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Medicare Accelerated and Advance Payments and COVID-19: Frequently Asked Questions

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SUMMARY

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Medicare Accelerated and Advance Payments and COVID-19: Frequently Asked Questions

In rare situations, Medicare Part A providers (e.g., acute care hospitals, skilled nursing facilities, and other inpatient care facilities) and Part B suppliers (e.g., physicians, nonphysician practitioners, durable medical equipment [DME] suppliers, and others who furnish outpatient services) face cash flow challenges due to specified circumstances beyond their control. Under such circumstances, the Centers for Medicare & Medicaid Services (CMS) can provide temporary relief through the accelerated payment program (Part A) and the advance payment program (Part B). CMS has offered these programs, collectively referred to as the Accelerated and Advance Payment (AAP) programs, in an attempt to alleviate some concerns about the financial challenges faced by Medicare suppliers and providers. These amounts eventually are recovered by Medicare, typically by withholding payment for subsequent claims up to the amount of the accelerated or advance payments.

Although the AAP programs have been used selectively since their inception during the 1980s, during the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), CMS and Congress initially expanded eligibility for these programs and modified other terms. This included changing the allowable payment amounts, the schedule for recovery of payments, and the determination of interest payments, when applicable. In response to enactment in March and April 2020 of relief funds to assist providers and suppliers during the COVID-19 PHE—$100 billion in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136) and $75 billion in the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA; P.L. 116-139)—CMS ceased accepting new applications for advance payments, stating that it was reevaluating new and pending applications for accelerated payments. As of December 9, 2020, $107.3 billion had been paid under the AAP programs in calendar year 2020 and during the COVID-19 PHE. Of that amount, nearly $99 billion was paid to Medicare Part A providers (e.g., hospitals) and $8.5 billion to Part B suppliers (e.g., physicians).

This report addresses frequently asked questions about the Medicare AAP programs, including the terms and conditions of eligibility, payment amounts and sources of funds, recovery of payments, applicable interest charges, and administrative and legislative changes during the COVID-19 PHE.

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Overview

In rare situations, Medicare Part A providers (e.g., acute care hospitals, skilled nursing facilities, and other inpatient care facilities) and Part B suppliers (e.g., physicians, nonphysician practitioners, durable medical equipment [DME] suppliers, and others who furnish outpatient services) face cash flow challenges due to specified circumstances beyond their control.[1] Under these circumstances, the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—can provide temporary relief through the accelerated payment program (Part A) and the advance payment program (Part B). Although these programs, collectively referred to as the Accelerated and Advance Payment (AAP) programs, have been in existence for decades, they rarely have been used. With the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), CMS made AAP programs available in an attempt to alleviate some concerns about the financial challenges faced by Medicare suppliers and providers.[2]

Typically, providers and suppliers submit claims for services furnished to program beneficiaries through private contractors—known as Medicare Administrative Contractors (MACs)—that formally process the claims and perform related administrative services for the program's beneficiaries and health care providers and suppliers. Among many other functions, MACs verify, pay, and collect any overpayments made for claims submitted by providers and suppliers for services furnished.[3]

A provider or supplier may request from a MAC a Medicare AAP when experiencing cash flow problems that result from (1) a provider or supplier temporarily unable to submit Medicare claims for payment or (2) a MAC unable to process claims for payment.[4] The Secretary of the U.S. Department of Health and Human Services (HHS Secretary) has authority to make AAPs broadly available, subject to certain conditions.

AAPs are not add-on or extra payments or loans. An AAP is an up-front payment secured by expected future claims for payment. Therefore, when a provider submits claims for payment after receiving an AAP, Medicare does *not* pay the claims. Rather, the dollar amount of the claims for payment is applied to recover the balance of the AAP.[5] This occurs until the full amount of the AAP is *recovered* by Medicare (i.e., the dollar amount of claims submitted after the provider or supplier received an accelerated or advance payment equals the amount of the accelerated or advance payment). If Medicare does not fully recover the amount of the accelerated or advance payment during the applicable repayment period, interest is assessed on the unrecovered amount, as this balance would be treated as a debt to the federal government.

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[1] Generally, cash flow for providers and suppliers refers to the outflow of money (cash and cash-equivalents) for expenses (e.g., payroll, rent/mortgage, equipment, insurance) and inflow of revenue (e.g., payments received from insurers, patients).

[2] The Secretary of Health and Human Services declared a public health emergency due to COVID-19 on January 31, 2020, under the authority of §319 of the Public Health Service Act.

[3] For more information about Medicare Administrative Contractors (MACs), see Centers for Medicare & Medicaid Services (CMS), "What is a MAC," at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.

[4] CMS, "Chapter 3–Overpayments," §150, in *Medicare Financial Management Manual*, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.

[5] Medicare recovers outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. See CMS, *Medicare Program Integrity Manual Exhibits*, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83exhibitspdf.pdf.

This report addresses frequently asked questions about the Medicare AAP programs, including the terms and conditions of eligibility, sources of funds, recovery of payments, applicable interest charges, and administrative and legislative changes made during the COVID-19 PHE.

Accelerated and Advance Payment Program Basics

What Are the Medicare AAP Programs?

Under the Medicare AAP programs, CMS makes payments before a Medicare provider or supplier submits a claim (i.e., bills) for services furnished to Medicare patients.[6] The payments are made up-front for expected future claims by a provider or supplier.[7] The *accelerated* payment refers to payment made to Part A providers, such as hospitals and other institutional providers; the *advance* payment refers to payment made to Part B suppliers, such as physicians and other practitioners.

Accelerated Medicare Part A payments to eligible hospitals experiencing cash flow problems were first authorized by the Omnibus Budget Reconciliation Act of 1986 (OBRA 86; P.L. 99-509), passed on October 21, 1986. OBRA 86, Part 2, Section 9311(a)(1) amended the Social Security Act (SSA) by adding Section 1815(c)(3), which gives the HHS Secretary authority to "make available appropriate accelerated payments." See 42 C.F.R. §413.64(g) for the regulations for the accelerated payment program for Medicare Part A providers.

Regulations to govern advance payments to Medicare Part B suppliers, which provide outpatient services (including physicians and other practitioners),[8] were first established in 1996 to "address deficiencies noted by the General Accounting Office in its report analyzing current procedures for making advance payments."[9] CMS cites SSA, Section 1842(c), "Prompt Payment of Claims," as the statutory basis for establishing the advance payment program under Part B.[10]

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[6] Some eligible providers—including certain hospitals, inpatient psychiatric facilities (IPF), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and skilled nursing facilities (SNFs)—may elect to not be paid on a claim-submitted basis; rather, they may elect to be paid under the Medicare Periodic Interim Payments (PIPs) method. PIPs involve flat payments to providers made on a fixed interval, such as every two weeks. The flat payment amount is determined based on an estimate of a provider's costs of providing inpatient services to Medicare beneficiaries. PIPs permit eligible providers to receive predictable Medicare payment amounts on a reliable schedule. CMS reconciles PIPs made with actual claims submitted after the close of the provider's fiscal year using the annual cost report. For more details about PIP-eligible providers and PIP payments, see 42 C.F.R §413.64(h) and CMS, "Chapter 1–General Billing Requirements," §80.4, in *Medicare Claims Processing Manual*.

[7] Per 42 C.F.R. §421.214(f)(3), "A carrier [now called Medicare Administrative Contractors (MACs)] must recover an advance payment by applying it against the amount due on the claim on which the advance was made. If the advance payment exceeds the Medicare payment amount, the carrier must apply the unadjusted balance of the advance payment against future Medicare payments due the supplier."

[8] 42 C.F.R. §421.214.

[9] The General Accounting Office (GAO) noted that advance payments to Part B providers in 1988 were made "without clear, specific authority to do so" and recommended that HCFA (the Health Care Financing Administration, the precursor to CMS) issue regulations concerning advance payments under Part B. See GAO, *Medicare: HCFA Should Improve Internal Controls Over Part B Advance Payments*, GAO/HRD-91-81, April 1991. In 2004, GAO's legal name changed from the General Accounting Office to the Government Accountability Office.

[10] See U.S. Department of Health and Human Services (HHS), "Medicare Program; Part B Advance Payments to Suppliers Furnishing Items or Services Under Medicare Part B," 61 *Federal Register* 49271, September 19, 1996.

How Are Medicare AAPs Different from Typical Medicare Part A and Part B Payments?

Under Part A and Part B, Medicare typically pays a provider or supplier *after* it has furnished a service and submitted a claim for payment to Medicare.[11] Providers and suppliers have processes and schedules for submitting claims (i.e., billing cycles). Claims are processed and paid by a MAC on behalf of Medicare and CMS. MACs also have processes and timelines by which they review and pay claims.[12]

An accelerated or advance payment occurs *before* a provider or supplier has furnished the service(s) and submitted a claim for payment. Such payments are made only after receiving a request from a provider or supplier and after approval by CMS when a (1) provider or supplier experiences a temporary delay in its typical billing cycle, or (2) MAC experiences a delay in processing and paying Medicare claims. If these delays lead to financial or cash flow difficulties for a provider or supplier, it may request an accelerated or advance payment from the MAC.

How Common Are AAPs?

Although statutory authority for accelerated payments was enacted in 1986 and regulations for advance payments were issued in 1996, CMS has not made historical data available about the programs. However, CMS recently stated that it had approved 100 AAP requests prior to 2020.[13]

The AAP programs are intended to be used in highly exceptional situations.[14] These situations consist of the following:

- a delay in payment by a MAC that has caused financial difficulties for the provider;
- a temporary delay incurred in the provider's bill processing beyond the provider's normal billing cycle; or
- where CMS deems an accelerated payment is appropriate.[15]

AAP Eligibility, Terms, and Conditions

What Types of Providers and Suppliers Are Eligible for Medicare AAPs?

By regulation, hospitals paid under a Medicare prospective payment system (PPS) are eligible for accelerated payments, subject to meeting certain qualifications. These hospitals are

[11] Note that some providers are paid under a PIPs basis as described under "What Are the Medicare AAP Programs?"

[12] For example, prompt pay requirements. See Social Security Act, §1816(b)(ii)(V).

[13] CMS, "CMS Approves Approximately $34 Billion for Providers with the Accelerated/Advance Payment Program for Medicare Providers in One Week," press release, April 7, 2020, at https://www.cms.gov/newsroom/press-releases/cms-approves-approximately-34-billion-providers-acceleratedadvance-payment-program-medicare.

[14] For example, see CMS, "Chapter 3–Overpayments," §150, in *Medicare Financial Management Manual*, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.

[15] "Chapter 3–Overpayments," §150, in *Medicare Financial Management Manual*.

- short-term acute care hospitals paid under the inpatient prospective payment system (IPPS);
- inpatient psychiatric facilities;
- long-term care hospitals; and
- inpatient rehabilitation facilities.[16]

Also, skilled nursing facilities (SNFs) paid under the SNF PPS, home health agencies, and hospice agencies are eligible for accelerated payments.[17]

Under Part B, all qualified suppliers are eligible to request advance payments.

There are exceptions to the aforementioned providers and suppliers' eligibility for AAPs. These exceptions are addressed in the, "Are There Conditions Under Which Providers or Suppliers Could Not Qualify to Receive AAPs?" section.

What Are the AAP Qualification Criteria?

To qualify for accelerated or advance payments, an eligible provider or supplier must meet each of the conditions listed below. The provider's or supplier's impaired cash position or financial difficulty

- leads to the inability to meet current financial obligations;
- is due to (1) abnormal delays in Medicare claims processing or payment by the MAC or (2) isolated and temporary delays in a provider's or supplier's billing;[18]
- would not be alleviated by cash receipts expected within 30 days;
- is due specifically to a lag in Medicare billing or payments, not to other payers; and
- the provider or supplier assures that AAP repayment will be made according to established time frames and processes.[19]

Are There Conditions Under Which Providers or Suppliers Could Not Qualify to Receive AAPs?

For Part A providers, the regulations for the hospital accelerated payments program are set forth in 42 C.F.R. §413.64(g).[20] For Part B suppliers, 42 C.F.R. §421.214 sets the requirements and procedures for the issuance and recovery of advance payments. Medicare may *not* make AAPs to any provider or supplier that

- is in bankruptcy;

[16] 42 C.F.R. §§412.116(f), 412.432(e), 412.541(f), and 412.632(e).

[17] 42 C.F.R. §§413.64(g), 413.350(d), and 418.307.

[18] In this instance, the provider or supplier must assure and demonstrate that the causes of its billing delays are being corrected and are not chronic.

[19] For example, see CMS, "Chapter 3–Overpayments," §150.3, in *Medicare Financial Management Manual*, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.

[20] For further details, see "Chapter 3–Overpayments," in *Medicare Financial Management Manual*, p. 53.

- is under Medicare active medical review or a program integrity investigation;[21]
- is delinquent in repaying a Medicare overpayment;[22] or
- has not submitted Medicare claims in the preceding 180 days.[23]

AAP Requested Amounts and Source of Funds

How Much Can Providers and Suppliers Receive in AAPs?

Typically, the amount of accelerated or advance payments available to providers and suppliers is based on the recent history (90 days) of Medicare claims. For providers, CMS determines the amount that is "sufficient to alleviate the impaired cash position," not to exceed 70% of the applicable Medicare claims. For suppliers, it is up to 80% of applicable Medicare claims amount.

What Is the Source of AAP Funding?

Funds to pay Medicare claims, including AAPs, come from the Hospital Insurance (HI) Trust Fund for Part A services and the Supplementary Medical Insurance (SMI) Trust Fund for Part B services (collectively, Medicare trust funds). The Medicare trust funds are financial accounts in the U.S. Treasury into which all income to Medicare is credited and from which all benefits and associated administrative costs are paid.[24] An AAP is a payment Medicare makes to a provider or supplier up-front for anticipated claims the provider or supplier would submit for Medicare payment in the future. Thus, an AAP is not an added "cost" to the Medicare program and does not change total program expenditures, but it does modify the timing of the payment.

How Do AAPs Affect the Medicare Trust Funds?

Long-term Medicare trust fund balances should not be affected as a result of AAPs, short of failures to recover any payments. Typically, Medicare pays claims after a provider or supplier has furnished a service and submitted a claim for payment. An AAP is made before a claim for payment is submitted to or processed by Medicare. In either case, the payment is made from the

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[21] *Medical review* is the collection of information and clinical review of medical records by MACs to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. For further information, see CMS, "Medical Review and Education" at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review. A Medicare program integrity investigation encompasses a number of analytic and investigative activities to detect suspected fraud, waste, or abuse.

[22] *Delinquent* means a debt that (1) has not been paid in full by a date specified in a federal agency's written notice, unless other payment arrangements have been made, or (2) at any time thereafter, the debtor defaults on a repayment agreement. See CMS, "Chapter 4–Definition of Delinquent Debt," §70.4, in *Medicare Financial Management Manual*, at https://www.cms.gov/files/document/chapter-4-debt-collection.pdf. Per "Chapter 3–Overpayments," §150, in the manual, "Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations."

[23] Providers' and suppliers' historical Medicare claims are the basis for determining the amount of an accelerated or advance payment. (See 42 C.F.R. §421.214(c)(1), and the "How Much Can Providers and Suppliers Receive in AAPs?" section.) If a provider or supplier has not submitted Medicare claims during the applicable period, the MAC has no basis on which to determine the AAP amount. Providers or suppliers that accept assignment agree to accept Medicare payment amounts as payment in full for Medicare-covered services (including applicable Medicare co-pays and deductibles).

[24] For an overview of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds and their revenue sources, see CRS Report R43122, *Medicare Financial Status: In Brief*.

appropriate Medicare trust fund. When a provider or supplier that has received an accelerated or advance payment subsequently submits a claim for Medicare payment, Medicare does not pay the claim but "offsets" the amount of any new claim (and future claims) until the amount of the accelerated or advance payment has been recovered (i.e., repaid).

In the short run, AAPs may temporarily increase Medicare trust fund expenditures, essentially by paying now for costs that would be incurred in the future. However, future trust fund expenditures would be expected to be lower, as payouts for claims for those future costs would not be made. In other words, the total amounts paid from the Medicare trust funds would be expected to be the same, but the timing of the payouts may shift from one time period (e.g., from a later year) to another (e.g., to an earlier year). If the AAPs are not fully offset, such as when providers or suppliers no longer bill Medicare for claims after receiving AAPs and pending any ongoing recoupment efforts, the trust fund balances would be reduced by such amounts. However, as noted above, AAPs typically represent a relatively small percentage of total Medicare expenditures for provider and supplier services, and thus, if not completely offset, the impact on the trust funds would be correspondingly small.

AAP Recovery, Repayment, and Recoupment

How Are AAPs Recovered?

The amount of accelerated or advance payments paid to a provider or supplier is *recovered* by CMS either initially through *repayment*, typically by holding payment for claims to offset up to the accelerated or advanced amount or, subsequently, by *recouping* from the provider or supplier the overpayment (i.e., the excess of payments made over claims submitted, where interest is applied on the overpayment).[25] Initially, CMS withholds 100% of the provider's or supplier's Medicare payments that are due to the provider or supplier during a specified period after receiving an AAP. This period is referred to as the "repayment period." If the full amount of the accelerated or advance payment is not recovered during the repayment period—through withholding or direct payment—the balance is considered "delinquent and is recouped as described below"[26]

How and When Does AAP Repayment Begin?

Typically, repayment begins immediately after a provider or supplier has received the AAP. All providers and suppliers are required to repay in full within *90 days* from the date of the accelerated or advance payment.[27]

What Happens If the Full AAP Is Not Repaid During the Repayment Period?

Any unrecovered amount remaining after the 90-day repayment period elapses is considered "delinquent" and is treated like a Medicare overpayment to be recouped. A delinquent amount is

[25] Providers and suppliers also may repay AAPs by making a direct payment(s).

[26] CMS, "Chapter 3–Overpayments," §150.3, in *Medicare Financial Management Manual*, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.

[27] "Chapter 3–Overpayments," §150.3, in *Medicare Financial Management Manual*.

subject to federal debt collection processes that include interest charges and referral to the U.S. Department of the Treasury (Treasury) for collection action.[28] When a Medicare delinquent balance exists, the MAC is to send an initial demand letter to the provider or supplier to recoup the outstanding balance. The demand letter notifies the provider or supplier that the remaining balance is due, provides the due date (30 days after the date of the initial demand letter), and includes information about applicable interest charges on the outstanding balance. (See the "Interest Charges" section for details about interest charges.) The letter also gives the provider or supplier the option to set an alternative, acceptable payment arrangement if unable to make payment in full under the terms specified in the letter.[29] The letter notifies the provider or supplier that the delinquent amount will be referred to Treasury for debt collection if an acceptable payment arrangement is not established.[30]

Can CMS Waive Recoupment of AAPs?

Under Medicare regulations, CMS may compromise (or terminate) claims for collection of overpayments made to Medicare providers or suppliers.[31] This authority is limited to certain circumstances, such as present and prospective inability of the debtor to pay, inability to collect the full debt, cost of collection, or doubt that the debt can be proven in court."[32]

Can CMS Modify the AAP Repayment Period and Terms?

SSA, §1893(f)(1) authorizes the use of repayment plans (called Extended Repayment Schedules or ERS) to recover overpayments in the event that recoupment would result in hardship to the provider.[33] An ERS can extend repayment obligations over a period ranging from at least six months to possibly up to several years.[34] Approval of an ERS is subject to CMS discretion, considering factors such as the "(i) total amount of the claim; (ii) debtor's ability to pay; and (iii) cost to CMS of administering an installment agreement."[35]

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[28] For more information about CMS overpayment collection, see CMS, *Medicare Overpayments*, fact sheet, March 2020, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OverpaymentBrochure508-09.pdf.

[29] This is formally referred to as an "Extended Repayment Schedule," or ERS.

[30] In addition, if the provider or supplier does not respond to or pay the remaining balance 60 days after the initial demand letter is sent, the MAC will send a separate "Intent to Refer" letter. See CMS, "Chapter 4–Debt Collection," in *Medicare Financial Management Manual*, pp. 8-9, at https://www.cms.gov/files/document/chapter-4-debt-collection.pdf.

[31] 42 C.F.R. §405.376.

[32] 45 C.F.R. §30.22.

[33] 42 U.S.C. §1395ddd(f)(1). In general, hardship exists where the aggregate amount of overpayments (inclusive of calculated interest) is in excess of 10% of the amount paid to the provider under the most recently submitted cost report. 42 U.S.C. §1395ddd(f)(1)(B)(i)(I). Most Medicare-certified providers are required to submit an annual cost report to CMS containing information such as facility characteristics, utilization data, and financial information—including cost and charges by cost center (in total and for Medicare) and financial statement data.

[34] 42 U.S.C. §1395ddd(f)(1)(A). ERS regulations are at 42 C.F.R. §401.607(c), and additional guidance can be found in CMS, "Chapter 4–Debt Collection," §50, in *Medicare Financial Management Manual*, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c04.pdf.

[35] 42 C.F.R. §401.607(c)(3)(i)-(iii).

What Appeals Can Be Made Under the AAP Programs?

The decision to provide accelerated or advance payment and the determination of the amount of accelerated or advance payment are not subject to appeal. However, administrative appeal rights would apply to the extent CMS issued overpayment determinations to recover any unpaid balances on accelerated or advance payments.[36] Under administrative appeal rights, providers and suppliers may request a review of the amount paid and recouped under the accelerated or advance payment program if the provider or supplier asserts the amounts were calculated incorrectly.[37]

Interest Charges on AAPs

When Is Interest Assessed on AAPs?

The MAC is required to send an initial demand letter "immediately" after the repayment period has elapsed and a balance remains.[38] Interest is *assessed* on the 31st day after the initial demand letter if the provider or supplier does not remit payment in full of any remaining balance by then.[39] (Note that interest *accrues* beginning on the date of the initial demand letter.) For details about changes to interest rates and other aspects of the AAP programs made by Congress and the Trump Administration, see the section "AAPs and the COVID-19 Public Health Emergency." Also, see **Figure 1** for an illustration of the applicable repayment and interest periods.

What Is the Applicable Interest Rate Applied to Unrecovered AAPs?

The applicable interest rate for the second quarter (January-March) of federal FY2021 (October 2020-September 2021) is 9.625%.[40] The applicable interest rate is determined on a quarterly basis. The interest rate is based on Treasury's quarterly rate certification to the U.S. Public Health Service for delinquencies in the National Research Service Awards and the National Health Service Corps Scholarship Program.[41] The HHS Secretary publishes this rate every quarter in the *Federal Register*.[42] The Continuing Appropriations Act, 2021 and Other Extensions Act (CAA

[36] Since AAPs are generally treated like Medicare overpayments for purposes of recovery, 42 C.F.R. Part 405–Federal Health Insurance for The Aged and Disabled, Subpart I - Determinations, Redeterminations, Reconsiderations, and Appeals Under Original Medicare (Part A and Part B) contains the appeal rights applicable to Medicare overpayments, including AAPs.

[37] 42 C.F.R. §421.214(i). For a general overview of Medicare overpayments collection and appeals processes, see CMS, *Medicare Overpayments*, fact sheet, March 2020. Also see CMS, *Fact Sheet: Expansion Of The Accelerated And Advance Payments Program For Providers And Suppliers During Covid-19 Emergency*, p. 6, at https://www.cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf (hereinafter CMS, *Fact Sheet: Expansion of the AAPs Program*).

[38] CMS, "Chapter 3–Overpayments," §150.3, in *Medicare Financial Management Manual*, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.

[39] "Chapter 4–Debt Collection," §10, in *Medicare Financial Management Manual*.

[40] The CMS notice announcing the quarterly interest rate is located at CMS, *Pub 100-06 Medicare Financial Management*, October 13, 2020, at https://www.cms.gov/files/document/r10394fm.pdf. HHS also publishes a chronological list of interest rates at HHS, "Interest Rates on Overdue and Delinquent Debts," at https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/interest-rates/index.html.

[41] 45 C.F.R. §30.18(b)(2).

[42] 45 C.F.R. §30.18(b)(2).

2021; P.L. 116-159) changed the applicable interest rate for certain AAPs made during the COVID-19 PHE. For more details, see "Interest Rate," below.

Can CMS Waive Interest Charges on Unrecovered AAPs?

CMS may waive interest on overpayments in limited circumstances, such as where an overpayment is repaid within 30 days from the date of final determination or where the cost of collection exceeds the interest charges.[43]

AAPs and the COVID-19 Public Health Emergency

What Changes Has Congress Made to AAPs During the COVID-19 Public Health Emergency?

The COVID-19 pandemic has and continues to place financial stress on many health care providers and suppliers. In areas where the impact of COVID-19 was severe, some health care organizations faced a surge in demand for health care services to treat those affected by the virus. Simultaneously during the early weeks of the pandemic, fewer patients sought care for nonemergency services out of caution, as well as in response to pleas to allow resources to be directed to responding to COVID-19-related needs.

To respond to the changes in demand for their services during the COVID-19 PHE, some health care providers and suppliers postponed furnishing elective and other nonemergency services, constraining revenue. Prior to 2020, AAPs were not commonly made—CMS has approved only 100 AAPs since the programs' inceptions in 1989 and 1996, respectively. CMS, administratively, expanded availability of AAPs, effective March 31, 2020.[44] Nearly simultaneously,[45] Congress modified the AAP programs in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136), enacted March 27, 2020.[46] Congress further modified the AAP programs in the CAA 2021 (P.L. 116-159, enacted October 1, 2020. Congress changed AAP eligibility, repayment, limits, interest rates, and data reporting requirements in these laws. The changes are summarized below.

Eligibility

To address potential cash flow challenges, the CARES Act expands the types of providers eligible for accelerated payments during the COVID-19 PHE to include the following:[47]

- critical access hospitals (CAHs),

[43] 42 C.F.R. §405.378. The rule defines several circumstances that establish a "final determination," including various types of written notices, as well as dates linked to the filing of Medicare cost reports in certain cases when written notices are not given.

[44] CMS, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency," 85 *Federal Register* 19230, April 6, 2020.

[45] CMS, "CMS Approves Approximately $34 Billion for Providers with the Accelerated/Advance Payment Program for Medicare Providers in One Week," press release, April 7, 2020, at https://www.cms.gov/newsroom/press-releases/cms-approves-approximately-34-billion-providers-acceleratedadvance-payment-program-medicare.

[46] CMS, *Fact Sheet: Expansion of the AAPs Program*, accessed on September 23, 2020.

[47] CMS, *Fact Sheet: Expansion of the AAPs Program*.

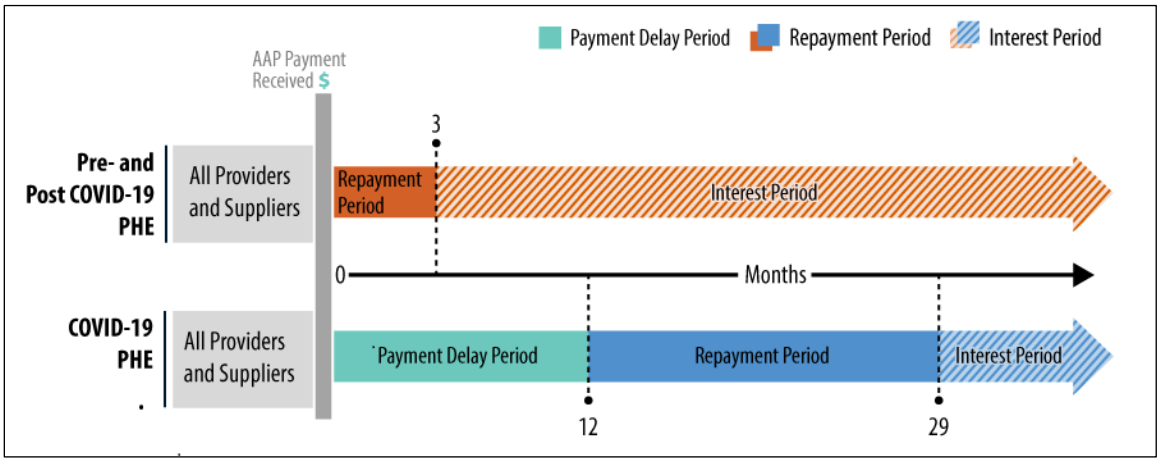
- pediatric hospitals, and
- IPPS-exempt cancer hospitals.

Repayment

For AAPs made during the COVID-19 PHE, as expanded by the CARES Act and modified by CAA 2021, providers and suppliers begin repaying after a delay period of up to one year (12 months from the date of the accelerated or advance payment).[48] The HHS Secretary must give the maximum one-year delay period upon a provider's or supplier's request. During the delay period, a provider or supplier is not required to repay or otherwise be subject to claims offset. If a provider or supplier requests the maximum delay period allowed, the repayment period begins on day 366 (or the 13th month) after the provider or supplier received the AAP and lasts through the 29th month. Any remaining balance at the end of the 29th month of the repayment period is subject to interest charges and debt collection by Treasury. **Figure 1** reflects the applicable maximum delay, repayment, and interest periods for AAPs made during the COVID-19 PHE—as modified by CMS, the CARES Act, and the CAA 2021—and for AAPs made outside of the COVID-19 PHE (i.e., pre- and post-COVID-19 PHE).

In addition, the repayment percentage ("offset") was reduced from 100% to 25% of the claims amount for the first 11 months after the payment delay period, then from 100% to 50% of the claims amount for the subsequent 6 months. After that time—a total of 29 months inclusive of the payment delay period—interest would be assessed on the remaining balance. (The applicable interest rate is addressed below.)

Figure 1. Maximum Repayment Timelines for Medicare Accelerated and Advance Payments



Source: CRS review of applicable laws and Medicare regulations and guidance.

Notes: For simplicity and consistency, time is indicated in months, although the deadlines for periods outside of the Covid-19 PHE are defined in days (e.g., 90 days). Covid-19 = Coronavirus Disease 2019; AAP = Medicare Accelerated and Advance Payment; PHE = public health emergency.

[48] See CMS, *Fact Sheet: Expansion of the AAPs Program*, p. 2. Also, the period during which AAP repayment is postponed is referred to as the payment "delay period" for the remainder of this report.

Limitation on Part B Advance Payments

The CAA 2021 created a $10 million limit on advance payments to Part B suppliers, beginning with the date of enactment (October 1, 2020) through the remainder of 2020 and for each subsequent year during which there is a COVID-19-related PHE.

Interest Rate

The interest rate is reduced from 10.25% to 4.00% for payments made under the AAP programs "and comparable programs" between the date of enactment of the CARES Act and the end of the COVID-19 PHE.

Data Reporting

CMS is required to publish data about the payments made under the AAP programs on its public website. The published data would include payment totals under each of the HI and SMI trust funds, as well as by type of provider or supplier receiving such payments. The outstanding amounts remaining to be recouped and repaid to the HI and SMI trust funds would be required to be published no later than 15 months after the passage of the CARES Act and every 6 months thereafter until all AAPs have been recovered.

What Administrative Changes Did CMS Make to the AAP Programs During the COVID-19 Public Health Emergency?

As Congress was deliberating the CARES Act, CMS made several changes to the AAP program during the early part of the COVID-19 PHE—March 2020.[49] CMS implemented an expedited process for providers and suppliers to request AAPs and ensured that all eligible Medicare providers and suppliers who submit a request to the appropriate MAC and meet the required qualifications will be approved to receive accelerated or advance payments. Applicants for accelerated or advance payments were asked to (1) assert the reason for the request as a "delay in provider/supplier billing process of an isolated temporary nature beyond the provider's or supplier's normal billing cycle and not attributable to other third party payers or private patients" and (2) state that the request was for an accelerated or advance payment due to the COVID-19 pandemic.[50]

CMS also made an additional modification to the advance payments program for suppliers furnishing items and services under Part B.[51] Specifically, through an interim final rule, CMS added "exceptional circumstances" under a "Public Health Emergency" or a "Presidential Disaster Declaration" to the conditions under which advance payments under Part B could be made.

As noted earlier in this report, AAPs were not widely used prior to the COVID-19 PHE. After the initial administrative expansion of AAPs, CMS paused COVID-19-related AAPs, effective April

[49] CMS administrative changes and changes enacted by Congress in the CARES Act occurred nearly simultaneously, during March 2020. Congress further modified the AAP programs in CAA 2021, enacted on October 1, 2020.

[50] See CMS, *Fact Sheet: Expansion of the AAPs Program*.

[51] See CMS, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," 85 *Federal Register* 19230, April 6, 2020.

26, 2020. CMS cited the availability of Provider Relief Fund (PRF) assistance in the CARES Act, enacted on March 27, 2020, as a reason for the pause.[52]

Did the Amount Providers and Suppliers Can Receive in AAPs Change During the COVID-19 Public Health Emergency?

Yes. During the COVID-19 PHE, the amount of AAPs available changed. Most providers and suppliers were able to request greater amounts in AAPs—up to 100% of their Medicare payment amount for a three-month period (rather than the 70% for providers and 80% for suppliers under regular program rules). Some providers were able to request an even higher amount: IPPS acute care hospitals, pediatric hospitals, and IPPS-exempt cancer hospitals were able to request up to 100% of their Medicare payment amount for a six-month period, and CAHs were able to request up to 125% of their Medicare payment amount for a six-month period. **Table 1** summarizes the AAP amounts available to providers and suppliers during the COVID-19 PHE.

Table 1. Maximum Amounts of Medicare Accelerated and Advance Payments Available to Providers and Suppliers During COVID-19 Public Health Emergency

Provider and Supplier Type	AAP Amount
Inpatient acute care, children's, and certain cancer hospitals	Up to 100% of the unbilled or unpaid Medicare amount for a six-month period
Critical access hospitals	Up to 125% of the unbilled or unpaid Medicare payment amount for a six-month period
All other providers and suppliers	Up to 100% of the unbilled or unpaid Medicare payment amount for a three-month period

Sources: CRS analysis of Centers for Medicare & Medicaid Services regulations and guidance, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136), and the Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159).

Notes: COVID-19 = Coronavirus Disease 2019; AAP = Medicare Accelerated and Advance Payment.

How Much in AAPs Has CMS Paid Since the COVID-19 Public Health Emergency Began?

As of December 9, 2020, CMS has paid $107.3 billion under the AAP programs during the COVID-19 PHE. Of that amount, nearly $99 billion was paid to Medicare Part A providers (e.g., hospitals) and $8.5 billion to Part B suppliers (e.g., physicians).[53]

What Is the Current Status of the AAP Programs?

Although the Medicare AAP programs predated the COVID-19 PHE declaration, they had previously been used selectively. Congress and CMS expanded the programs' use during the COVID-19 PHE. In addition, in response to the pandemic, Congress provided $100 billion in the

[52] CMS, "CMS Reevaluates Accelerated Payment Program and Suspends Advance Payment Program," press release, April 26, 2020, at https://www.cms.gov/newsroom/press-releases/cms-reevaluates-accelerated-payment-program-and-suspends-advance-payment-program.

[53] CMS, *Medicare Accelerated and Advance Payments Program COVID-19 Public Health Emergency Payment Data*, December 2020.

CARES Act and $75 billion through the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) to assist providers and suppliers during the COVID-19 PHE. In response to enactment of these relief funds distributed through the PRF, CMS ceased accepting new applications for advance payments for Medicare suppliers and stated it was reevaluating new and pending applications for accelerated payments for Medicare providers, effective April 26, 2020.[54] Since then, the CAA 2021 changed the repayment timeline for AAPs made to all providers and suppliers during the COVID-19 PHE, as noted above. On October 8, 2020, CMS announced that it would no longer accept COVID-19-related applications for AAPs but would continue to monitor COVID-19-related provider and supplier impacts.[55]

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Brion Long, a CRS Visual Information Specialist, designed **Figure 1** in this report.

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[54] CMS, *Fact Sheet: Expansion of the AAPs Program*.

[55] CMS, *Fact Sheet: Repayment Terms for Accelerated and Advance Payments Issued to Providers and Suppliers During COVID-19 Emergency*, October 8, 2020.