under active medical review or program integrity investigation, and
4. Not have any outstanding delinquent Medicare overpayments.

Medicare started accepting and processing the Accelerated/Advance payment requests immediately.

Each MAC worked to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these Accelerated/Advance payments begins at 90 days; however, for the purposes of the COVID-19 pandemic, CMS extended the repayment of these Accelerated/Advance payments to begin 120 days after the date of issuance of the payment.¹

On April 26, the Centers for Medicare & Medicaid Services (CMS) announced that it is reevaluating the amounts that will be paid under its **Accelerated** Payment Program and **suspending its Advance Payment Program to Part B suppliers** effective immediately. The agency made this announcement following the successful payment of over \$100 billion to health care providers and suppliers through these programs and in light of the \$175 billion recently appropriated for health care provider relief payments.²

Beginning Monday, April 27, 2020 CMS **will not be accepting any new applications** for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments in light of historical direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund.

and suppliers. CMS expanded the program for all Medicare providers throughout the country during the public health emergency related to COVID-19. The payments could be requested by hospitals, doctors, durable medical equipment suppliers and other Medicare Part A and Part B providers and suppliers.

See the nThrive update regarding the **Provider Relief Fund** at <https://www.nthrive.com/covid19>.

Providers can get more information at: <https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf>

Medicare Appeals in Fee for Service, Medicare Advantage (MA) and Part D

1. CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs), to allow extensions to file an appeal.
2. CMS is allowing MACs and QICs in the FFS program and the Part C and Part D IREs to waive requirements for timeliness for requests for additional information to adjudicate appeals; MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if:
 - a. The enrollee requests the extension;
 - b. The extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or
 - c. The extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest.
3. CMS is allowing MACs and QICs in the FFS program and MA and Part D plans, as well as the Part C and Part D IREs to process an appeal even with incomplete Appointment of Representation forms. However, any communications will only be sent to the beneficiary.
4. CMS is allowing MACs and QICs in the FFS program and MA and Part D plans, as well as the Part C and Part D IREs to process requests for appeal that don't meet the required elements using information that is available.

5. CMS is allowing MACs and QICs in the FFS program and MA and Part D plans, as well as the Part C and Part D IREs, to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Medical Review

CMS has suspended most Medicare Fee-For-Service (FFS) medical review during the emergency period due to the COVID-19 pandemic. This includes pre-payment medical reviews conducted by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate program, and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC).

No additional documentation requests will be issued for the duration of the PHE for the COVID-19 pandemic. Targeted Probe and Educate reviews that are in process will be suspended and claims will be released and paid. Current post payment MAC, SMRC, and RAC reviews will be suspended and released from review. This suspension of medical review activities is for the duration of the PHE. However, CMS may conduct medical reviews during or after the PHE if there is an indication of potential fraud.

Changes to MIPS

CMS is making two updates to the Merit-based Incentive Payment System (MIPS) in the Quality Payment Program. CMS is modifying the MIPS Extreme and Uncontrollable Circumstances policy to allow clinicians who have been adversely affected by the COVID-19 public health emergency to apply and request reweighting of the MIPS performance categories for the 2019 performance year. This is an important change that allows clinicians who have been impacted by the COVID-19 outbreak and may be unable to submit their MIPS data during the current submission period, to request reweighting and potentially receive a neutral MIPS payment adjustment for the 2021 payment year.

Additionally, CMS is adding one new Improvement Activity for the CY 2020 performance year that, if selected, would provide high-weighted credit for clinicians within the MIPS Improvement Activities performance category. Clinicians will receive credit for this Improvement Activity by participating in a clinical trial utilizing a drug or biological product to treat a patient with COVID-19 and then reporting their findings to a clinical data repository or clinical data registry. This would help contribute to a clinicians overall MIPS final score, while providing important data to help treat patients and address the current COVID-19 pandemic.

Resident Time at Alternate Locations

Existing regulations have specific rules on when a hospital may count a resident for purposes of Medicare direct graduate medical education (DGME) payments or indirect medical education (IME) payments. Currently, if the resident is performing activities with the scope of his/her approved program in his/her own home, or a patient's home, the hospital may not count the resident.

A hospital that is paying the resident's salary and fringe benefits for the time that the resident is at home or in a patient's home, but performing duties within the scope of the approved residency program and meets appropriate physician supervision requirements can claim that resident for IME and DGME purposes. This allows medical residents to perform their duties in alternate locations, including their home or a patient's home so long as it meets appropriate physician supervision requirements.³

Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission

CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. CMS is currently granting an extension for data submission for hospitals nationwide affected by COVID-19 until August 3, 2020. If hospitals encounter difficulty meeting this extended deadline date, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Cost Reporting

CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. CMS is currently authorizing delay for the following fiscal year end (FYE) dates.

1. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020.
2. The extended cost report due dates for these October and November FYEs will be June 30, 2020.
3. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020.
4. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020.

Several FAQ released on August 26, 2020 provided direction for filing the cost report including the guidance provided below. The FAQ may be accessed at (Page 98): <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

Question: How will the Provider Relief Fund (PRF) payments be reported on the Medicare Cost Report in terms of revenue?

Answer: All providers must report the PRF payments on the cost report's statement of revenues for informational purposes. The revenue amount must be identified as COVID-19 PHE PRF. PRF payment amounts must be reported in aggregate on the following forms:

- ✓ Hospital, form CMS-2552-10, Worksheet G-3, line 24.50;
- ✓ Skilled Nursing Facility, form CMS-2540-10, Worksheet G-3, line 24.50;
- ✓ HHA, form CMS-1728-94, Worksheet F-1, line 31.50;
- ✓ Hospice, form CMS-1984-14, Worksheet F-2, column 3, line 16.50;
- ✓ ESRD, form CMS-265-11, Worksheet F-1, line 31.50;
- ✓ FQHC, form CMS-224-14, Worksheet F-1, line 28.50; and
- ✓ CMHC, form CMS-2088-17, Worksheet F, line 20.50.

Question: Should PRF payments offset expenses on the Medicare cost report?

Answer: No, providers should not adjust the expenses on the Medicare cost report based on PRF payments received. However, providers must adhere to HRSA's guidance regarding appropriate uses of PRF payments, in order to ensure that the money is used for permissible purposes (namely, to prevent, prepare for, or respond to coronavirus, and for health care related expenses or lost revenues that are attributable to coronavirus) and that the uses of the PRF payments do not violate the prohibition on using PRF money to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Recipients may find additional information on the terms and conditions of the PRF at <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html>. Questions regarding use of the funds, pursuant to the Fund Terms and Conditions and any questions about overpayments should be directed to HRSA.

Guidance

1. Review guidelines and waivers for appeals and pending medical reviews and modify or suspend activities as needed.
2. Assess impact of changes to MIPS and Resident time calculations.
3. Note delayed dates for submission of Wage Index Occupational Mix and Cost Reporting data.
4. Review all guidance regarding submission of cost reports and submit accordingly.



Sources

1. <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>
2. CMS MLN Connects, Special Edition, April 27, 2020.
3. <https://www.cms.gov/files/document/covid-teaching-hospitals.pdf> ■