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Official CMS news from the Medicare Learning Network®

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News

CMS Approves Approximately \$34 Billion for Providers with the Accelerated/Advance Payment Program for Medicare Providers in One Week

The Centers for Medicare & Medicaid Services (CMS) has delivered nearly \$34 billion in the past week to the health care providers on the frontlines battling the 2019 Novel Coronavirus (COVID-19). The funds have been provided through the expansion of the Accelerated and Advance Payment Program to ensure providers and suppliers have the resources needed to combat the pandemic.

“Health care providers are making massive financial sacrifices to care for the influx of coronavirus patients,” said CMS Administrator Seema Verma. “Many are rightly complying with federal recommendations to delay non-essential elective surgeries to preserve capacity and personal protective equipment. They shouldn’t be penalized for doing the right thing. Amid a public health storm of unprecedented fury, these payments are helping providers and suppliers – so critical to defeating this terrible virus – stay afloat.”

The streamlined process implemented by CMS for COVID-19 has reduced processing times for a request of an accelerated or advance payment to between four to six days, down from the previous timeframe of three to four weeks. In a little over a week, CMS has received over 25,000 requests from health care providers and

suppliers for accelerated and advance payments and have already approved over 17,000 of those requests in the last week. Prior to COVID-19, CMS had approved just over 100 total requests in the past five years, with most being tied to natural disasters such as hurricanes.

The payments are available to Part A providers, including hospitals, and Part B suppliers, including doctors, non-physician practitioners, and durable medical equipment (DME) suppliers. While most of these providers and suppliers can receive three months of their Medicare reimbursements, certain providers can receive up to six months.

The CMS Accelerated and Advance Payment Program is funded from the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) trust funds, which are the same funds used to pay out Medicare claims each day. The advance and accelerated payments are a loan that providers must pay back. CMS will begin to apply claims payments to offset the accelerated/advance payments 120 days after disbursement. The majority of hospitals including inpatient acute care hospitals, children's hospitals, certain cancer hospitals, and critical access hospitals will have up to one year from the date the accelerated payment was made to repay the balance. All other Part A providers and Part B suppliers will have up to 210 days to complete repayment of accelerated and advance payments, respectively.

It is important to note, this funding is separate from the \$100 billion provided in the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The CARES Act appropriation is a payment that does not need to be repaid. The Department of Health and Human Services (HHS) will be providing additional information on how health care providers and suppliers can access CARES Act funds in the coming weeks.

The fact sheet on the accelerated/advance payment process and how to submit a request can be found here: [Fact Sheet](#). Providers can also contact their Medicare Administrative Contractor for any questions.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the [Current Emergencies Website](#).

COVID-19: Dear Clinician Letter

CMS posted a letter to clinicians that outlines a summary of actions CMS has taken to ensure clinicians have maximum flexibility to reduce unnecessary barriers to providing patient care during the unprecedented outbreak of COVID-19. The summary includes information about telehealth and virtual visits, accelerated and advanced payments, and recent waiver information.

[Letter](#)

COVID-19: Non-Emergent, Elective Medical Services and Treatment Recommendations

CMS recently updated recommendations to postpone non-essential surgeries and other procedures to conserve critical health care resources and limit exposure of patients and staff to COVID-19. Developed in collaboration with medical societies and associations, the recommendations outline a tiered approach for state and local officials, clinicians, and delivery systems to consider to prioritize services and care to those who require emergent or urgent attention to save a life, manage severe disease, or avoid further harms from an underlying condition.

[Recommendations](#)

Quality Payment Program: MIPS Extreme and Uncontrollable Circumstances Policy in Response to COVID-19

CMS is offering multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. In addition to extending the 2019 Merit-based Incentive Payment System (MIPS) data submission deadline to April 30 at 8 pm ET, the MIPS automatic extreme and uncontrollable circumstances policy will apply to MIPS eligible clinicians who do not submit their MIPS data by the April 30 deadline.

If you are a MIPS eligible clinician and do not submit any MIPS data by April 30, you will not need to take any additional action to qualify for the automatic extreme and uncontrollable circumstances policy. You will be automatically identified and will receive a neutral payment adjustment for the 2021 MIPS payment year. Note: We updated the [Participation Status Tool](#), so you can see if the policy is automatically applied.

We are also reopening the [MIPS extreme and uncontrollable circumstances application](#) for individuals, groups, and virtual groups. An application submitted by April 30, citing COVID-19 will override any previous data submission.

For More Information:

- [Quality Payment Program COVID-19 Response Fact Sheet](#)
- Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Multi-Factor Authentication Requirement Delayed for PECOS, I&A, and NPPES

In an effort to reduce provider burden, CMS delayed Multi-Factor Authentication (MFA) requirements for the following systems:

- Provider Enrollment, Chain, and Ownership System (PECOS): MFA is delayed until further notice.
- Identity and Access Management System (I&A): You have a 360-day grace period to set up MFA after your first login. By September 30, 2021, you are required to use MFA to successfully access the system. Set up the appropriate surrogacy and employer connections to ensure access.
- National Plan and Provider Enumeration System (NPPES): You have a 360-day grace period to set up MFA after your first login. By September 30, 2021, you are required to use MFA to successfully access the system.

Open Payments: Pre-Publication Review and Dispute through May 15

Open Payments Pre-Publication Review and Dispute is available through May 15. During this time, [covered recipients](#) can review and if necessary dispute their attributed data prior to the annual Open Payments data publication:

- Register in the Open Payments System; see the [Registration Quick Reference Guide](#)
- Participation is voluntary and not required under the statute

Review and dispute actions can be completed within the Open Payments system through December 31, 2020:

- Disputes initiated by the May 15 deadline will be reflected in the June 2020 data publication
- Disputes initiated after the pre-publication review and dispute period will be reflected in a later system data refresh

Open Payments COVID-19 Update:

- CMS cannot extend the pre-publication review and dispute period, but covered recipient review and dispute actions can be completed within the Open Payments system throughout the calendar year.
- We understand the health care community is working tirelessly to respond to the COVID-19 pandemic and appreciate the dedication of health care providers during this time. We remain committed to ensuring covered recipients are aware of and take advantage of their opportunity to review their data and dispute it if needed.
- Read the [Open Payments Pre-Publication Review and Dispute COVID-19 Announcement](#).

Claims, Pricers & Codes

Pneumococcal Pneumonia Vaccination: Eligibility Transactions Includes DOS Starting April 13

Starting April 13, CMS beneficiary eligibility transactions will return the Pneumococcal Pneumonia Vaccination (PPV) Date(s) of Service (DOS) for HCPCS codes 90670 and 90732 when a beneficiary has already received the service. Eligibility transactions will also return the related National Provider Identifier (NPI): Institutional NPI for Part A or rendering NPI for Part B to help you better coordinate care. See the [MLN Matters Article](#) for more information.

Events

Ground Ambulance Organizations: Data Collection for Medicare Providers Call — May 7

Thursday, May 7 from 2 to 3 pm ET

[Register](#) for Medicare Learning Network events.

During this call, learn how to allocate costs, collect data, and report data for the new Ground Ambulance Data Collection System.

A question and answer session follows the presentation; however, you may email questions in advance to AmbulanceDataCollection@cms.hhs.gov with “May 7 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call. For more information, including ground ambulance organizations selected for the first round of reporting, see the [Ambulances Services Center](#) webpage, CY 2020 Physician Fee Schedule [final rule](#), and [Bipartisan Budget Act of 2018](#).

Target Audience: Ground ambulance organizations that are Medicare providers, including hospitals, critical access hospitals, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and hospices.

MLN Matters® Articles

Supplier Education on Use of Upgrades for Multi-Function Ventilators

A new MLN Matters Special Edition Article SE20012 on [Supplier Education on Use of Upgrades for Multi-Function Ventilators](#) is available. Find out how you can bill for multi-function ventilators described by code E0467 as an upgrade in situations where beneficiaries only meet the coverage criteria for a ventilator.

Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised

A revised MLN Matters Article MM11632 on [Second Update to CR 11152 Implementation of the Skilled Nursing Facility \(SNF\) Patient Driven Payment Model \(PDPM\)](#) is available. Learn about corrected edits to allow proper adherence to Medicare's interrupted stay policy.

Publications

Civil Rights, HIPAA, and COVID-19

HHS published a bulletin on [Civil Rights, HIPAA, and the Coronavirus Disease 2019 \(COVID-19\)](#) to ensure that entities covered by civil rights authorities keep in mind their obligations under laws and regulations that prohibit discrimination on the basis of race, color, national origin, disability, age, sex, and exercise of conscience and religion in HHS-funded programs.

Medicare Advance Written Notices of Noncoverage — Revised

A revised [Medicare Advance Written Notices of Noncoverage](#) Medicare Learning Network Booklet is available. Learn how to:

- Complete the forms
- Collect payment

Medicare Preventive Services — Revised

A revised [Medicare Preventive Services](#) Medicare Learning Network Educational Tool is available. Learn about:

- Coding
- Coverage
- Copayment/coinsurance and deductible

Medicare Preventive Services Poster — Revised

A revised [Medicare Preventive Services Poster](#) Medicare Learning Network Educational Tool is available. Get quick-reference information for your billing office.

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