Holding Providers Harmless From Medicare Cuts During COVID-19 Act of 2020 (H.R. 8702)

Separating the Myths from the Facts

Background

Pending changes in the Medicare Physician Fee Schedule (MPFS) include improvements for maternity care and much-needed payment increases for physicians delivering primary and complex office-based care to some of our nation's most vulnerable patients. However, a statutory budget neutrality rule requires that any increases in Medicare payments for these office visits — also known as evaluation and management (E/M) services — must be offset by corresponding decreases. Payment cuts of this magnitude will surely strain a health care system that is already stressed by the COVID-19 pandemic and could jeopardize patient access to medically necessary services.

Bill Summary

This bipartisan legislation would maintain the scheduled payment increases, while holding health care providers harmless from these Medicare payment cuts in 2021 and 2022 at a time when the nation continues to contend with the effects of the COVID-19 pandemic. Similar to an essential tenet in medicine, the overarching principle of H.R. 8702 is to "first do no harm."

Under the legislation:

- Providers billing for eligible Medicare services — including certain E/M services — would receive an additional per service relief payment in 2021 and 2022 if the payment is lower than the 2020 payment rate.
- The additional relief payment will equal the difference between the Medicare payment amount in 2021 and 2022 and the amount the service was paid in 2020.
- Services with 2021 and 2022 payment rates higher than in 2020 are not eligible for the additional relief payment. (This includes E/M codes paired with a GPC1X add-on code for complex medical visits, as these two codes together are a payment increase over 2020.)

Example One: Medical service ABC is paid $100 in 2020 and is scheduled to receive $90 in 2021. Under H.R. 8702, the provider would receive the $90 plus an additional $10 payment in 2021.

Example Two: Medical service XYZ is paid $100 in 2020 and is scheduled to receive $110 in 2021. Per the bill, the provider would **not** receive an additional relief payment because the $110 payment in 2021 is greater than the 2020 amount.

Myths vs. Facts

Myth: This legislation will factor into future MPFS and budget neutrality calculations. Additionally, because the bill provides additional relief payments for two years, the burden of any Medicare 2022 budget neutrality cut would fall entirely on primary and comprehensive care physicians, leading to deeper cuts than without this bill.

Fact: **H.R. 8702 does *not* make any changes to the MPFS and has zero effect on the budget neutrality calculation.** This legislation was modeled after Sec. 1833(x) of the Social Security Act, which provided for five years of bonus payments for primary care physicians. No other specialty saw cuts because of these payments, and the Congressional Research Service has said H.R. 8702 would work the same way in that regard. Any budget neutrality adjustment made to the conversion factor in 2022 would occur irrespective of this bill, **and no provider would be made worse off because of this bill.**

Myth: This bill excludes primary and comprehensive care physicians who are on the frontlines of treating COVID-19 patients from COVID-19 relief.

Fact: ***All*** health care professionals, including primary and comprehensive care physicians, are eligible for the additional relief payment in H.R. 8702. As Congress considers additional COVID-19 relief funding, preventing cuts during a pandemic should be an urgent priority.

Myth: H.R. 8702 expressly excludes the majority of office visits used by primary and comprehensive care physicians from any additional relief payment.

Fact: Five out of the nine office and outpatient E/M codes — which primary and comprehensive care physicians use — are ***explicitly eligible*** for the additional relief payment when billed without the add-on code GPC1X (which will already provide an additional payment for more complex medical visits). The other four office and outpatient E/M codes are not eligible for additional relief payments because they are scheduled for significant payment increases in 2021.

Myth: H.R. 8702 affects various elements of the MPFS, including:

- Alters the relative value units (RVUs)[1] on which Medicare payments are based;
- Distorts the "relativity" of the MPFS by providing additional relief payments to certain, but not all, services paid under the fee schedule, and there is no precedent for this; and
- Creates two separate Medicare conversion factors — one for certain primary care and cognitive care physician services and one for all other services.

Fact: **H.R. 8702 does *not* make any changes to the MPFS itself, including *no* changes to RVUs,** to wit:

- Medicare will determine the MPFS as it otherwise would — including the RVUs, conversion factor and any budget neutrality adjustment;
- Clinicians will be paid the regular Medicare payment amount for each service; and
- A ***separate*** calculation will then occur outside of the MPFS to determine whether a service is eligible to receive the bill's additional relief payment.

Further, there are numerous examples where Congress has provided a subset of clinicians with additional payments. For instance, in 2011 through 2016, primary care and general surgeons practicing in rural areas of the country were paid a 10% bonus payment on top of the MPFS payment amount. Another example is a 10% incentive payment for physicians' services furnished in underserved areas. Finally, the Medicare Access and CHIP Reauthorization Act (MACRA) awards qualifying physicians a 5% alternative payment model (APM) incentive payment from 2019 through 2024

Myth: H.R. 8702 will create a reimbursement cliff in 2023, similar to the annual cuts caused by Medicare's former flawed sustainable growth rate (SGR) payment formula.

Fact: The additional relief payment provided under the bill is intended to be ***temporary*** in light of the financial stresses related to the COVID-19 pandemic and ***does not*** create a cliff. The SGR payment formula was permanent, which required Congress to act each time there was a payment "cliff."

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[1] Under the fee schedule, payment rates are based on relative value units (RVUs), which account for the relative costliness of the inputs used to provide clinician services: clinician work, practice expenses, and professional liability insurance (PLI) costs. The RVUs for clinician work reflect the relative levels of time, effort, skill, and stress associated with providing each service and are weighted as compared to other services within the MPFS, and the work RVUs are what were substantially increased for the E/M codes.

Myth: The bill will result in increased beneficiary co-payments.

Fact: Because the additional relief payment provided by H.R. 8702 is made outside the structure of the MPFS, Medicare beneficiaries will not be required to pay higher co-payments.

Myth: This bill will further exacerbate the current and future shortage of primary care physicians since it provides additional payments to specialists.

Fact: According to a recent study conducted by the Association of American Medical Colleges, the nation faces a shortage of physicians between 54,100 and 139,000 physicians by 2033. The shortage of primary care physicians is between 21,400 and 55,200. However, the shortage of between 33,700 and 86,700 is even greater for specialty physicians. H.R. 8702 will help ***stabilize all*** physician practices during the COVID-19 pandemic, keeping more physicians available to care for patients.

H.R. 8702 is a WIN-WIN-WIN solution:

WIN: Primary and comprehensive care physicians will receive increased Medicare payments;
WIN: Specialty clinicians will not face Medicare payment cuts during a pandemic; and
WIN: Medicare patients will have access to the full range of health care professionals.