



The Impact of the COVID-19 Pandemic on Medicare Beneficiary Utilization and Provider Payments: Fee-For-Service (FFS) Data for 2020

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Medicare FFS beneficiary service use and associated payments to providers dropped substantially from mid-March through mid-April, but had returned to near-2019 levels by the fall of 2020. The rebound in the fall was not sufficient to offset the earlier declines in the spring, and cumulative payment levels across all states were lower in 2020 compared to 2019.

KEY POINTS

- Patterns in Medicare FFS beneficiary use of services changed markedly in 2020 compared to 2019 as a result of the COVID-19 pandemic.
- Medicare FFS payments declined sharply at the beginning of the pandemic in March and April. For the 2-week period ending April 8, payments declined by 33% relative to the same period in 2019. The comparable declines were 31% for inpatient services and 47% for physician services.
- By the last two weeks in 2020, the 2-week payment amounts for most services had rebounded to slightly above 2019 levels: 5% higher for all claims, 8% higher for inpatient services, and 6% higher for physician services. However, the 2-week payment amounts for outpatient services remained 4% lower than in 2019.
- Despite this rebound in payment levels, the cumulative payment deficits for 2020 relative to 2019 ranged from 7% to 9% for these service categories.
- There was geographic variation in the magnitude of the payment declines and the rate of recovery across counties and across states. All states had a cumulative payment deficit; it ranged from a low of a 1% deficit to as much as a 20% deficit.
- A surge in telehealth helped offset some of the pandemic-related reduction in primary care visits, but it was not enough to prevent lower overall rates of primary care that persisted throughout 2020.

BACKGROUND

Since March 2020, the COVID-19 pandemic has had an unprecedented impact on almost every aspect of life in the U.S. The pandemic itself and stay-at-home orders slowed the economy and also led to deferred health care utilization for non-COVID related services. The impact on patients, their families, and the health care system was significant. A recent study estimated that the direct cost of COVID-19 medical care for Medicare FFS beneficiaries was \$6.3 billion, roughly 3% of program costs.¹ But the indirect effects of COVID-19 through other

changes in utilization and payment likely far exceed those direct costs. Most health care providers faced a significant reduction in volume as elective and other services were suspended and patients may have been reluctant to seek care, even for needed treatment and diagnostic services. These impacts varied by geography, facility, and type of provider.² For example, hospitals and physician specialties faced significant financial losses from postponed or foregone elective procedures, whereas hospitals in areas of high COVID-19 infection rates faced capacity constraints on beds, staffing, and supplies. While the Provider Relief Fund payments under the CARES Act and Medicare's COVID-19 Accelerated and Advance Payments may have offset some of the financial consequences of the pandemic, some providers have expressed concerns that an extended period of reduced utilization could result in the inability of some to continue operating over the long term.

This Issue Brief analyzes the impact of the COVID-19 pandemic on changes in Medicare FFS utilization and spending over the course of 2020, updating our previous Issue Brief.² In the previous report, we compared weekly Medicare fee-for-service beneficiary utilization and provider payment data for the first half of 2020 to the same weeks in 2019. In this Issue Brief, we update our analysis and use Medicare fee-for-service data for the full year of 2020 and compare 2-week payment and utilization to the same 2-week period in 2019, with additional attention to utilization of primary care services.

We note that primary care is essential for all patients, especially for Medicare beneficiaries, many of whom need ongoing chronic disease management and care coordination due to high rates of comorbidities. The large reduction in primary care visits during the pandemic has been documented in previous research,²⁻⁴ which may result in adverse health consequences. Therefore, understanding how the COVID-19 pandemic has affected primary care visits among Medicare beneficiaries likely has important implications for quality of care and health outcomes.

METHODS

We used Medicare Part A and B FFS provider claims submitted for payment from January through December of 2020. For these analyses, 2-week claims were aggregated to smooth over variations in utilization and claims submission over the two weeks. We present 2-week averages to avoid artifactual spikes associated with changing holidays year to year, such as Memorial Day, Labor Day, and Thanksgiving. A weekly version of the results is available in the Appendix. Because claims arrive on a flow basis with some delay from the actual date of services, completeness of the claims increases over time. Although some claims are available with only a few days' lag, this analysis used claims submitted to CMS by April 23, 2021, to allow enough claims to make preliminary estimates about health service use and payments during 2020. Since providers have a year to file claims, final numbers may vary from these estimates.^a

We compared 2020 health service use and payments to claims in 2019 that had been submitted by April 23, 2021, to keep the time frame for reporting similar. Claims for both years were aggregated into two weeks intervals, matching the same 2-week period in 2019 and 2020 in order to similarly account for variations over a week and low-utilization days such as holidays. We first estimated the percent change in 2020 utilization and payments from 2019. We then evaluated cumulative payments aggregated through the end of December. As changes in utilization and payment varied by service, we used Part B drugs as an example and estimated percent change in number of claims, payment, and mean cost per claim. We also estimated the cumulative

^a CMS reported that in July 2016, 90% of all fee-for-service claims are received within 3 months from date of service; 96% inpatient, 95% outpatient, 94% skilled nursing facility, 92% hospice, and 90% durable medical equipment. Almost 96-99% of claims are received by the sixth month from date of service, and 99% and 100% by the ninth and twelfth month, respectively.

<https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>

The 2020 data used in this Issue Brief were received by CMS as of April 23, 2021, and therefore data completeness is expected to be high (100% in January-May, 99% in June-August, 96-99% in September-November, and more than 90-96% in December).

payment changes by county and the percent change by state. Finally, we analyzed trends in numbers of Medicare fee-for-service primary care visits, including telehealth.

We used 2019 payment and utilization as a benchmark for two reasons. First, in a normal year, it would be expected that for a given week the previous year's payments in the comparable week would be a good approximation for what would be expected to occur. Second, because of the varying lags in claims submission, estimating the total payments for a given 2-week period is difficult. It is more accurate to compare claims data available in a 2-week in period 2020 to a snapshot of claims data available in the same two weeks in 2019. For these reasons we use 2019 as a benchmark although an imperfect one since it does not include any of the price or utilization increases that might have been included in full year projections for 2020.

We evaluated both Medicare services provided and payments using CMS FFS Medicare claims data. For services, we used Medicare's shared systems data, the most up-to-date source for claims submitted to Medicare, which includes all claims processed past the enumeration stage. Because the shared systems data have not been reconciled with enrollment information, they cannot be used for evaluating payments. Instead, we used the Common Working File, where claims have been reconciled with enrollment, to evaluate the Medicare allowed amount of submitted claims.

We evaluated payments for the nation as a whole, by state, and by county. Services and payments were assigned based on the provider's state or county, rather than the patient's. We included all claims and the major payment categories of Medicare spending and sub-categories as shown in Tables 1 and 2:

- Inpatient hospital services, including long term care, rehabilitation, psychiatric, and other facilities
- Physician/supplier services, including Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs
- Outpatient facility services, including dialysis and non-dialysis
- Skilled nursing facility
- Durable medical equipment
- Hospice

There is no overlap between Physician/supplier and outpatient services. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.^b

It is important to note that the findings presented below are a snapshot at the end of 2020 and specific to Medicare's FFS program.^c Understanding the full financial impact on providers will require an accounting of the payments between Medicare Advantage plans and providers, payments by other payers including Medicaid and commercial insurance, and payments made under the Provider Relief Fund.

^b Specifically, physician/supplier pays the clinicians for the professional component of care rendered by a TIN-NPI (Taxpayer Identifier Number-National Provider Identifier) paid under physician fee schedule, while outpatient pays the facility component of care rendered by a CMS Certification Number (CCN) paid under the Hospital Outpatient Prospective Payment System (OPPS). We excluded home health pre-payments (known as Requests for Anticipated Payments, or RAPS) as the home health payment system changed from a 60-day episode in 2019 to a 30-day episode in 2020, and this change is likely to affect the percent change in 2020 from 2019 payments.⁵ Medicare Advantage data are not yet available for this analysis.

^c It is worth noting that FFS enrollment went down by nearly 0.8 million beneficiaries between 2019 and 2020

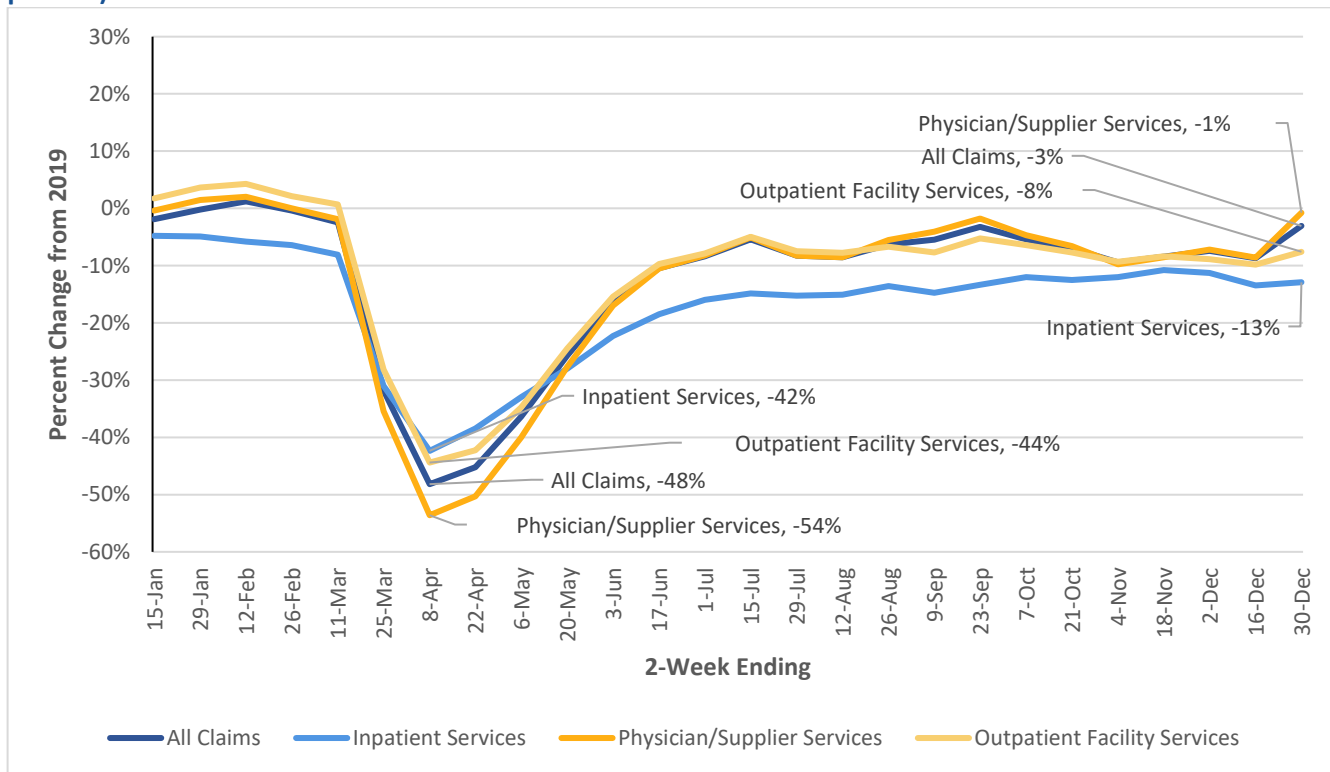
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>

FINDINGS

Utilization Changes, 2020 versus 2019

Figure 1 shows utilization, presented as number of claims, by 2-week period. In late March and early April, utilization dropped for all claims. In the 2-week ending April 8, all claims dropped by 48% below 2019 levels. Physician services and outpatient facility services dropped by 54% and 44%, respectively. Inpatient claims dropped by 42% in the same time period. Utilization of all services started to recover gradually by end of April, and all claims were only about 5% below 2019 levels by mid-July. By the end of 2020, utilization of all services was still below 2019 levels, with a decline of 3% in total claims.

Figure 1. Percent Change from 2019 Medicare fee-for-service number of claims by service type (2-week periods)



Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

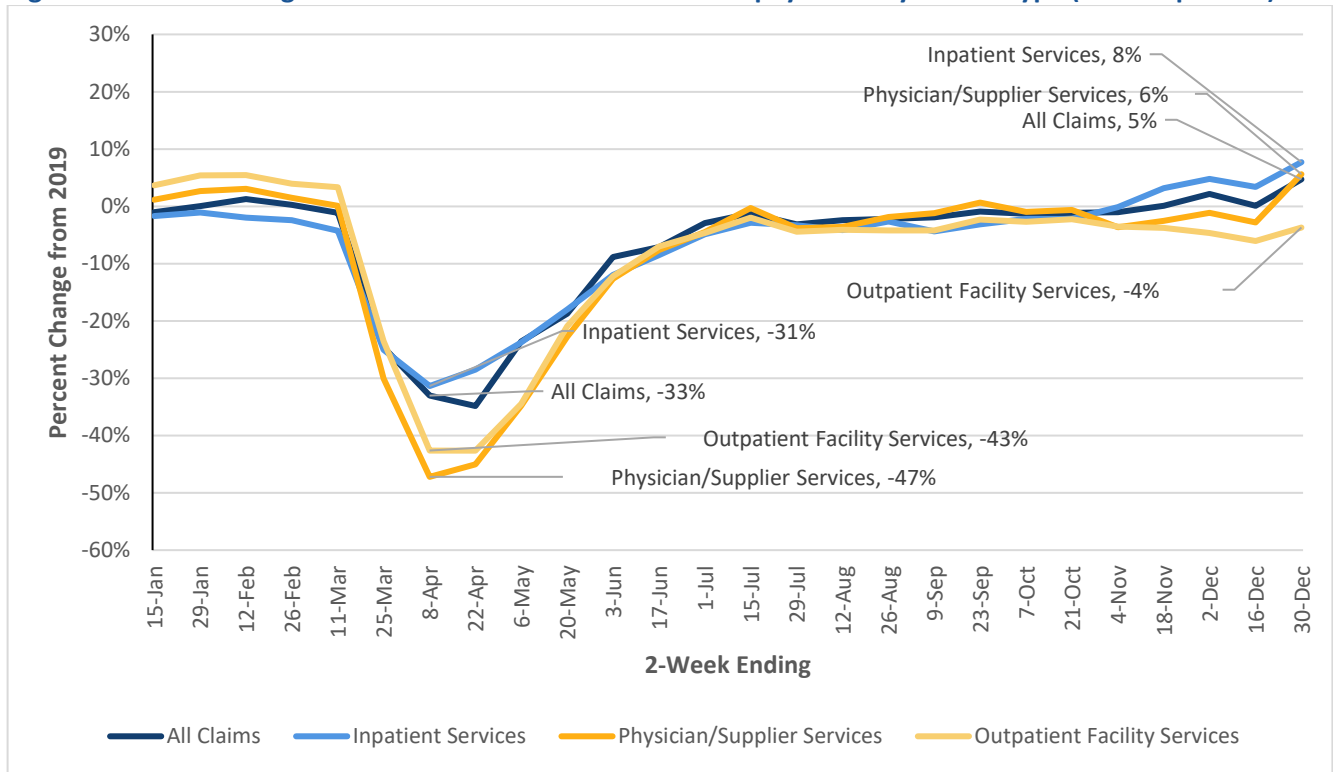
Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

Payment Changes, 2020 versus 2019

As displayed in Figure 2, payments for all claims dropped steeply in late March and early April. Total claims payments reached the lowest point – nearly 33% below 2019 levels – in the 2-week period ending April 8. Similarly, payments for inpatient services, outpatient facility services, and physician services declined by 31% - 47%, relative to 2019. By late April 22, payment began to recover for these services, and by July 1 total payment was just 3% below its 2019 levels. Similarly, payment for the other services in that 2-week period was 4-5% below the 2019 payments. All claims payments continued to slightly increase until they were only 1% lower than 2019 levels by late September and 5% above 2019 levels by December. Similarly, by the end of 2020, payments for inpatient and physician services were 8% and 6% higher than in 2019, respectively. In

contrast, payments for outpatient services did not ever fully catch up to 2019 levels. They remained 4 percent lower in December 2020 than they were in December 2019.

Figure 2. Percent Change from 2019 Medicare fee-for-service payments by service type (2-week periods)



Source: Data from Medicare’s common working file as of claims submitted by April 23, 2021

Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

Table 1 displays the percent change in 2020 from 2019 for additional service groupings at select points in time. As displayed in Table 1, while payments for most services were still below 2019 levels at the end of September and December, payments for some services were at or near 2019 levels. For example, payments for all claims, inpatient services, physician services (including Part B and non-Part B drugs), and skilled nursing facility were above 2019 levels by the end of December.

Table 1. Percent Change from 2019 Medicare fee-for-service by service type, selected 2-week periods

	Percent Change from 2019 payments in 2-week period ending				
	15 JAN 2020	8 APR 2020	1 JUL 2020	23 SEP 2020	30 DEC 2020
All Claim Settings (In aggregate, Home Health pre-payments excluded)	-1%	-33%	-3%	-1%	5%
Inpatient Services: All	-2%	-31%	-5%	-3%	8%
Inpatient: Long Term Care Hospital (LTCH)	-12%	-13%	6%	0%	4%
Inpatient: Inpatient Rehabilitation Facility (IRF)	4%	-30%	1%	6%	-2%
Inpatient: Inpatient Psychiatric Facility (IPF)	-8%	-35%	-13%	-15%	-19%
Inpatient: All Other Facilities (Non-LTCH, Non-IRF, Non-IPF)	-2%	-32%	-5%	-3%	9%
Physician/Supplier Claims: All	1%	-47%	-4%	1%	6%
Part B Physician/Supplier Claims: Non-Part B Drug	0%	-53%	-6%	-1%	5%
Part B Physician/Supplier Claims: Part B Drug	7%	-16%	4%	7%	8%
Outpatient Facility Services: All	4%	-43%	-5%	-2%	-4%
Outpatient: Non-Dialysis	4%	-48%	-5%	-2%	-2%
Outpatient: Dialysis	-1%	-3%	-4%	-5%	-13%
Skilled Nursing Facility: All	1%	-4%	7%	9%	25%
Durable Medical Equipment	-9%	-12%	5%	6%	5%
Hospice	9%	2%	2%	5%	0%

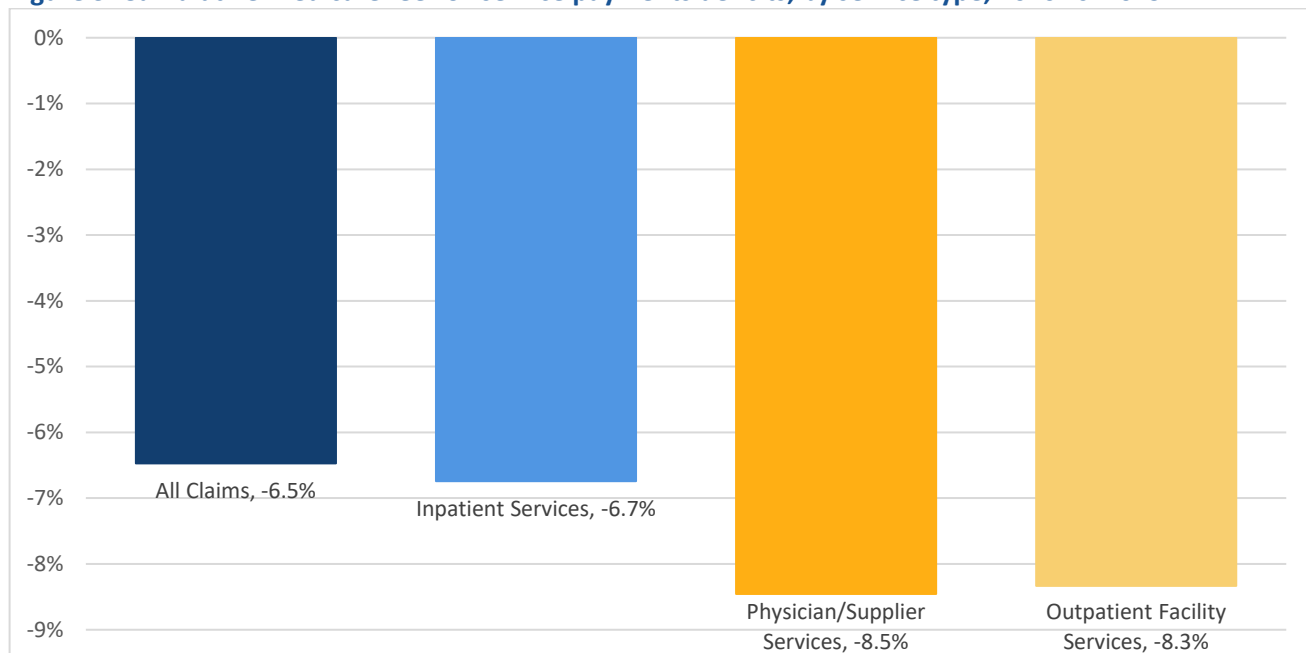
Source: Data from Medicare’s common working file as of claims submitted by April 23, 2021

Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

Cumulative Payment Changes, 2020 versus 2019

Figure 2 and Table 2 display the cumulative effect of the service declines on payments from the beginning of the year through December. Although the 2-week payment amounts described above rebounded in the summer and fall of 2020 toward 2019 levels, the decline in utilization over the full year resulted in a significant cumulative deficit in Medicare FFS payments in 2020 relative to 2019. As displayed in Figure , these cumulative deficits ranged from 6.5% (about \$29.2 billion) for all claims to nearly 8.5% (about \$11.2 billion) for physician services. Between July and September, aggregate 2-week payments for Part B drugs, skilled nursing facility, and hospice recovered to levels at or above 2019 levels. Because different services have had different 2-week patterns of recovery, these cumulative deficits relative to 2019 varied across type of service (Table 2).

Figure 3. Cumulative Medicare fee-for-service payments deficits, by service type, 2020 vs. 2019



Source: Data from Medicare’s common working file as of claims submitted by April 23, 2021

Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

Table 2. Cumulative Medicare fee-for-service payment changes, by detailed service type, 2020 vs. 2019

	2020 vs. 2019 Cumulative payments deficits in 2-week period ending				
	15 JAN 2020	8 APR 2020	1 JUL 2020	23 SEP 2020	30 DEC 2020
All Claim Settings (In aggregate, Home Health pre-payments excluded)	-1%	-7%	-12%	-9%	-6%
Inpatient Services: All	-2%	-9%	-13%	-10%	-7%
Inpatient: Long Term Care Hospital (LTCH)	-13%	-8%	-7%	-5%	-3%
Inpatient: Inpatient Rehabilitation Facility (IRF)	4%	-2%	-5%	-3%	-2%
Inpatient: Inpatient Psychiatric Facility (IPF)	-8%	-12%	-16%	-16%	-17%
Inpatient: All Other Facilities (Non-LTCH, Non-IRF, Non-IPF)	-2%	-9%	-13%	-10%	-7%
Physician/Supplier Claims: All	1%	-8%	-15%	-11%	-8%
Part B Physician/Supplier Claims: Non-Part B Drug	0%	-11%	-18%	-14%	-10%
Part B Physician/Supplier Claims: Part B Drug	8%	3%	0%	2%	1%
Outpatient Facility Services: All	4%	-5%	-13%	-10%	-8%
Outpatient: Non-Dialysis	5%	-6%	-15%	-11%	-9%
Outpatient: Dialysis	0%	-1%	-2%	-3%	-4%
Skilled Nursing Facility: All	1%	1%	3%	4%	5%
Durable Medical Equipment	-9%	-11%	-5%	-2%	0%
Hospice	9%	5%	4%	3%	3%

Source: Data from Medicare’s common working file as of claims submitted by April 23, 2021

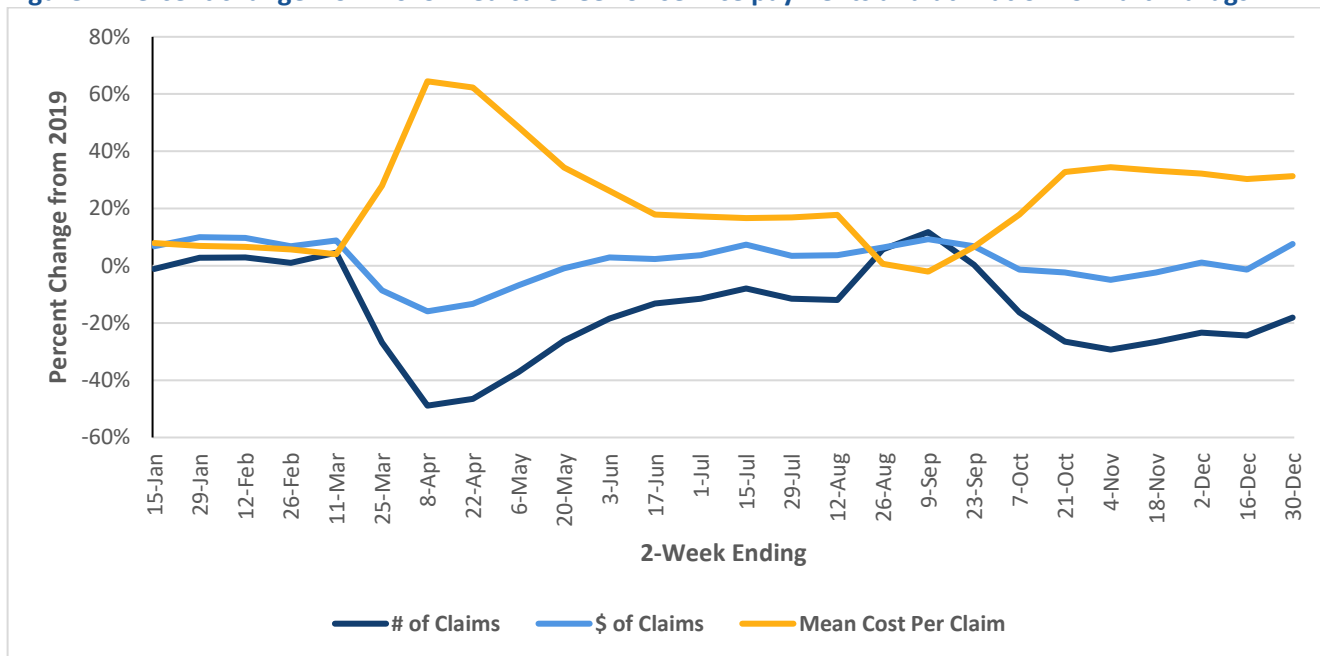
Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

Payment and Utilization Changes for Part B Drugs, 2020 versus 2019

As displayed in Tables 1 and 2, the payment declines in response to the COVID-19 public health emergency varied by service category. Payment and utilization for Part B drugs provide an interesting example. Since these drugs are generally administered in physician offices and hospital outpatient departments, it would be expected that their use would fall along with other visits in these settings. Indeed, as we have previously presented² and as displayed on

Figure , the total number of claims for Part B drugs did decline by more than 50% in March and April. However, total payment for Part B drugs declined by only 20% during this period. The total number of Part B drugs claims and payment increased gradually in May and remained nearly the same in June through August, until it peaked in early September and declined afterwards through December. Despite the fact that total payment recovered to levels almost equivalent to 2019 payment, the total number of claims for the full year in 2020 was still 30% lower than in 2019. The reason for the difference between the trends of total number of claims and payment is that provision of the higher priced drugs was less affected by the pandemic than lower priced drugs, as indicated by the sharp increase in payment per claim in March and April.^d

Figure 4. Percent change from 2019 Medicare fee-for-service payments and utilization for Part B drugs



Source: Data from Medicare’s common working file as of claims submitted by April 23, 2021

County and State Level Geographic Variation of Cumulative Payment Changes, 2020 versus 2019

Utilization and payment changes in response to the COVID-19 pandemic also varied significantly by county and by state.

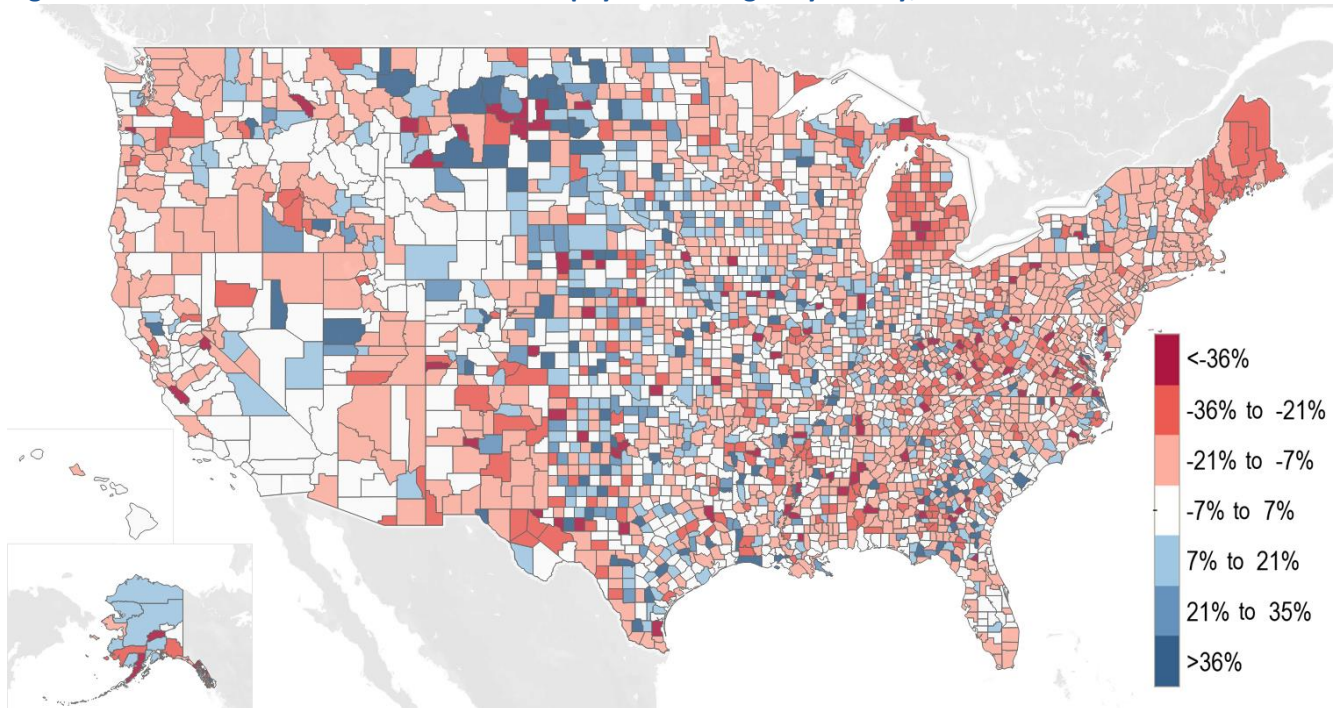
County Level Changes: Figure shows the variation in cumulative deficit by county in the U.S. While providers in most counties are still facing deficits, some providers in other counties experienced 2020 payments that exceeded their 2019 payments for the same time period. Overall, counties in the Northeast had larger

^d Drugs with higher payment per service that also are among the top 20 in terms of Medicare Part B drug spending include Opdivo, Keytruda, and Nuelasta for cancer; Rituxan and Remicade for autoimmune diseases such as rheumatoid arthritis; and Eylea for age related macular degeneration

cumulative payment deficits for 2020 vs 2019 than counties in the West. In addition, about 83.5% of Medicare beneficiaries live in counties with a cumulative payment deficit of 1% or larger.

State Level Changes: Table 3 presents the variation in the 2020 percent change from 2019 payments across the states. In April, the range of payment deficit was between 20% in New York to 74% in Washington. Over the summer and the fall, payments in most states approached 2019 levels. By the end of December, payments in 41 states and the District of Columbia were above the 2019 levels. Payment changes compared to 2019 ranged from 0% (same as December 2019) in Connecticut and Iowa to 18% higher in 2020 in Wyoming. In contrast, the deficit in 2020 versus 2019 ranged from 1% in Kentucky to 10% in Maine. Table 4 presents cumulative payment deficits in 2020 relative to 2019 across the states. As of December 2020, every state had a cumulative payment deficit. The deficit across the states ranged from 1% in North Dakota and Wyoming to 20% in Maine.

Figure 5. Cumulative Medicare fee-for-service payment changes by county, 2020



Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

Table 3: Percent Change from 2019 Medicare fee-for-service payments by state, selected 2-week periods

State	Percent Change from 2019 payments in 2-week periods ending				
	5 JAN 2020	8 APR 2020	1 JUL 2020	23 SEP 2020	30 DEC 2020
Alaska	7%	-50%	-2%	7%	6%
Alabama	-5%	-57%	-5%	-3%	5%
Arkansas	-2%	-50%	-3%	0%	3%
Arizona	2%	-52%	1%	-1%	10%
California	1%	-41%	2%	-1%	9%
Colorado	-1%	-63%	0%	1%	-2%
Connecticut	-5%	-46%	-8%	-7%	0%
District of Columbia	4%	-31%	-1%	3%	11%
Delaware	3%	-59%	-2%	2%	6%
Florida	0%	-52%	1%	-1%	5%
Georgia	0%	-47%	-1%	-2%	8%
Hawaii	4%	-51%	-3%	-6%	-5%
Iowa	1%	-61%	-2%	2%	0%
Idaho	-1%	-47%	-3%	7%	4%
Illinois	-2%	-56%	-7%	-6%	1%
Indiana	-1%	-53%	-4%	-3%	4%
Kansas	1%	-49%	1%	5%	6%
Kentucky	-7%	-56%	-7%	-5%	-1%
Louisiana	-6%	-45%	1%	-3%	5%
Massachusetts	-1%	-55%	-9%	-2%	1%
Maryland	4%	-51%	-2%	4%	10%
Maine	-4%	-70%	-19%	-13%	-10%
Michigan	-9%	-68%	-15%	-10%	-7%
Minnesota	-3%	-71%	-6%	0%	-2%
Missouri	-2%	-53%	-1%	2%	1%
Mississippi	-5%	-45%	-4%	-2%	6%
Montana	0%	-66%	0%	1%	6%
North Carolina	-1%	-54%	-4%	-1%	5%
North Dakota	3%	-48%	1%	8%	12%
Nebraska	-1%	-70%	-6%	0%	4%
New Hampshire	-1%	-44%	-7%	-2%	3%
New Jersey	-1%	-44%	-7%	-2%	3%
New Mexico	1%	-48%	-3%	-5%	5%
Nevada	-2%	-40%	-1%	-3%	4%
New York	2%	-20%	-8%	-2%	5%
Ohio	-2%	-62%	-6%	3%	3%
Oklahoma	-3%	-51%	-7%	2%	8%
Oregon	0%	-61%	0%	-1%	4%
Pennsylvania	-2%	-63%	-6%	-2%	3%
Rhode Island	-3%	-50%	-10%	-1%	-4%
South Carolina	0%	-47%	1%	0%	9%
South Dakota	3%	-64%	2%	4%	4%
Tennessee	-3%	-51%	-1%	0%	1%
Texas	-1%	-46%	-1%	1%	8%
Utah	-2%	-45%	-1%	2%	9%
Virginia	-2%	-54%	-4%	-2%	3%

Vermont	19%	-44%	19%	28%	4%
Washington	0%	-74%	-5%	-4%	1%
Wisconsin	-5%	-56%	-4%	-2%	-3%
West Virginia	-6%	-66%	-5%	-8%	-3%
Wyoming	-1%	-51%	0%	3%	18%

Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

Table 4: Cumulative Payment Deficits from 2019 Medicare fee-for-service payments by state, selected 2-week periods

State	Cumulative Payment Change from 2019 payments in 2-week periods ending				
	5 JAN 2020	8 APR 2020	1 JUL 2020	23 SEP 2020	30 DEC 2020
Alaska	5%	-4%	-10%	-5%	-2%
Alabama	-5%	-11%	-15%	-11%	-8%
Arkansas	-2%	-8%	-13%	-9%	-6%
Arizona	2%	-5%	-9%	-7%	-5%
California	1%	-5%	-10%	-6%	-4%
Colorado	-1%	-10%	-15%	-10%	-7%
Connecticut	-5%	-11%	-17%	-14%	-10%
District of Columbia	4%	-5%	-11%	-8%	-6%
Delaware	3%	-6%	-15%	-10%	-7%
Florida	0%	-7%	-11%	-7%	-6%
Georgia	1%	-8%	-12%	-8%	-6%
Hawaii	5%	-5%	-11%	-9%	-7%
Iowa	2%	-6%	-13%	-9%	-5%
Idaho	0%	-7%	-12%	-7%	-4%
Illinois	-2%	-9%	-16%	-12%	-10%
Indiana	-1%	-10%	-16%	-12%	-8%
Kansas	1%	-5%	-11%	-7%	-3%
Kentucky	-7%	-15%	-21%	-16%	-12%
Louisiana	-6%	-11%	-12%	-9%	-7%
Massachusetts	-1%	-10%	-17%	-13%	-10%
Maryland	3%	-6%	-12%	-7%	-4%
Maine	-4%	-17%	-27%	-23%	-20%
Michigan	-9%	-16%	-26%	-22%	-18%
Minnesota	-3%	-9%	-17%	-13%	-9%
Missouri	-2%	-8%	-13%	-9%	-6%
Mississippi	-5%	-9%	-13%	-9%	-6%
Montana	1%	-7%	-13%	-8%	-5%
North Carolina	-1%	-9%	-14%	-10%	-7%
North Dakota	3%	-3%	-9%	-5%	-1%
Nebraska	-1%	-9%	-12%	-7%	-4%
New Hampshire	-1%	-11%	-18%	-13%	-10%
New Jersey	-1%	-8%	-17%	-13%	-9%
New Mexico	1%	-8%	-14%	-11%	-9%
Nevada	-2%	-6%	-11%	-8%	-5%
New York	2%	-3%	-13%	-10%	-7%
Ohio	-2%	-11%	-18%	-13%	-8%
Oklahoma	-1%	-10%	-15%	-10%	-7%

Oregon	0%	-8%	-15%	-10%	-8%
Pennsylvania	-2%	-10%	-17%	-12%	-9%
Rhode Island	-3%	-8%	-17%	-14%	-11%
South Carolina	1%	-6%	-9%	-5%	-3%
South Dakota	3%	-4%	-12%	-7%	-2%
Tennessee	-3%	-8%	-12%	-9%	-6%
Texas	0%	-7%	-11%	-8%	-5%
Utah	-3%	-6%	-11%	-7%	-4%
Virginia	-2%	-9%	-15%	-11%	-9%
Vermont	0%	-12%	-19%	-14%	-11%
Washington	-3%	-11%	-16%	-12%	-10%
Wisconsin	1%	-6%	-16%	-11%	-8%
West Virginia	-7%	-12%	-19%	-15%	-12%
Wyoming	-4%	-6%	-11%	-6%	-1%

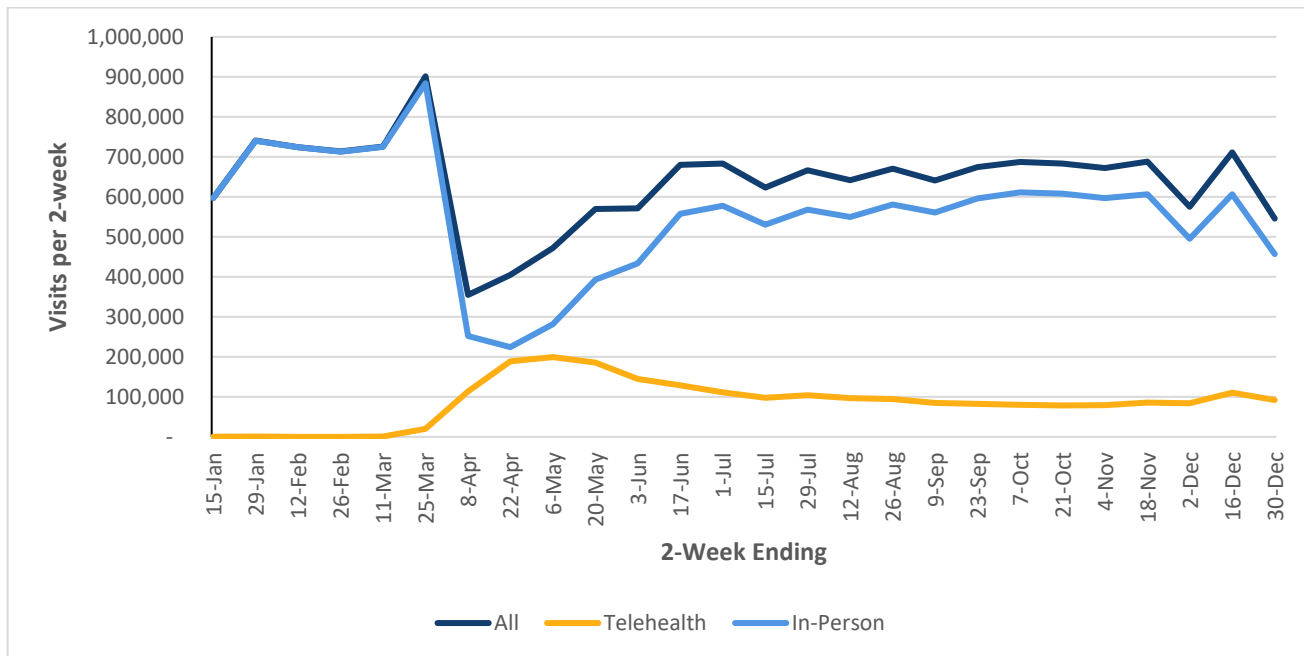
Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

Trends in Primary Care Visits, including Telehealth, 2020

In prior work, ASPE evaluated the use of telehealth for primary care services and found that Medicare's new telehealth flexibilities played a critical role in helping to partially offset the decline in in-person primary care services.⁵ Despite these flexibilities, total primary care visits declined by more than half between March and April 2020. Total primary care visits increased in June through December but remained about 4% below pre-pandemic levels (Figure 6).^e

^e Comparing all visits in 2-week ending December 16 with January 29

Figure 6. Trends in Numbers of Medicare fee-for-service primary care visits, including telehealth, 2020



Source: Data from Medicare’s shared systems as of claims submitted by April 23, 2021

CONCLUSION

The COVID-19 pandemic has affected the health care delivery system in numerous ways. During the early months of the pandemic, many hospitals - especially those in hard hit areas - were overwhelmed, raising concerns about shortages of staff, acute care beds, ventilators, and protective equipment. At the same time, elective services were cancelled and many non-emergent services, including primary care, were postponed across the country. The reduction in service utilization is potentially problematic for two reasons: beneficiaries may experience adverse health effects related to the foregone services, and the associated reduction in payments may have lasting financial consequences for some providers. The severity of both problems depends on the magnitude of the service reduction, how long it lasted, and how rapidly services recovered to expected levels. This Issue Brief provides an analysis of the COVID-19 related changes in service utilization, provider payments, and beneficiary primary care visits during 2020 with Medicare FFS claims data available to date.

In summary, we find that the sharp reduction in health service use and payments in March and April began to rise again in May and June, and by the end of 2020, payment for most services were almost back to normal. However, the payment declines in the spring led to a cumulative payment decline across all services of about 7-9% nationally for the year. Moreover, the cumulative change in payment ranged widely across the country at both the county and state level.

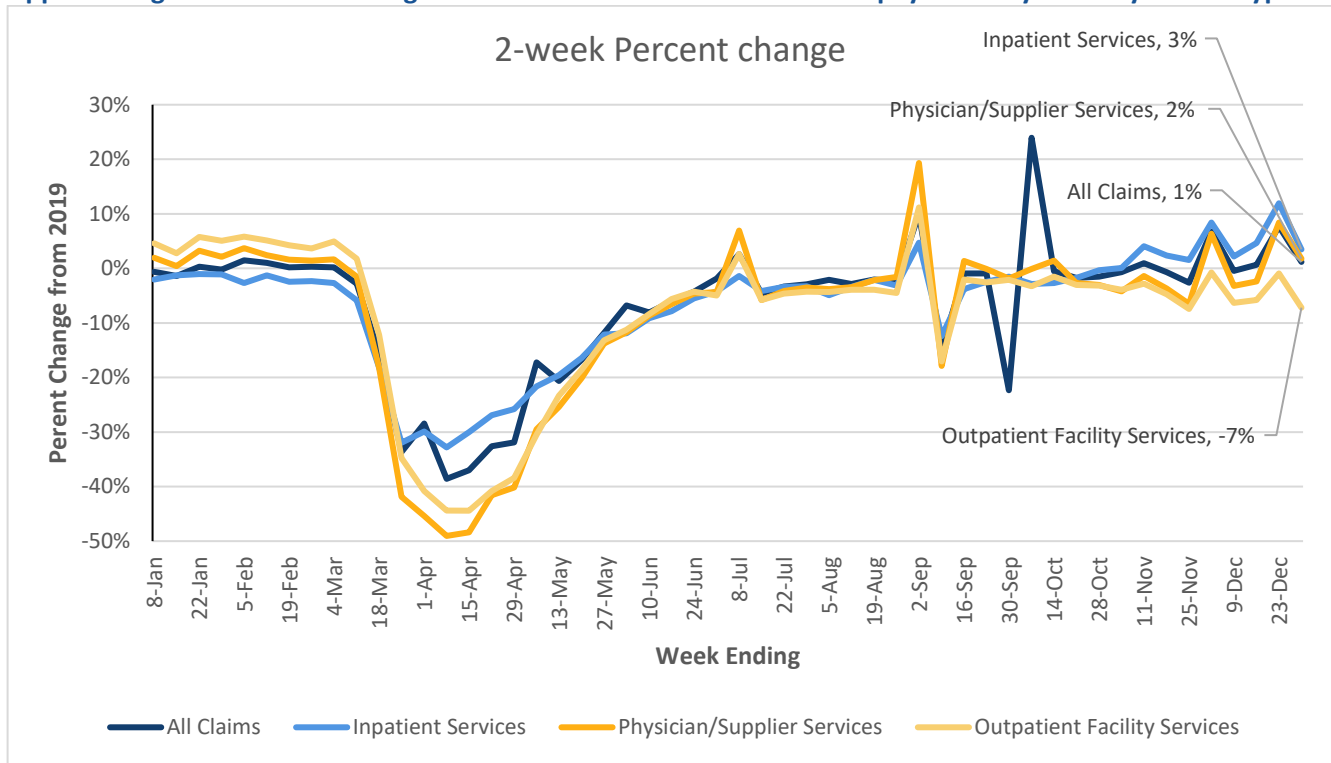
Furthermore, use of primary care at the end of 2020 was still lower than pre-pandemic levels. The reduction in primary care use aligns with the overall reduction in claims. However, primary care is important for Medicare beneficiaries as they need ongoing chronic disease management and care coordination due to high rates of comorbidities. Future ASPE analyses will further explore a number of the patterns discussed in this paper including: the types of outpatient care that were most affected by the pandemic, changes in use of Part B drugs, changes in the use of telehealth, and variation in utilization across counties.

Despite these overall trends, there was substantial variation across service types and geographies. It is unclear how much of the reduction in health service use and spending will recover during 2021. Some care may have been delayed, meaning there will be pent-up demand in 2021 for those services, while other care may have been foregone and will not ever be fully recaptured. Future research will help clarify these issues. Medicare payment rules often factor in patterns from previous calendar years; our findings on the trends in Medicare payment during 2020 can help inform those decisions in the future.

We do not yet know the long-term health effects of 2020 changes in utilization on Medicare beneficiaries or the impact on the financial circumstances of providers. Careful monitoring of both trends will be important over the coming year.

APPENDIX: Tables and Figures Using Weekly

Appendix Figure 1. Percent Change from 2019 Medicare fee-for-service payments by week by service type



Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

Appendix Table 1. Percent Change from 2019 Medicare fee-for-service weekly payments by service type, selected weeks

	Percent Change from 2019 payments in week ending				
	15 JAN 2020	8 APR 2020	1 JUL 2020	23 SEP 2020	30 DEC 2020
All Claim Settings (In aggregate, Home Health pre-payments excluded)	-1%	-39%	-2%	-1%	1%
Inpatient Services: All	-1%	-33%	-4%	-2%	3%
Inpatient: Long Term Care Hospital (LTCH)	-11%	-18%	4%	0%	6%
Inpatient: Inpatient Rehabilitation Facility (IRF)	6%	-31%	2%	6%	-3%
Inpatient: Inpatient Psychiatric Facility (IPF)	-7%	-37%	-11%	-13%	-19%
Inpatient: All Other Facilities (Non-LTCH, Non-IRF, Non-IPF)	-1%	-33%	-5%	-3%	4%
Part B Physician/Supplier Claims: All	0%	-49%	-4%	0%	2%
Part B Physician/Supplier Claims: Non-Part B Drug	0%	-55%	-5%	-1%	2%
Part B Physician/Supplier Claims: Part B Drug	3%	-19%	2%	4%	2%
Outpatient: All	3%	-44%	-5%	-3%	-7%
Outpatient: Non-Dialysis	3%	-50%	-5%	-2%	-7%
Outpatient: Dialysis	-1%	-3%	-4%	-5%	-7%
Skilled Nursing Facility: All	1%	-16%	8%	14%	32%
Durable Medical Equipment	-10%	-13%	5%	6%	-2%
Hospice	8%	-10%	2%	7%	-2%

Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

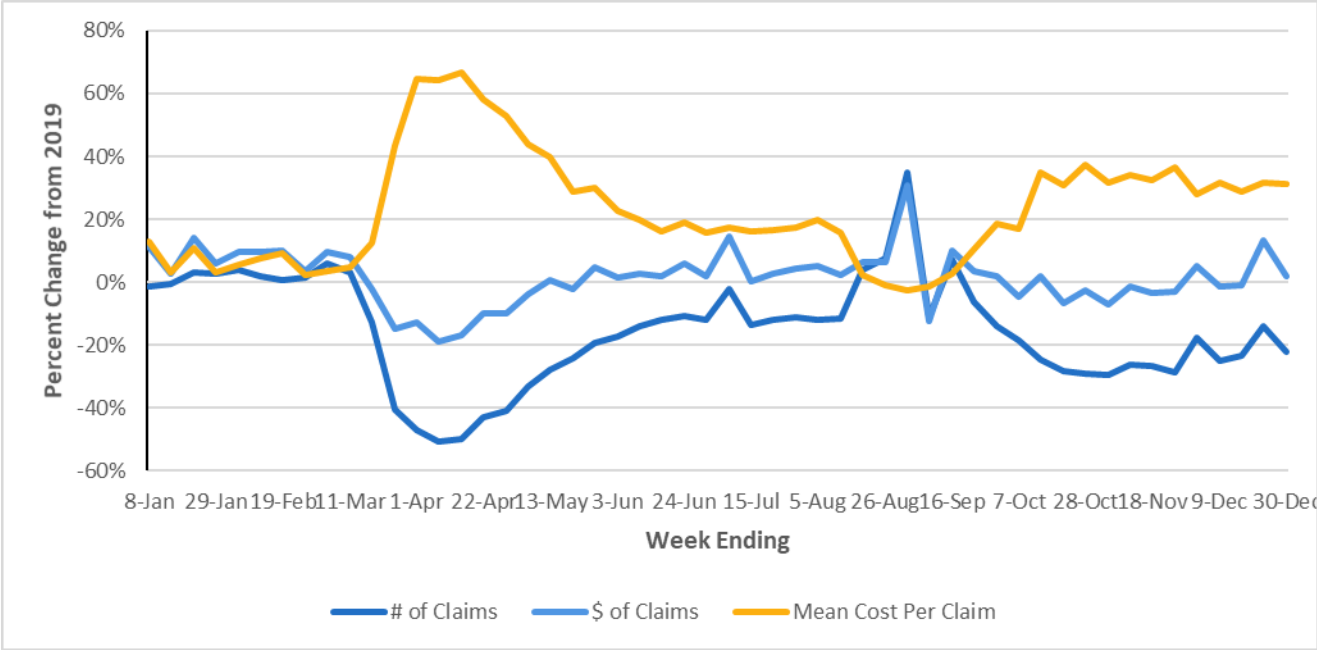
Appendix Table 2. Weekly Cumulative Medicare fee-for-service payment deficits, by detailed service type, 2020 vs. 2019

	2020 vs. 2019 Cumulative payments deficits in week ending				
	15 JAN 2020	8 APR 2020	1 JUL 2020	23 SEP 2020	30 DEC 2020
All Claim Settings (In aggregate, Home Health pre-payments excluded)	-1%	-8%	-12%	-9%	-6%
Inpatient Services: All	-2%	-10%	-12%	-10%	-7%
Inpatient: Long Term Care Hospital (LTCH)	-12%	-9%	-7%	-5%	-3%
Inpatient: Inpatient Rehabilitation Facility (IRF)	4%	-3%	-5%	-3%	-2%
Inpatient: Inpatient Psychiatric Facility (IPF)	-8%	-13%	-16%	-16%	-17%
Inpatient: All Other Facilities (Non-LTCH, Non-IRF, Non-IPF)	-2%	-10%	-13%	-10%	-7%
Part B Physician/Supplier Claims: All	1%	-10%	-15%	-11%	-8%
Part B Physician/Supplier Claims: Non-Part B Drug	0%	-12%	-18%	-13%	-10%
Part B Physician/Supplier Claims: Part B Drug	7%	2%	0%	2%	1%
Outpatient: All	4%	-6%	-13%	-10%	-8%
Outpatient: Non-Dialysis	4%	-7%	-14%	-11%	-9%
Outpatient: Dialysis	-1%	-1%	-2%	-3%	-4%
Skilled Nursing Facility: All	1%	1%	3%	4%	5%
Durable Medical Equipment	-9%	-11%	-5%	-2%	0%
Hospice	9%	5%	3%	3%	3%

Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

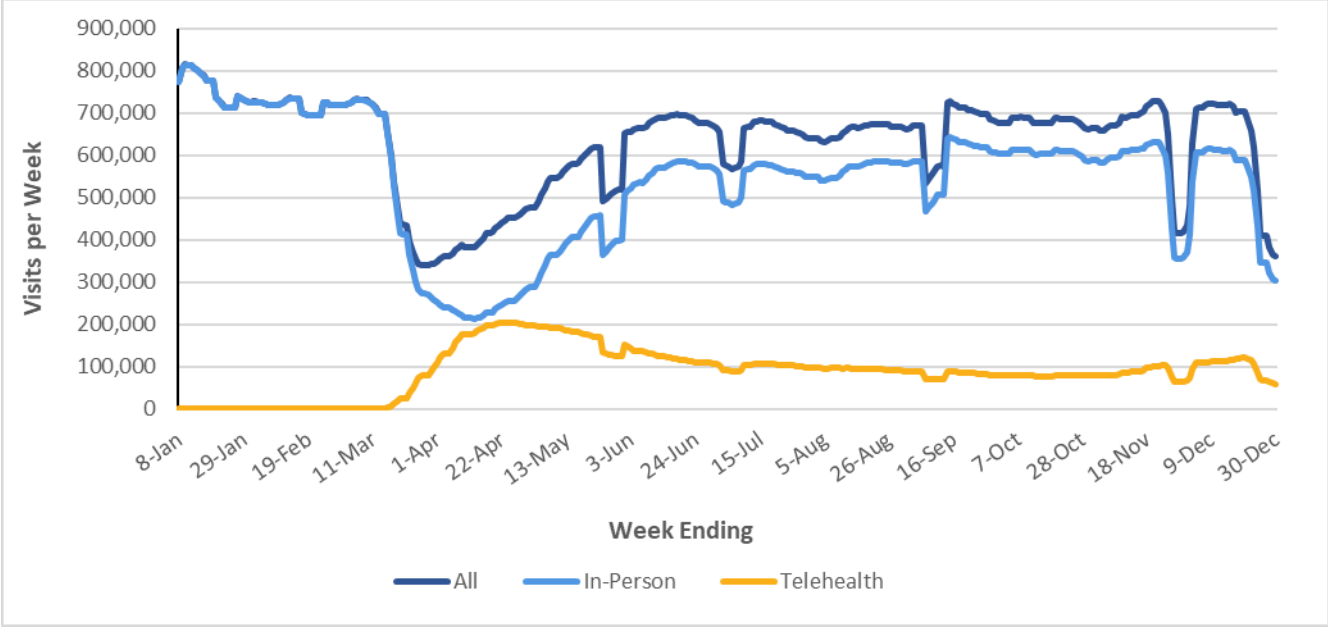
Notes: Physician/supplier services includes Ambulatory Surgical Centers (ASC), non-ASC, Part B drugs, and non-Part B drugs. Outpatient facility services include dialysis and non-dialysis. The difference between physician/supplier services and outpatient facility services is that physician/supplier services include physician payment, while outpatient facility services include facility payment.

Appendix Figure 2. Percent Change from 2019 Medicare fee-for-service weekly payments and utilization for Part B drugs



Source: Data from Medicare’s common working file as of claims submitted by April 23, 2021

Appendix Figure 3. Trends in Numbers of weekly Medicare fee-for-service primary care visits, including telehealth, 2020



Source: Data from Medicare’s shared systems as of claims submitted by April 23, 2021

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