MILLIMAN WHITE PAPER

E/M-erging payment rates:

Effects of 2020 federal funding legislation on the 2021 Medicare Physician Fee Schedule

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On December 27, 2020, Congress passed H.R. 133, the Consolidated Appropriations Act of 2021, which funded the federal government for fiscal year 2021 as well as another round of coronavirus emergency response and relief.[1]

As with most appropriations bills, this act touched on nearly all aspects of the U.S. economy, and healthcare was no exception. Two notable changes were made:

1. An additional $3 billion in funding for the Medicare Physician Fee Schedule (PFS) in 2021 to offset payment cuts for procedure-focused physicians.
2. Phasing in the reimbursement shift from procedure-focused physicians to patient interaction-focused physicians from 2021 to 2023 with full implementation in 2024.

In total, the additional funding increases payments to physicians for 2021 by 3.75%. This is a significant increase from the historical 0%-0.5% overall PFS reimbursement changes seen in the last several years.[2] These changes are focused on the Medicare fee schedules used by the Centers for Medicare and Medicaid Services (CMS) to reimburse physicians for services provided through Medicare fee-for-service (FFS). However, the reach of these changes extends much farther, with implications on all aspects of the U.S. healthcare system—Medicare Advantage, Medicaid, and commercial coverage, along with care provided through other government programs.

E/M services and the 2021 Medicare Physician Fee Schedule

When finalized in December 2020, the 2021 PFS was widely noted for its significant shifts in provider compensation.[3] Notably, these changes had meaningful effects on different provider specialties, with the most significant impacts to the specialties shown in Figure 1. These changes are predominantly driven by changes in payment rates for evaluation and management (E/M) services.

FIGURE 1: PROJECTED CHANGE IN REIMBURSEMENT PRIOR TO H.R. 133

Specialty	Allowed Charges (millions)	Projected Change in Reimbursement
Endocrinology	$508	16%
Rheumatology	$548	15%
Hematology/Oncology	$1,707	14%
Family Practice	$6,020	13%
Allergy Immunotherapy	$247	9%
Pathology	$1,265	-9%
Physical/Occupational Therapy	$4,973	-9%
Chiropractor	$765	-10%
Nurse Anesthesiologist / Anesthesiologist Assistant	$1,321	-10%
Radiology	$5,275	-10%

Final 2021 Medicare Physician Fee Schedule, Table 106. See https://www.federalregister.gov/d/2020-26815/p-4811.

Prior to calendar year (CY) 2021, CMS reimbursed physicians for E/M services using a simple set of healthcare common procedure coding system (HCPCS) codes that categorized visits based on the level of complexity, duration of visit, site of care, and whether the patient was new or established. In 2019, the American Medical Association (AMA) suggested a change to this paradigm, with a system of five sets of codes each for new patients and established patients, distinguished based on the severity levels of the specific service.[4] In the 2020 PFS final rule, CMS finalized a policy to overhaul the reimbursement for physician E/M services.

[1] Consolidated Appropriations Act of 2021, passed December 27, 2020. Full text of this legislation is available at https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

[2] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) limits the PFS updates to 0% from 2020 to 2025.

[3] One example of this reporting can be found at https://www.fiercehealthcare.com/practices/cms-finalizes-physician-fee-schedule-including-controversial-updates-to-e-m-visits.

[4] AMA Guidance on E/M Coding on can be found at https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management.

The policy generally adopted the new E/M coding guidance from the AMA but, given the significance of the changes, CMS set an effective date of January 1, 2021.

Additionally, in the final 2021 PFS rule, CMS added supplemental codes for time related to established patients, most notably HCPCS code G2211 (complex office/outpatient E/M), which was expected to add about $3 billion in revenue for E/M services.[5] Most physician and professional specialties utilize these E/M codes at least minimally, but E/M services represent a significantly larger portion of care for patient interaction-focused physicians and professionals such as primary care providers and oncologists than for procedure-focused physicians such as radiologists and pathologists. CMS estimates these E/M codes make up 40% of all PFS allowed charges,[6] so changes in the overall value of E/M payments relative to other payments can have a significant impact on the overall fee schedule.

In addition to services that can be coded using an E/M HCPCS code, CMS also sets reimbursement for many services via the building block methodology, under which E/M visits are included in the overall payment rate.[7] These services were similarly revised to reflect additional E/M reimbursement:

1. Global surgical codes
2. End-stage renal disease (ESRD) capitation payments
3. Transitional care management (TCM) services
4. Maternity services
5. Cognitive impairment assessment and care planning
6. Annual wellness visits and preventive physical exams
7. Emergency department visits
8. Therapy evaluations
9. Some behavioral health services (e.g., psychotherapy)

In the absence of any other changes, the E/M service reimbursement increases would have increased payments for these services by 25% to 30%. However, The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required the overall PFS change to be 0%. Given that E/M services make up 40% of CMS's PFS reimbursement, the significant E/M changes contributed to an offsetting 10.2% decrease in the PFS conversion factor to meet this budget neutrality requirement.[8] This had the effect of offsetting some of the reimbursement increase for E/M services—resulting E/M payments are only about 15% higher in total, but with an accompanying 10% reduction for non-E/M services. This level of disparity left some physician specialties seeing significant increases in reimbursement, while others were facing material reductions in reimbursement based on their relative volumes of E/M services.

Key Changes to E/M Services Included in the 2021 PFS, Prior to H.R. 133

Severity of the E/M service will no longer be based on the history and exam, but instead based on the level of medical decision-making (MDM) as defined by AMA guidance.

Termination of code 99201 (lowest-severity E/M visit), reducing the new patient E/M codes from five to four levels. This also materially increases the reimbursement for the simplest E/M services for new patients as physicians will now be required to code 99202 rather than 99201.

Establishing a new G2211 (complex office/outpatient E/M) add-on code to facilitate E/M visits that are for services provided as part of an ongoing care plan related to a patient's serious or complex condition.

Establishing a new G2212 (prolonged office/outpatient E/M) code and discontinuing existing prolonged E/M codes 99258 and 99359. G2212 will be used by physicians when the required time for the service exceeds the maximum time for the service by at least 15 minutes. This increases reimbursement to physicians when providing unusually long procedures.

Overhaul of the relative value units (RVUs) assigned for each E/M code, generally increasing both practice and work RVUs.

[5] The AMA estimated the impact of code G2211 at $3 billion, as noted in its high-level overview of the CAA. See https://www.ama-assn.org/system/files/2020-12/select-provisions-2020-legislation-summary.pdf.

[6] Physician reimbursement and fee schedule update requirements are found in Section 1848 of the Social Security Act. The Government Publishing Office maintains consolidated statutory text for the Social Security Act, including Title XVIII, which can be found at https://www.govinfo.gov/content/pkg/COMPS-8768/pdf/COMPS-8768.pdf.

[7] These are described in the final PFS rule at https://www.federalregister.gov/d/2020-26815/p-721.

[8] The revenue neutrality adjustment is illustrated in Tables 104 and 105 of the final rule, which can be found at https://www.federalregister.gov/d/2020-26815/p-4810.

While Figure 1 above shows outliers, the rule impacted nearly all specialties to some extent. Figure 2 shows the 2020 payments for all physician specialties stratified by each specialty's change in payment in 2020.

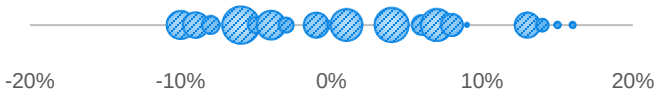
FIGURE 2: DISTRIBUTION OF SPECIALTY IMPACTS BY VOLUME OF 2020 PFS CHARGES, PRIOR TO H.R. 133

Absolute Change Relative to 2020	Percentage of PFS Charges
Within 1%	17%
2% to 4%	22%
5% to 8%	39%
9% and up	23%

Source: Final 2021 Medicare Physician Fee Schedule, Table 106. See https://www.federalregister.gov/d/2020-26815/p-4811.

As would be expected, this spread is not confined to upward or downward adjustments. Figure 3 plots each specialty by the percentage of the payment change, with bubble sizes reflecting the total 2019 claim volume.

FIGURE 3: PERCENTAGE CHANGES TO SPECIALTY PAYMENTS BY VOLUME, PRIOR TO H.R. 133



Source: Final 2021 Medicare Physician Fee Schedule, Table 106. See https://www.federalregister.gov/d/2020-26815/p-4811.

In a world where 2% payment increases due to sequestration represent a significant impact to provider revenues, these changes resulted in an outcry from a variety of physician groups whose members were negatively impacted.[9]

Changes in H.R. 133 and impacts on physician payments under traditional Medicare

Must-pass legislation such as the annual funding bill for the federal government is often targeted as a vehicle for other unrelated policies, a dynamic that was enhanced in the December 2020 funding bill negotiations as Congress sought to combine the funding bill with a fifth coronavirus response bill. When the dust settled, physicians and other practitioners affected by changes in the PFS were directly impacted by three separate provisions in in the Consolidated Appropriations Act of 2021 (CAA):

1. Congress postponed the resumption of Medicare's 2% sequestration reduction from December 31, 2020, to March 31, 2021, avoiding a 2% cut to Medicare payments received by physicians and other providers at the start of the year.[10]
2. Congress increased payments under the PFS in 2021 by 3.75%, or about $3 billion.[11] This increase is outside of the budget neutrality requirement for 2021 and does not establish a new baseline for future years. This provision is intended to help non-E/M physicians with the transition but was applied as a flat increase in reimbursement across all services, increasing reimbursement for E/M services as much as other services.[12]
3. Congress delayed implementation of HCPCS code G2211 until 2024. This code contributed over $3 billion in additional E/M reimbursement before the applicability of MACRA's 0.0% budget neutrality requirement, and represents a shift of approximately $2 billion from E/M services to non-E/M services for the duration of the implementation delay, as a result of the budget neutrality requirement.[13]

Figure 4 illustrates updated E/M service reimbursement following the changes of H.R. 133 relative to the final 2020 PFS.

[9] Numerous professional organizations submitted comments that were generally supportive of the new E/M reimbursement but specifically opposed to the application of revenue neutrality to generate this increase. PolicyMed has a useful summary of comments at https://www.policymed.com/2020/10/cms-proposed-2021-medicare-physician-fee-schedule-physician-groups-call-for-permanent-changes-to-telehealth-reimbursement-and-other-comments.html.

[10] Congress has since passed a further extension of the 2% Medicare sequestration delay through the end of 2020. As of the time of publication, the House and Senate are resolving differences in their bills and President Biden is expected to sign the resulting legislation. Full legislative text is available at https://www.congress.gov/117/bills/hr1868/BILLS-117hr1868eas.pdf.

[11] 42 USC 1395w-4(t) as established by H.R. 133, Division N, Title I, Section 101. While the statutory language specifies $3 billion in funding, the full 3.75% will be paid as any necessary additional monies are also appropriated for payment of the fee schedule increase.

[12] While the statutory language specifies $3 billion in funding, the full 3.75% will be paid as any necessary additional monies are also appropriated for payment of the fee schedule increase.

[13] Based on an analysis of changes to the 2021 physician conversion factor as a result of the CAA, total physician charges as outlined in supporting materials for the 2021 PFS, and validated against service costs in the original 2021 PFS and utilization estimates from supporting materials for the 2020 PFS.

FIGURE 4: E/M REIMBURSEMENT – 2020 PFS TO 2021 PFS, AFTER H.R. 133

		2020 PFS Payment[1]		2021 PFS Payment[2]		% Change	
CPT/HCPCS	HCPCS Description	Non-Facility[a]	Facility[b]	Non-Facility[a]	Facility[b]	Non-Facility	Facility
99201[3]	Office/outpatient visit new	$46.56	$27.07	n/a	n/a	n/a	n/a
99202	Office o/p new sf 15-29 min	$77.23	$51.61	$73.97	$49.90	-4.2%	-3.3%
99203	Office o/p new low 30-44 min	$109.35	$77.23	$113.75	$84.44	4.0%	9.3%
99204	Office o/p new mod 45-59 min	$167.09	$132.09	$169.93	$137.48	1.7%	4.1%
99205	Office o/p new hi 60-74 min	$211.12	$172.51	$224.36	$186.68	6.3%	8.2%
99211	Office o/p est minimal prob	$23.46	$9.38	$23.03	$9.07	-1.8%	-3.3%
99212	Office o/p est sf 10-19 min	$46.19	$26.35	$56.88	$36.29	23.1%	37.7%
99213	Office o/p est low 20-29 min	$76.15	$52.33	$92.47	$68.04	21.4%	30.0%
99214	Office o/p est mod 30-39 min	$110.43	$80.48	$131.20	$100.49	18.8%	24.9%
99215	Office o/p est hi 40-54 min	$148.33	$113.68	$183.19	$147.95	23.5%	30.1%
G2211[4]	Complex outpt/office visit	n/a	n/a	n/a	n/a	n/a	n/a
G2212	Prolong outpt/office visit	n/a	n/a	$33.50	$32.45	n/a	n/a

Notes:
1) 2020 PFS Conversion Factor: 36.0896; assumes 1.000 GPCI
2) 2021 PFS Conversion Factor: 34.8931; assumes 1.000 GPCI
3) Terminated in 2021 PFS final rule
4) Implementation delayed to 2024 by the Consolidated Appropriations Act of 2021. The proposed reimbursement for G2211 was approximately $16 per visit.

Calculations:
a) (Work RVUs + Non-Facility Practice RVUs + Malpractice RVUs) * Conversion Factor * GPCI
b) (Work RVUs + Facility Practice RVUs + Malpractice RVUs) * Conversion Factor * GPCI

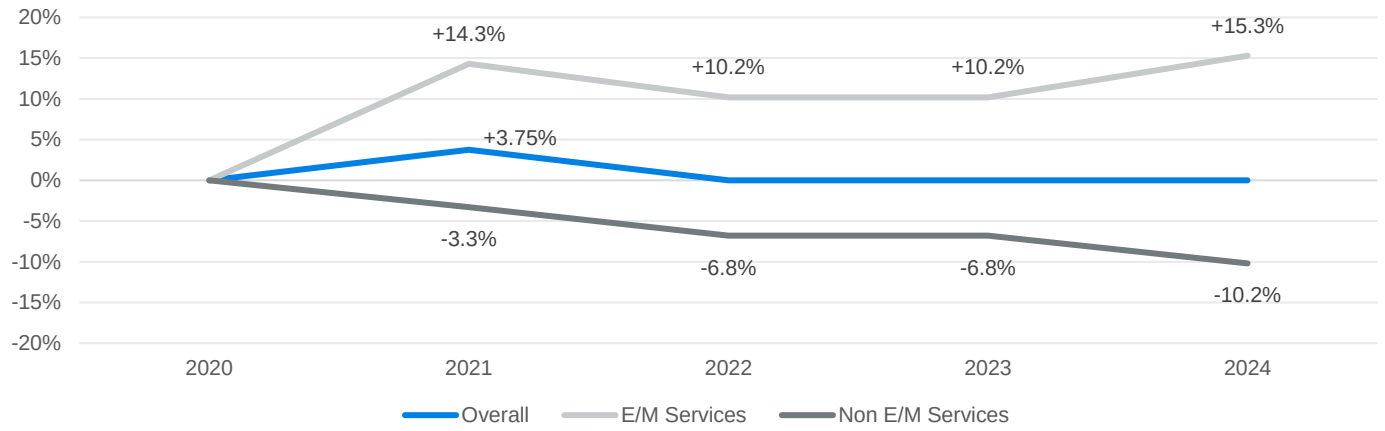
Source: Final 2020 and 2021 Medicare Physician Fee Schedules, as published by CMS at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched.

Due to the combination of additional funding and lower E/M reimbursement mandated by the CAA, the revised final 2021 PFS conversion factor dropped by 3.3% rather than the initially finalized 10.2%.[14] Providers furnishing non-E/M services will still see a reimbursement reduction in 2021, though a much smaller one than initially finalized by CMS. Providers who were due to benefit from E/M services will see a modest decrease from the originally finalized PFS increase. This is due to the largely offsetting effects of the funding increase and the lower E/M reimbursement caused by the delay in the implementation of the G2211 procedure code. This impact will vary significantly by the volume of patients with chronic conditions who would have been assigned HCPCS code G2211, where some E/M-focused providers with fewer chronic patients may see even greater payment increases than originally anticipated, while patients with heavier chronic case E/M loads will see smaller payment increases than planned in 2021.

Because MACRA requires overall PFS reimbursement to stay budget neutral through 2025, the end of the current bolus of additional PFS funding will reduce payments for all providers in 2022. Moreover, the scheduled implementation of HCPCS code G2211 in 2024 will return payment rates for E/M services and non-E/M services to the levels envisioned in the final 2021 PFS. Figure 5 shows changes to payments for E/M and non-E/M services over this transitional period, assuming no additional fee schedule changes shifting reimbursement between E/M and non-E/M services. Currently, there is no difference between 2022 and 2023 in the three-year transitional period laid out, leaving room for Congress to make a partial adjustment to 2022 to further smooth out the transition.

[14] The final PFS conversion factor for 2021 is 34.8931, as noted by CMS under the CY 2021 Physician Fee Schedule Update at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched.

FIGURE 5: TRANSITIONAL PAYMENT LEVELS FOR E/M AND NON-E/M SERVICES RELATIVE TO THE 2020 PFS, UNDER H.R. 133



Source: Milliman analysis of final 2020, original 2021, and revised 2021 PFS conversion factors relative to provisions of the CAA.

Implications for health plans and providers

The biggest, and most obvious, implication of these changes is the significant reimbursement increase for physicians furnishing E/M services and offsetting reduction to procedure-focused physicians who perform few E/M services. While initially this may seem to have the biggest impact on CMS through Medicare FFS reimbursement, it has many potentially significant downstream impacts on other public and private sector payers:

MEDICARE ADVANTAGE

Most Medicare Advantage plans contract with providers at a percentage of Medicare FFS allowable, and are reimbursed by CMS via a fixed per member per month reimbursement rate established via plan bids in June of the preceding year (June 1, 2020, for calendar year 2021). The provisions of the CAA do not provide any additional reimbursement to Medicare Advantage plans for 2021 to offset any additional reimbursement required under the modified PFS. With neither additional revenue from CMS nor the ability to revise their bids, Medicare Advantage plans will likely see higher costs erode priced-for margins in 2021. Furthermore, it is not known whether Congress will extend the 3.75% into future years. In the past, Congress has shown a willingness to extend temporary Medicare payment relief for many years, such as with the Medicare sustainable growth rate.[15] This uncertainty could leave plans needing to decide whether they anticipate these payment increases will continue in some form through 2022 and require higher medical costs in 2022 Medicare Advantage bids.

Additionally, unit cost trends for professional services under the updated final 2021 PFS vary widely, with E/M services increasing significantly and many other services seeing decreases, as illustrated in Figure 2 above. The 3.75% overall PFS trend set by CMS reflects a mix of services consistent with the FFS Medicare population. To the extent Medicare Advantage plans experience higher E/M utilization than FFS Medicare, cost trends used for the 2022 bid should be correspondingly higher. Conversely, lower cost trends should be used if the plans have lower E/M utilization compared to the national average for FFS Medicare.

RISK-BEARING PHYSICIAN PROVIDER ORGANIZATIONS

Some physician groups participate in accountable care organizations (ACOs) that contract with Medicare under one of many value-based programs, such as Medicare Shared Savings Program (MSSP) or Direct Contracting. These programs compare actual expenditures against benchmarks based on the group's trended historical experience. If the group's experience comes through lower than expected, it can share in some savings. If it comes through higher than expected, it may be required to share in some of the loss.

MSSP's benchmarks are calculated retrospectively using a blend of nationwide and regional trends calculated by CMS, which are then compared to the MSSP ACOs' actual costs. This approach means the benchmark and actual trends should, theoretically, reflect the 3.75% overall increase. However, the PFS trends vary widely by specialty, with primary care physicians, for example, seeing much higher increases. If a group leverages a higher percentage of E/M services to help better manage members and

[15] Wynne, B. (April 15, 2015). May The Era Of Medicare's Doc Fix (1997-2015) Rest In Peace. Now What? Retrieved on March 30, 2021, from https://www.healthaffairs.org/do/10.1377/hblog20150415.046932/full/.

improve performance relative to the benchmark, the resulting increase in costs could cause the performance to exceed the benchmark, in which case CMS could claw back some of the perceived excess reimbursement. Conversely, specialists with low E/M reimbursement would likely have lower trends than the benchmark, thus creating similar illusionary "savings" against a 3.75% trend.

The newer Direct Contracting model uses prospective trends that can be adjusted at the discretion of CMS. Similar specialty mix risk exists for these providers, and they also bear the risk that CMS chooses not to update the trends for 2021 in the benchmark calculation, thus making most physician providers appear more costly.

COMMERCIAL HEALTH PLANS

While most commercial health plans have historically contracted on a discount or per-service fee schedule basis, health plans are increasingly moving toward contracting on a percentage-of-Medicare basis that uses the Medicare fee schedule as a reference price. These types of contracts target a percentage of the Medicare rate, and frequently have provisions allowing for a rate adjustment if there is a significant change in Medicare reimbursement for the contract year. This would protect specialty providers facing reimbursement reductions, as well as payers facing unexpected increases in reimbursement for E/M services. Health plans without these provisions (or that choose not to exercise them) could face noticeable underpricing of their business in 2021.

Furthermore, providers without an adjustment provision, which would benefit from the change to the PFS, may still expect an adjustment to their reimbursement for 2021 and later, particularly if they are facing significant payment reductions due to the PFS change on other procedure-based services where reimbursement is decreasing in 2021. Many providers have recently taken significant losses in 2020 due to forgone care related to the COVID-19 pandemic, and so, payers may be more receptive to renegotiating contracts in 2021 to help sustain these providers. However, payers should be careful when restructuring any contracts to accommodate the possibility that Congress may implement changes to restore reimbursement for non-E/M professional services. Failure to do so could lead to a repeat of 2021 dynamics, with payers facing increased costs that may not be reflected in premiums.

Longer term, as physicians get used to the higher Medicare E/M reimbursement, commercial E/M reimbursement could increase even for contracts priced at a discount of billed charges or using a fee schedule. However, there could be downward pressure on rates from some physician practices that may have sought to use commercial rates to offset lower Medicare payment rates. Health plans should evaluate how changes to Medicare reimbursement may impact their commercial contracts when setting trends for commercial rate development and filings.

STATE MEDICAID AGENCIES

While Medicaid reimbursement is typically lower than Medicare payment rates, many state Medicaid agencies base state payment rates on a multiple of the Medicare PFS. Exact terms may vary significantly by state. Some states fix physician payment rates to a specific year's conversion factor and relative value scale, while other states update fee schedules annually to align with changes in the PFS. Depending on the mix of enrollees and services, states could see unanticipated effects on state expenditures—a perpetual concern. In light of recent state revenue challenges and the resulting pressure on all state expenditures, state agencies should understand the impact of these changes on plan costs as they project expenditures for any payments that may be based upon the 2021 PFS.

MANAGED MEDICAID PLANS

Most states operate a managed care program as part of their Medicaid programs. In these states, managed care generally operates in a fashion similar to Medicare Advantage, where the state pays a fixed per member per month capitation rate to health plans, which are then responsible for providing care to the Medicaid population. In states that base their Medicaid fee schedule reimbursements on current Medicare reimbursement, managed care organizations operating managed Medicaid plans face the same considerations and potential revenue issues that face Medicare Advantage plans. This concern may be offset to some degree in states that utilize a risk corridor on managed care expenses, though these risk corridors are frequently driven by other considerations such as the ongoing coronavirus pandemic and may not apply when this issue impacts Medicaid providers.

OTHER ENTITIES

Several other healthcare payer entities key reimbursement levels to Medicare. For example, the U. S. Department of Veterans Affairs bases reimbursement on Medicare rates when purchasing care for veterans from the private sector provider community, such as through the provisions expanded in the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act).[16] Additionally, TRICARE rates for professional services are generally compared to Medicare rates.[17]

[16] VA MISSION Act targets 100% of Medicare for most services. See https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf.

[17] For more details on the relationship between TRICARE's CHAMPUS Maximum Allowable Costs for professional services, please refer to 32 USC 199.14(j).

While the final payment structure for physician services under Medicare is now known for calendar year 2021, a high level of uncertainty remains for 2022 and beyond. Under current law, the 3.75% increase will expire after 2021 and physicians paid under the PFS will all experience a 3.75% drop in reimbursement in 2022. Health plans, providers, and government entities will need to consider how to deal with this uncertainty when negotiating contracts, analyzing proposed risk-sharing arrangements, and projecting physician costs as pricing season for the 2022 plan year in the commercial and Medicare markets enters full swing.

Conclusion

The 2020 PFS final rule introduced significant changes to E/M reimbursement, shifting a large portion of the 2021 Medicare physician spending from procedure-focused physicians to patient interaction-focused physicians. When CMS finalized the 2021 PFS final rule keeping the 2020 framework largely intact and dramatically decreasing the reimbursement for procedure-focused physicians, Congress intervened. Congress infused over $3 billion in additional funding into the PFS and suspended the E/M HCPCS code G2211 until 2024, providing physicians facing significant reimbursement reductions with some transitional relief. This increase in overall physician reimbursement for 2021 will impact all payers, providers, and other entities that key reimbursement to the 2021 PFS. This leaves those same groups wondering how, or whether, Congress will intervene in 2022 and beyond to limit the impact of CMS's restructuring of physician E/M reimbursement within the Medicare FFS program. Payers assuming the transitional relief follows current law may find themselves underpricing claim expense in 2022 and later if additional funding is extended in some form, while payers assuming elevated PFS reimbursement continues at some level may end up priced uncompetitively if Congress makes no new changes.

Caveats and Limitations

The analysis provided in this brief is based on the information made available by the Centers for Medicare and Medicaid Services (CMS) and other entities. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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