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4 Looming Medicare Payment Cuts: What You Need to Know

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Even as physician practices nationwide continue to suffer from economic precarity due to the pandemic's lingering effects, there are four looming Medicare reimbursement cuts that will take effect in 2022 unless Congress intervenes. An overview of each issue is provided below.

1. The upcoming expiration of the moratorium on the 2% sequestration cuts that went into effect in 2013. These payment cuts were suspended temporarily in the omnibus spending bill that passed at the end of last year, but only from Jan. 1 through March 31 of this year. Subsequently, the moratorium was extended again through a separate act of Congress in March – this time through the end of 2021.

2. An additional and entirely new 4% Medicare sequestration cut is scheduled to be implemented in 2022. These cuts were triggered automatically by the latest COVID reconciliation bill. Essentially, under the provisions of the so-called federal "PAYGO" rules, certain automatic cuts — including Medicare payment cuts of up to 4% — are triggered to take effect if Congress passes certain legislation that is "unfunded" and adds to the deficit. Since the most recent COVID reconciliation bill was considered to be unfunded and subject to PAYGO, these Medicare cuts were automatically triggered. So, nobody really intended for these cuts to take place per se. They're simply required to go into effect unless Congress expressly waives the PAYGO requirement through legislation by the end of this year.

3. The scheduled expiration of a key component of the E/M code payment rule fix will lead to an additional 3.75% Medicare payment cut in 2022. A one-year, 3.75% across-the-board Medicare payment increase was enacted at the end of last year to partially stave off the cuts that would have otherwise occurred due to the effects of the 2021 Medicare Physician Fee Schedule Final Rule. That rule dramatically increased the value of E/M codes – which is good in and of itself – but because the fee schedule has to be implemented in a budget-neutral manner, offsetting cuts were triggered that would have reduced reimbursement for all other services. To fix this problem, Congress did two things: First, it suspended until 2024 a new add-on code for complex E/M visits that CMS planned to adopt and redistributed the funds allocated for that code back across the entire fee schedule. Second, Congress implemented an across-the-board 3.75% Medicare pay increase to offset most of the remaining cuts, but this increase expires at the end of this year. The FMA is fighting hard for an extension.

Now, for those of you doing the math (likely all of you), these three cuts will add up to a whopping 9.75% cumulative cut that will take effect Jan. 1, 2022 unless

Congress acts to prevent this from happening. Allowing all of these cuts to take effect would be disastrous for the 4.6 million Medicare beneficiaries who call Florida their home. A little more information regarding how these particular cuts may affect the Medicare program is included at the end of this report.

4. Additionally, while the Medicare program currently pays for telehealth services anywhere in the country, the flexibilities in the law that have enabled this will expire at the end of the pandemic-related Public Health Emergency (PHE). Without additional legislation, once these flexibilities expire, telehealth utilization under Medicare Part B will likely decline to pre-pandemic levels. That's because current law outside of the PHE generally limits telehealth services to patients in rural areas who receive care at a specified "qualifying sites," such as a hospital or doctor's office. Outside of the pandemic, very few Medicare patients qualify to receive telehealth services and very few doctors can bill for those services. This is not simply a payment issue. It's a huge access-to-care issue. Patients across the nation came to rely on telehealth services for vital care during the pandemic, and the utility of these services will not diminish once the pandemic ends. We've seen that this technology can be used safely and effectively to help patients receive medically appropriate care with fewer risks and less hassle – all without compromising the standard of care. In short, the expiration of telehealth flexibilities beyond the PHE represents one of the most significant access concerns in recent history. Moreover, the FMA hopes Congress will expressly authorize CMS to continue paying for audio-only telehealth services after the pandemic, as these services have proven vital for older seniors and those without reliable access or any access to smartphones or personal computers paired with high-speed internet connections.

Additional issue: addressing 'surprise billing' the right way

As the FMA has reported in previous updates, the federal government currently is tasked with conducting the rulemaking process to implement the No Surprises Act passed at the end of last year. These implementing regulations will need to be completed by the time the law takes effect in 2022, leaving a very short timeframe to implement a very complex law. This rulemaking is additionally complicated by its status as a "tri-agency rule" — that is, a rule that will involve the cooperation of three separate agencies, specifically, the U.S. Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

It is extremely important that the No Surprises Act be implemented in a way that lives up to its Congressional intent and thereby provides a fair, balanced arbitration process that doesn't hand additional leverage to insurers. The agencies will address many, many issues that ultimately will determine how fair the law is to physicians. But one of top concerns is ensuring that arbiters do not simply select whichever arbitration offer is closest to the median in-network rate as the de facto rate.

Instead, to paraphrase Sens. Bill Cassidy (R-La.) and Maggie Hassan (D-N.H.) from a letter they recently sent to HHS Secretary Xavier Becerra and the other relevant agency heads: The law's arbitration framework was designed to ensure that neither payors nor providers have a financial incentive to remain out of network as a tool to establish leverage for contract negotiations. To achieve this balance, the law was written with the intent that arbiters give each of the numerous arbitration factors equal weight and consideration.

In addition to the information brought forth by either party or requested by the arbiter, these arbitration considerations include:

- The median in-network rates;
- Provider training and quality of outcomes;
- Market share of arbitration parties;
- Patient acuity or complexity of the services;
- Status, case mix and scope of services of the facility; and
- Demonstrations of previous good faith efforts to negotiate in-network rates and prior contract history between the two parties over the previous four years.

Letting groups bring forward relevant information that arbiters will consider equally will allow for more fair and clear determinations that reflect the specific circumstances of each dispute.

Why is this regulatory issue so important?

One of the FMA's biggest fears about the implementation of this law is that absent instruction to consider each factor equally, arbiters may rely too heavily on the median in-network rate (also known under the law as the "qualifying payment amount") and therefore ignore or pay too little attention to the other factors Congress included in the legislation. In fact, according to our counterparts in California – this is precisely how their state legislation played out – the arbiters tend to gravitate toward the median in-network rate while giving little consideration to everything else in front of them. This has made California's arbitration process largely unwinnable for physicians who do not believe the median in-network rate is a fair and reasonable payment amount.

The insurance lobby is already fighting to ensure that arbiters are not given any specific instruction to consider the criteria equally. Payors absolutely hope that arbiters will simply select the offer closest to the median in-network rate in order to make their jobs as easy as possible. Consequently, it's very important that we advocate for the bill to be implemented in a way that instructs arbiters to consider each of the factors listed above equally, without giving too much weight to the median in-network rate or any other singular criterion. While individual members of Congress will have no decision-making authority during the regulatory process, multiple members of our state congressional delegation have expressed an interest in ensuring that the law is implemented fairly. They may be able to help collectively influence regulators as the process moves forward. The FMA is already working to educate members about the importance of the regulatory matters surrounding the law's implementation.

What impact would these cuts have on the practice of medicine?

A pretty devastating one. And to understand the magnitude of the problem, it helps to know a few things about the Medicare program.

First, Medicare rates frequently affect the rates paid by other insurers. So, when Medicare rates decline, that loss of revenue tends to spill over into commercial rates as well. However, since commercial rates are also (generally) higher than Medicare rates, it is likely that a number of physicians would restrict their Medicare patient panels out of economic necessity if these cuts were to take effect.

Second, the sheer magnitude of the cuts is absolutely enormous – 9.75%, not counting any additional lost Medicare revenue due to the expiration of the telehealth flexibilities at the end of the PHE, which may well

happen about the same time. Given that so many practices have struggled throughout the pandemic, these cuts couldn't come at a worse time, particularly in a Medicare-heavy state such as a Florida. Florida has the second largest number of Medicare beneficiaries in the U.S., with more than 4.6 million beneficiaries in total. While California has more Medicare beneficiaries in number, they represent a smaller share of the state's total population. Certain parts of Florida are known to be very densely populated with vulnerable seniors.

Whatever effects these policies have nationally, they'll be greater in Florida.

Finally, Medicare has a history of declining payment rates, which has set the program on a trajectory that even the CMS Office of the Actuary thinks will become unsustainable in due time. After adjusting for inflation, the AMA found that the Medicare Physician Fee Schedule declined 19% in real value between 2001 and 2018, driven by low to non-existent annual pay increases under both MACRA and the SGR that proceeded it.

In addition, future statutory Medicare payment updates are not projected to keep pace with inflation. In fact, updates to the Medicare Physician Fee Schedule conversion factor are pegged at 0% annually from 2020 through 2025 under current law, meaning that physician Medicare pay will effectively be frozen during this period outside of any budget-neutral shifts in reimbursement for specific services. And, in 2026 and beyond, physicians will receive only a .25% or .75% annual pay increase, depending upon whether they participate in MIPS or an Advanced Alternative Payment Model (A-APM).

Again, this trajectory is already unsustainable. Piling on additional payment cuts up to 9.75% would make things dramatically worse, particularly for smaller and independent practices, and perhaps even for some hospitals and regional health systems.

While addressing these looming cuts and then enacting automatic annual Medicare payment increases tied to inflation would constitute an ideal solution, we certainly can't afford to worsen the situation by layering on new cuts.

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