ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF
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THE IMPACT OF THE COVID-19 PANDEMIC ON MEDICARE BENEFICIARY USE OF HEALTH CARE SERVICES AND PAYMENTS TO PROVIDERS: EARLY DATA FOR THE FIRST 6 MONTHS OF 2020

Medicare beneficiary service utilization and associated Medicare payments to providers dropped substantially from mid-March through mid-April and have been returning towards 2019 levels since that time

KEY FINDINGS

- Medicare beneficiary utilization of services declined substantially beginning in mid-March 2020, bottomed out the week ending April 8, and have increased through June.
- Payments for all fee-for-service (FFS) claims declined by 39% in the week ending April 8, 33% for inpatient services and 49% for physician services.
- By the week ending July 1, weekly payments had nearly returned to 2019 levels. They had risen to 96% of the comparable week in 2019 for all claims, 93% for inpatient services, and 95% for physician services.
- At the end of June, cumulative year to date payment deficits relative to 2019 ranged from 12-16% for these service categories.
- Utilization of individual preventive screening and surgical services declined substantially during March and April and have increased through June. Mammography preventive screening services have returned to pre- COVID levels, colonoscopies to 85% of pre-COVID levels.
- There is geographic variation in the magnitude of both the utilization declines and the rate of recovery.

BACKGROUND

Beginning in mid-March 2020, the COVID-19 pandemic has had an unprecedented impact on almost every aspect of life in the U.S. The shutdown of many businesses and stay at home orders issued across the country slowed the economy, resulted in rising unemployment, and deferred health care utilization for non-COVID related services. The impact on patients, their families and the health care system was significant. Most health care providers have faced a significant reduction in volume as elective services were suspended and patients may have been reluctant to seek care, even for needed treatment and diagnosis services. It is likely these impacts vary by geography, facility, and type of provider. For example, hospital systems, post-acute providers and many physician specialties faced significant potential financial losses from postponed or foregone elective procedures and non-urgent visits. In contrast, hospitals in areas of high COVID-19 infection

rates faced capacity constraints on acute care beds, ventilators, and other supplies such as personal protective equipment. While relief payments under the CARES Act offset some of financial consequences for providers, it is likely an extended period of reduced utilization could result in the inability of some to continue operating over the long term.

The reduction in service utilization and associated reduction in provider revenues raise two very important questions.

- The first question concerns the potential adverse health consequences of postponed or foregone services. Specifically, will morbidity and mortality increase for patients who delayed or cancelled screening, diagnostic, or treatment services due to the pandemic?
- The second question concerns the financial impact on providers and their resilience. Specifically, which providers can withstand the reduction in revenues and resume full operation over both the short and long term?

The answer to both of these questions may depend on the magnitude and distribution of the utilization decline. That is, how much did utilization decline, for which types of services, how long did service utilization remain low, and how rapidly did recovery of utilization occur? In this brief, we address utilization and payment changes using Medicare fee-for-service (FFS) beneficiaries' claims to track patient service utilization and payments to providers.

METHODS

ASPE used Medicare Part A and B FFS provider claims submitted for payment from January through June of 2020. For these analyses, claims were aggregated weekly to smooth over variations in utilization and claims submission over the week. 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 uses claims submitted to CMS by August 11, 2020 to allow enough claims to make preliminary estimates about health service use and payments during the first half of 2020. The data in this brief are preliminary estimates because providers have a year to file claims, so final numbers may vary from these estimates.

We compare 2020 health service use and payments to claims for the first half of 2019 that had been submitted by August 13, 2019. Claims for both years are aggregated weekly, matching the first Thursdays of each week (January 2, 2020 and January 3, 2019), in order to similarly account for variations over a week and low-utilization days such as holidays. We also evaluate cumulative payments aggregated through the end of June (July 1, 2020 and July 3, 2019). We use 2019 utilization and payments as a benchmark for two reasons. First, in a normal year, it would be expected that the previous year's payments would be a good approximation for what would be expected to occur. For example, the first two months of 2020 have similar payments and utilization to 2019. Certainly, adjustment could be made for payment rate increases and population changes but these factors have tended to offset each other in recent years.[a] Second, because of the varying lags in claims submission, estimating the total payments for a given week is difficult. It is more accurate to compare claims data available in a given week in 2020 to a snapshot of claims data available in that same week in 2019.

We evaluate 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

[a] While rates in Medicare's various payment systems have tended to have small updates, the number of FFS beneficiaries has declined in recent years due to the rapid increase in Medicare Advantage enrollment.

has not been reconciled with enrollment information, they cannot be used for evaluating payments. Instead, we use the Common Working File, where claims have been reconciled with enrollment, to evaluate the Medicare allowed amount of submitted claims.

We evaluate payments and utilization across the country, for specific regions (New York and New Jersey), and at the county level. Services and payments are assigned based on the provider's state or county. Included are Medicare spending for the major payment categories of all claims, inpatient hospital services, outpatient hospital services, physician services, dialysis services, durable medical equipment (DME), hospice, and skilled nursing facility. We exclude 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 ratios of 2020 to 2019 payments.[1]

We also examine the ratios of service utilization for specific services including elective, diagnostic, surgical, and primary care services. We use hip and knee replacements (total hip arthroplasty and total knee arthroplasty), as examples of elective procedures. We look at mammograms and colonoscopies as illustrative preventive screening services; breast cancer procedures, cardiac procedures, and hip/knee replacements for surgical services. Specific diagnosis codes for these services are provided in Appendix B.

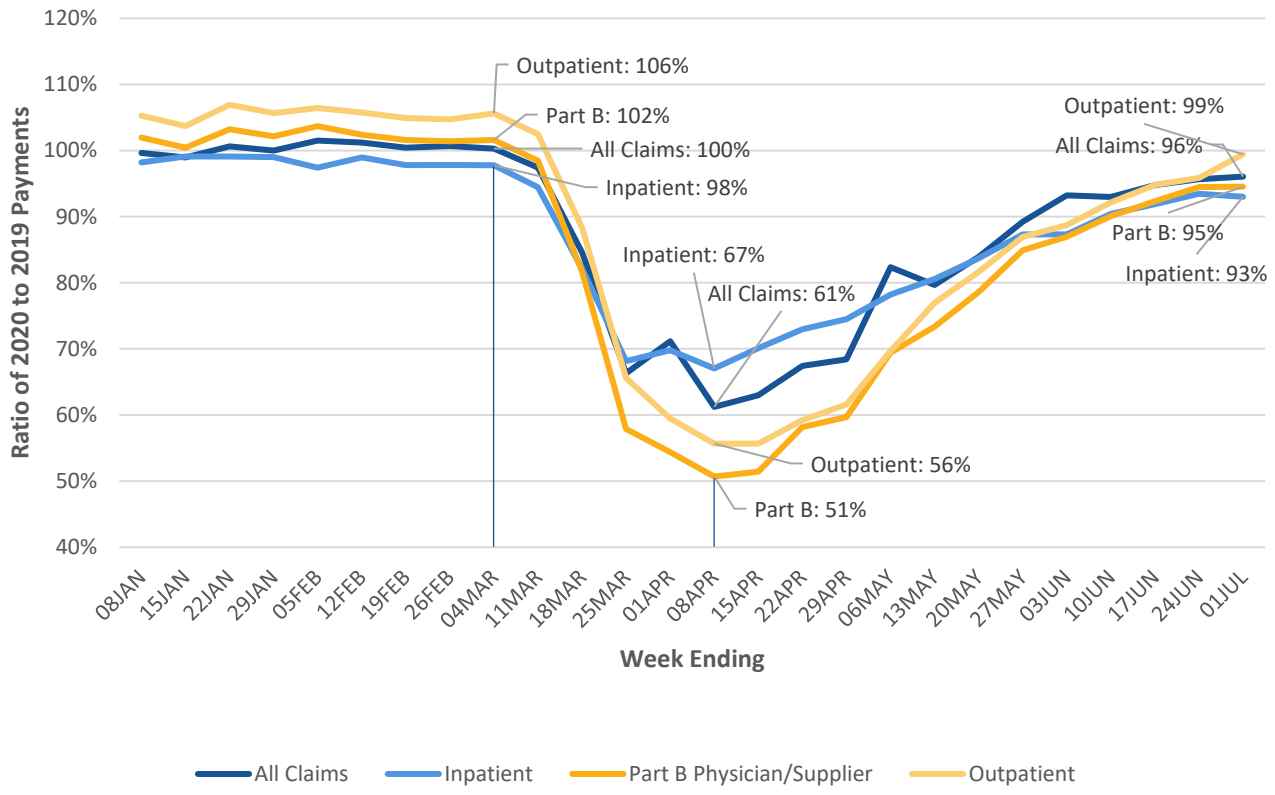
It is important to note that the findings presented below are a snapshot at mid-year and specific to Medicare's FFS program. Understanding the full financial impact on providers as we close out 2020 will require an accounting of the payments between Medicare Advantage plans and providers, payments by other payers and include payments made under the Provider Relief Fund.

FINDINGS

Medicare fee-for-service payments

As displayed in Figure 1, payments for all claims declined by nearly 40% by the week ending April 8. Similarly, payments for inpatient services, hospital outpatient services and Part B physician services declined by 33% - 49%. By the week of April 22, payment began to recover for these services, increasing to 96% of 2019 payments for all claims in the week ending July 1. Similarly, ratios for the other services in that week climbed to 93-99% of 2019 payments. Table 1 provides the ratios for additional service groupings at select points in time. As displayed in Table 1, while most services were still below 2019 levels at the end of June, payments for some services remained at or near 2019 levels. For example, hospice services, dialysis services, durable medical equipment and Part B drug use were at or above 2019 levels.

Figure 1. Ratio of 2020 to 2019 Medicare fee-for-service payments by week by service type



Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

Table 1. Ratio of 2020 to 2019 Medicare fee-for-service weekly payments by service type, selected weeks

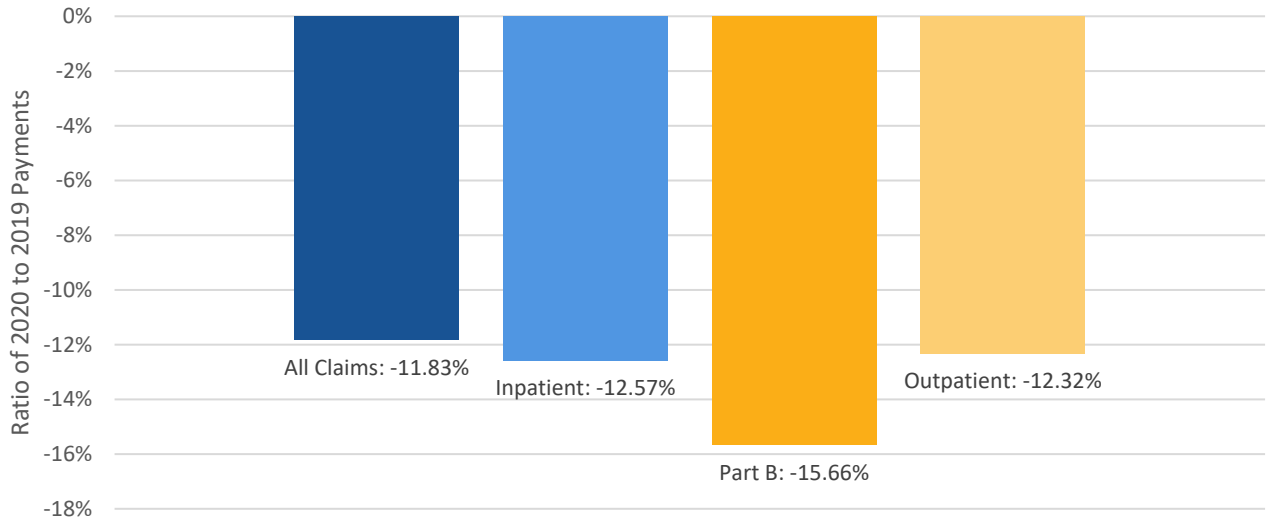
	Ratios of 2020 to 2019 payments in week ending		
	15 JAN 2020	8 APR 2020	1 JUL 2020
All Claim Settings (In aggregate, Home Health pre-payments excluded)	0.99	0.61	0.96
Inpatient: All	0.99	0.67	0.93
Inpatient: Long Term Care Hospital (LTCH)	0.89	0.81	0.77
Inpatient: Inpatient Rehabilitation Facility (IRF)	1.07	0.69	0.99
Inpatient: Inpatient Psychiatric Facility (IPF)	0.91	0.61	0.83
Inpatient: All Other Facilities (Non-LTCH, Non-IRF, Non-IPF)	0.99	0.67	0.93
Part B Physician/Supplier Claims: All	1.00	0.51	0.95
Part B Physician/Supplier Claims: Non-Part B Drug	1.00	0.45	0.93
Part B Physician/Supplier Claims: Part B Drug	1.03	0.81	1.01
Outpatient: All	1.04	0.56	0.99
Outpatient: Non-Dialysis	1.04	0.50	0.98
Outpatient: Dialysis	0.99	0.97	1.17
Skilled Nursing Facility: All	1.01	0.82	1.19
Durable Medical Equipment	0.90	0.85	1.06
Hospice	1.08	0.90	1.14

Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

Figure 2 and Table 2 display the cumulative effect of the service declines on payments from the beginning of the year through June. Although the weekly ratios described above are climbing back toward 2019 amounts,

the decline in utilization over the past several months has resulted in a significant cumulative year to date deficit in Medicare FFS payments relative to 2019. As displayed in Figure 2, these cumulative deficits range from 12% for all claims to nearly 16% for physician services. This means that on average, total provider payments were on average, 0.46% per week below 2019 levels for the first half of 2020. In order to achieve aggregate fee for service payments equivalent to 2019 by December 31, 2020, weekly payments would need to be roughly this same amount above 2019 levels for the remainder of the year. It remains to be seen whether utilization will rise above 100% of 2019 levels as beneficiaries potentially begin to receive services delayed over the past few months. Because different services have had different weekly patterns of recovery, the year to date these cumulative deficits relative to 2019 vary across type of service (Table 2).

Figure 2. Ratio of 2020 to 2019 Medicare fee-for-service cumulative year to date payments, by service type, through June



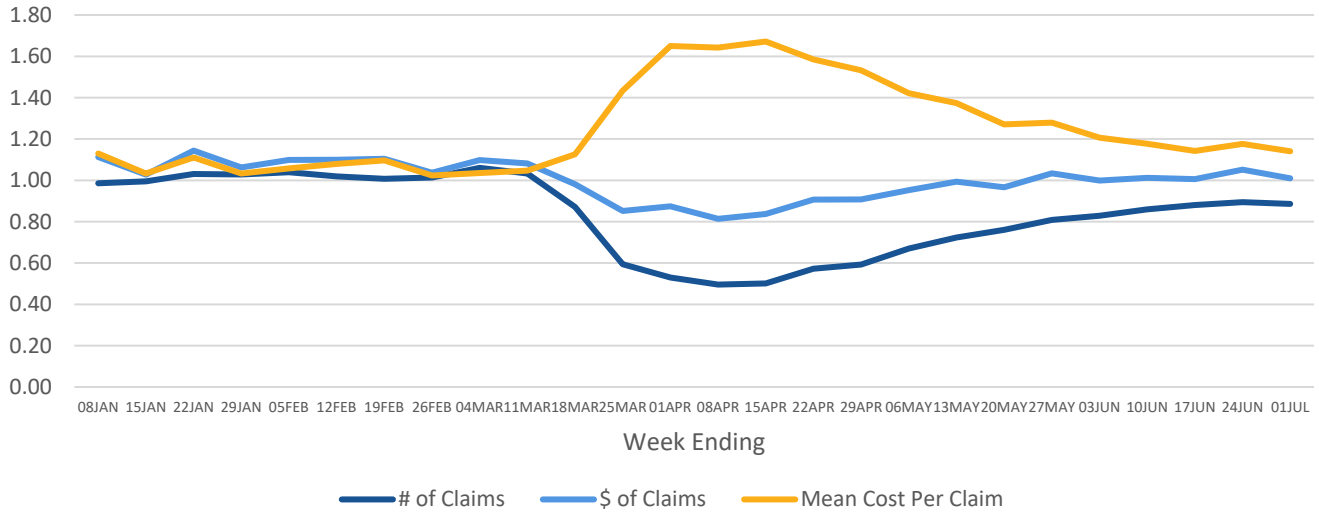
Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

Table 2. Cumulative year to date Medicare fee-for-service payment deficits, by service type, through June

	Ratios of 2020 to 2019 payments in week ending		
	15 JAN 2020	8 APR 2020	1 JUL 2020
All Claim Settings (In aggregate, Home Health pre-payments excluded)	0.99	0.92	0.88
Inpatient: All	0.99	0.91	0.87
Inpatient: Long Term Care Hospital (LTCH)	0.87	0.91	0.90
Inpatient: Inpatient Rehabilitation Facility (IRF)	1.05	0.97	0.95
Inpatient: Inpatient Psychiatric Facility (IPF)	0.91	0.87	0.83
Inpatient: All Other Facilities (Non-LTCH, Non-IRF, Non-IPF)	0.99	0.90	0.87
Part B Physician/Supplier Claims: All	1.01	0.90	0.84
Part B Physician/Supplier Claims: Non-Part B Drug	1.00	0.88	0.81
Part B Physician/Supplier Claims: Part B Drug	1.07	1.03	1.00
Outpatient: All	1.04	0.94	0.88
Outpatient: Non-Dialysis	1.05	0.94	0.86
Outpatient: Dialysis	1.00	0.99	0.99
Skilled Nursing Facility: All	1.01	1.00	1.00
Durable Medical Equipment	0.90	0.88	0.94
Hospice	1.09	1.05	1.04

As displayed in Tables 1 and 2, the payment decline 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 displayed on Figure 3, 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 reason for this difference is that provision of the higher price drugs was less affected by the pandemic than lower price drugs, as indicated by the sharp increase in payment per claim.[b]

Figure 3. Ratio of 2020 to 2019 Medicare fee-for-service weekly payments and utilization for Part B drugs

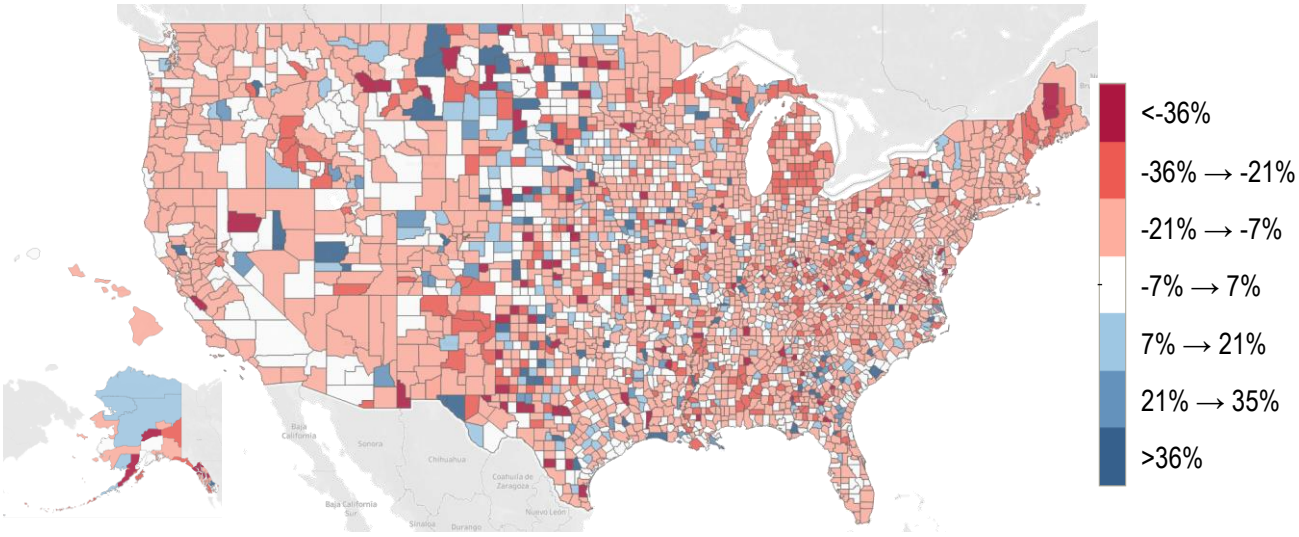


Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

As described in the introduction, utilization and payment changes in response to the COVID-19 pandemic has also varied by geography. See Appendix A for variation across the states. Figure 4 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 have experienced 2020 payments thus far that exceed their 2019 payments for the same time period.

[b] Drugs with higher payment per service that also are among the top 20 in terms of Medicare Part B drug spending include opdivo and keytruda and nuelasta for cancer; rituxan and remicade for autoimmune diseases such as rheumatoid arthritis; and eylea for age related macular degeneration

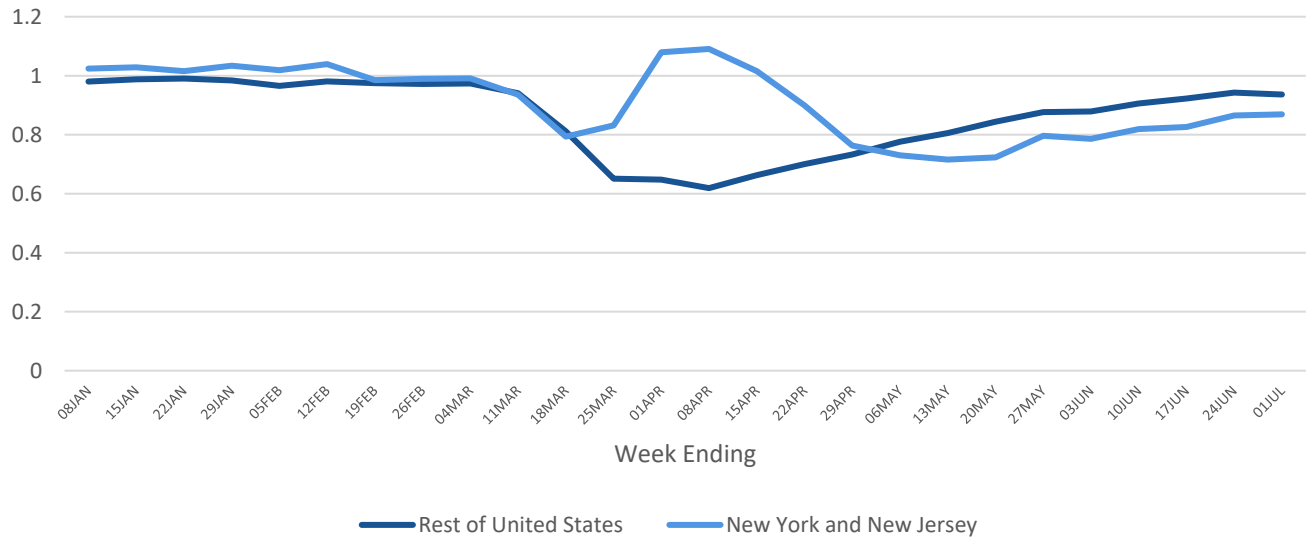
Figure 4. Ratio of 2020 to 2019 cumulative year to date Medicare fee-for-service payments, by county, through June



Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

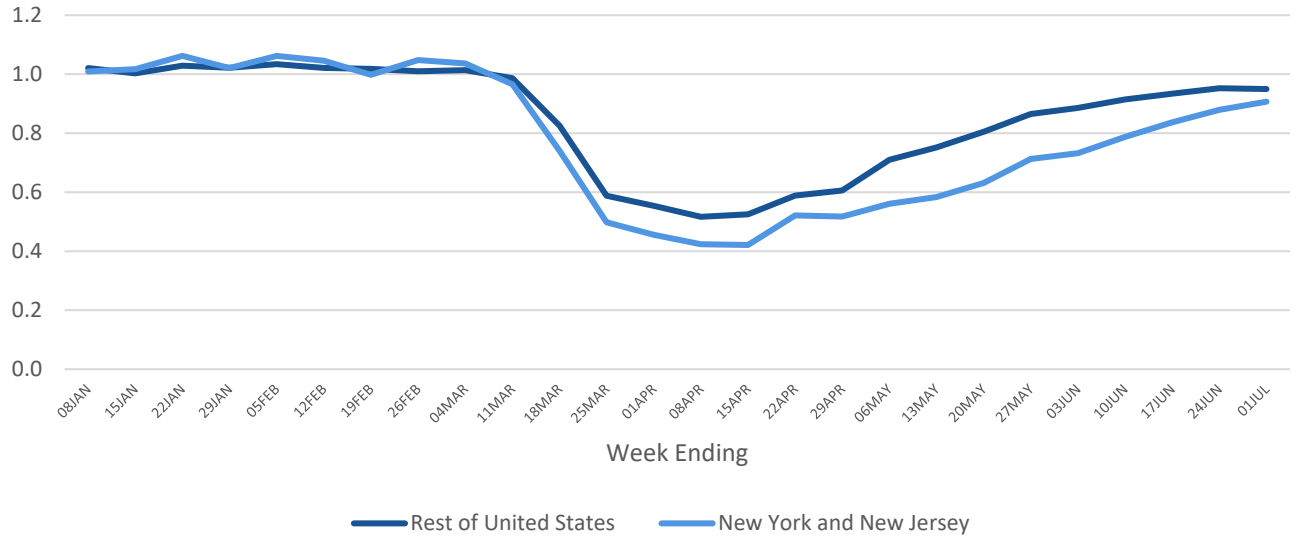
Areas with higher rates of COVID infection may actually see an increase in some services while others are in decline. As an example, Figure 5 displays the trend in inpatient services for New York and New Jersey relative to the rest of the United States. During March and April, inpatient services outside of New York and New Jersey declined by up to 38% relative to pre-pandemic levels, but increased in New York and New Jersey due to a significant number of COVID-19 admissions. Beginning in May, inpatient utilization was higher in 2020 relative to 2019 outside of New York and New Jersey than it was in those states. In contrast, Part B payments actually declined somewhat more in New York and New Jersey than in the rest of the country (Figure 6).

Figure 5. Ratio of 2020 to 2019 Medicare fee-for-service weekly payments for inpatient hospital services in New York/New Jersey and elsewhere



Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

Figure 6. Ratio of 2020 to 2019 Medicare fee-for-service weekly payments for Part B services in New York/New Jersey and elsewhere



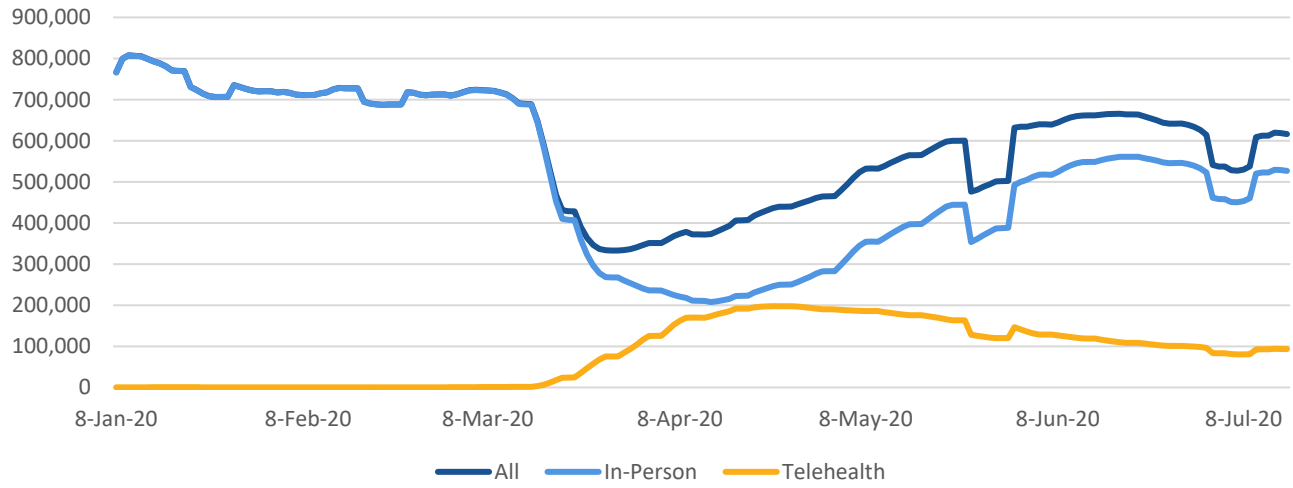
Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

Utilization patterns for select services: primary care, preventive screenings, and surgical procedures

In addition to Medicare payments presented above, we have also tracked utilization patterns for select services; particularly if delay or cancellation of their provision may be associated with adverse health consequences. Thus, we have selected primary care services for which policy changes allowed expanded telehealth visits. We selected coronary, orthopedic and breast cancer surgeries for treatment services; and mammography and colonoscopy for preventive screening services. The results are presented in this section in terms of ratios of 2020 utilization in a given week relative to 2019 utilization for that week. As expected, all of the services selected experienced steep decline in March and April and began a recovery in May.

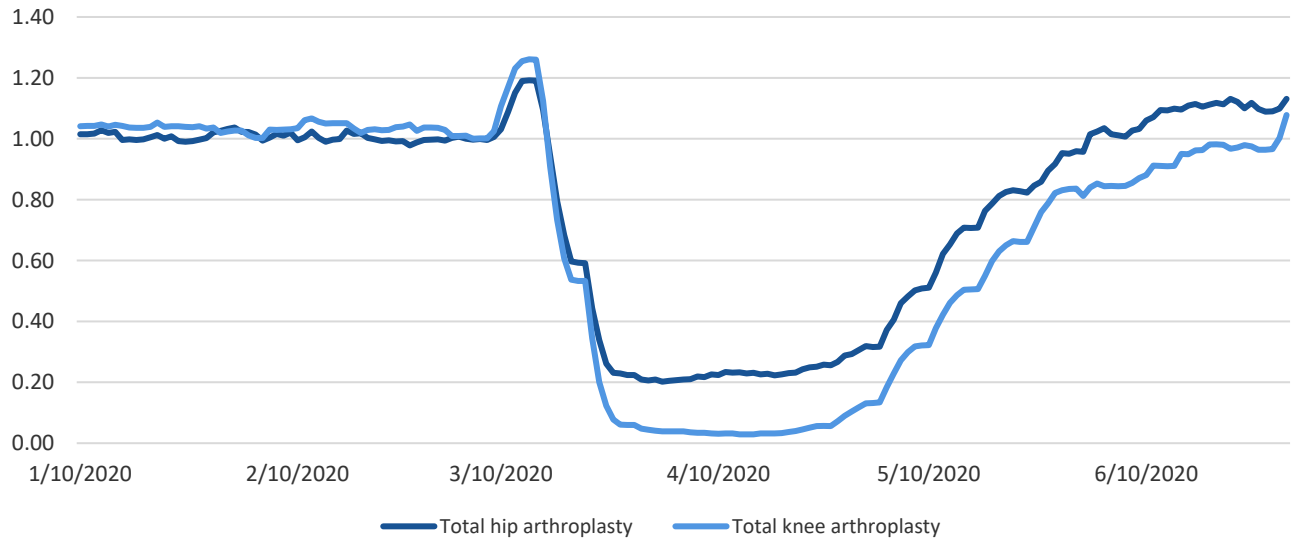
In prior work, ASPE evaluated the use of telehealth for primary care services and found that Medicare's new telehealth flexibilities played a critical role in helping to maintain access to primary care services.[2] Despite these flexibilities, primary care visits, including telehealth, remain well-below pre-pandemic levels (Figure 7).

Figure 7. 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 August 21, 2020

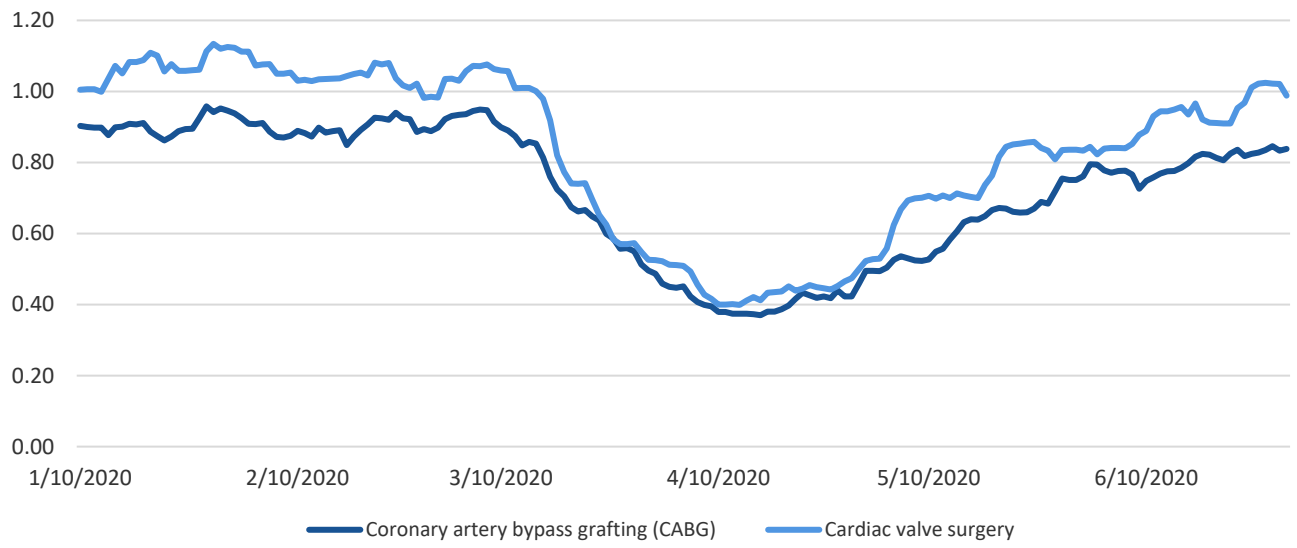
Figure 8. Ratio of 2020 to 2019 Trends in Medicare fee-for-service orthopedic surgeries



Source: Data from Medicare's shared systems as of claims submitted by August 21, 2020

Common orthopedic surgeries fell precipitously as many states imposed restrictions on elective surgery. (Figure 8). Cardiac surgeries also declined during March and April (Figure 9). Since May, these procedures have steadily increased, though are not yet back to pre-pandemic levels.

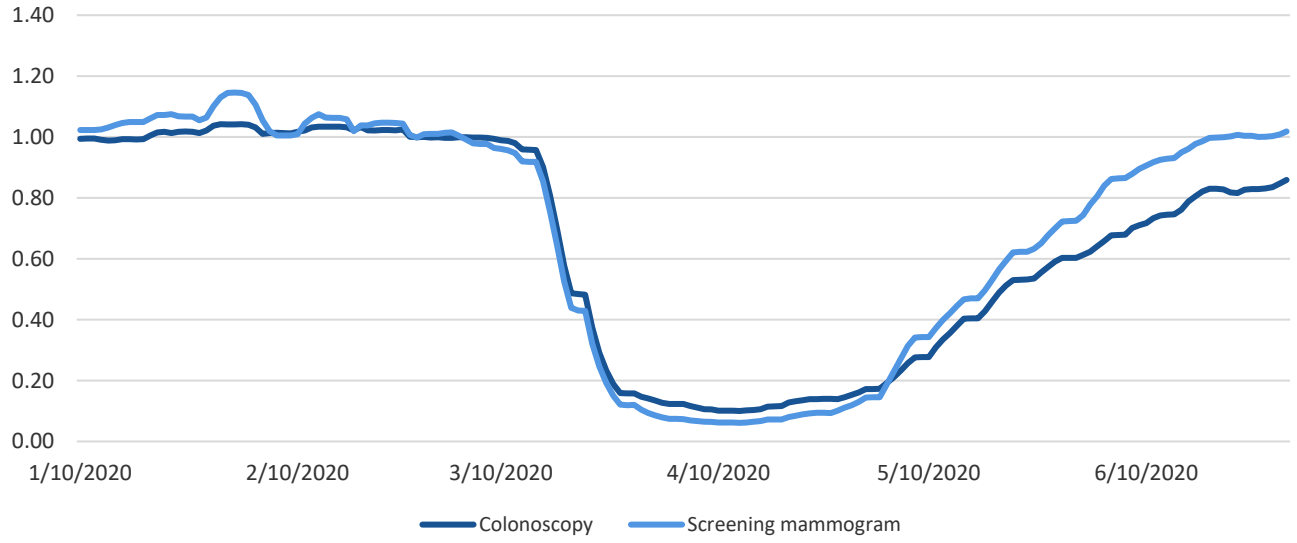
Figure 9. Ratio of 2020 to 2019 Trends in Medicare fee-for-service cardiac surgeries



Source: Data from Medicare's shared systems as of claims submitted by August 21, 2020

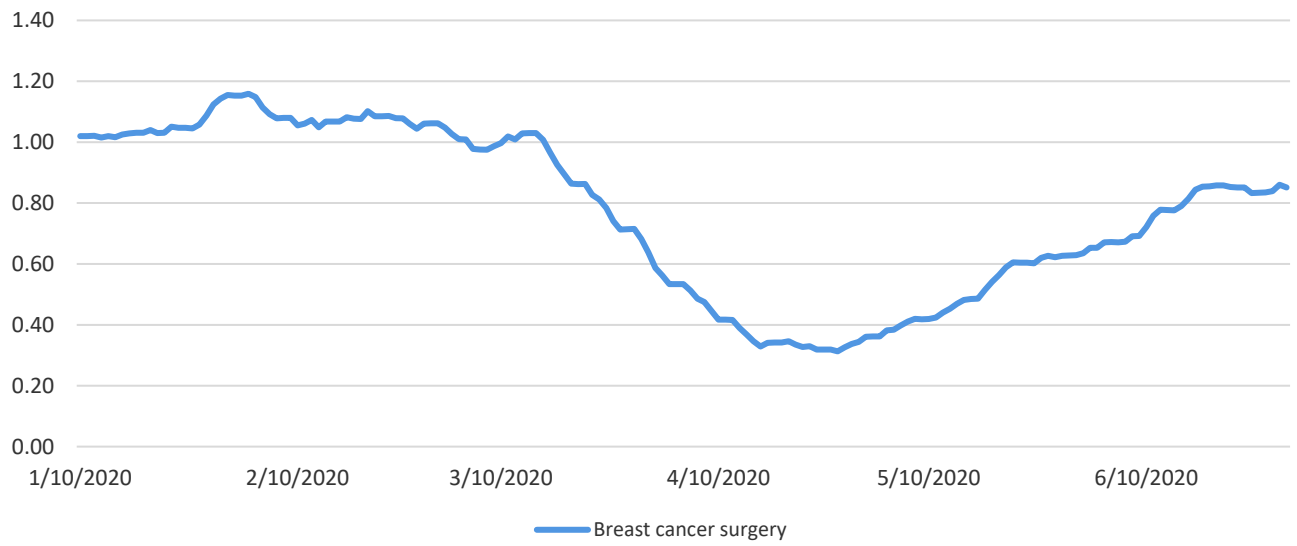
Common cancer screenings also fell in March and April, but have since returned to nearly pre-pandemic levels across the country (Figure 10). The national trend in reduction in breast cancer surgeries is shown in Figure 11, the recovery of utilization has been much more rapid in some areas than in others (Figure 12).

Figure 10. Ratio of 2020 to 2019 Trends in Medicare fee-for-service mammography and colonoscopy



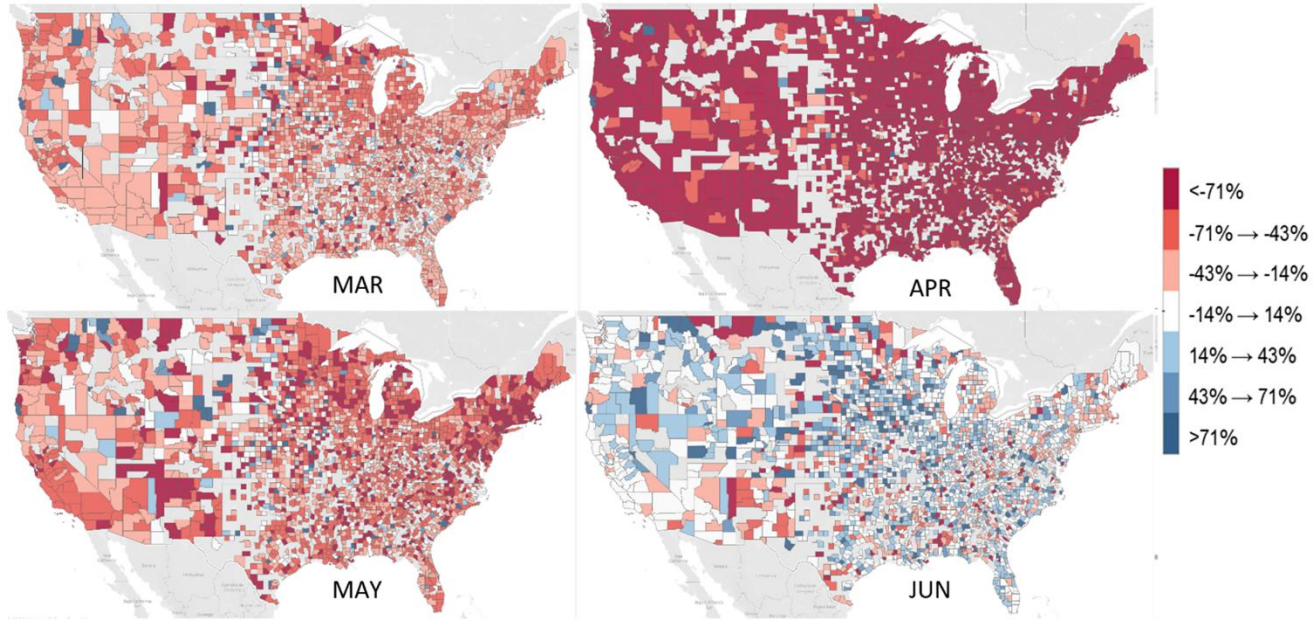
Source: Data from Medicare's shared systems as of claims submitted by August 21, 2020

Figure 11. Ratio of 2020 to 2019 Trends in Medicare fee-for-service breast cancer surgery



Source: Data from Medicare's shared systems as of claims submitted by August 21, 2020

Figure 12. Trends in Medicare fee-for-service mammography, by county, 2020



Source: Data from Medicare's shared systems as of claims submitted by September 3, 2020

SUMMARY

The COVID-19 pandemic has affected the health care delivery system in numerous ways. In hard hit areas, many hospitals were overwhelmed raising concerns about shortages of acute care beds, ventilators and protective equipment. On the other hand, elective services were cancelled and many non-emergent services were postponed across the entire 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 will depend on the magnitude of the service reduction, how long it lasts and how rapidly services recover to expected levels. This Issue Brief provides a snapshot of the COVID-19 related changes in beneficiary service utilization and provider payments for the first 6 months of 2020 with early data available to date.

In the Medicare FFS population, health service use and payments fell sharply in mid-March, bottomed out in mid-April, and began to rise again in May and June. Part B payments fell the furthest in March. Overall, utilization and payments in major service categories is still somewhat below 2019 levels and cumulative aggregate year to date deficits range from 12% - 16% to date. Despite these overall trends, there is substantial variation across service types and geographies. It is unclear how much of the reduction in health service use and spending will be recovered in the second half of the year. We do not yet know the short and long term health effects of these changes in utilization on Medicare beneficiaries or the impact on the financial resilience of providers. Careful monitoring of both trends will be important over the coming months.

APPENDIX A: Ratio of 2020 to 2019 Medicare fee-for-service weekly payments by state, selected weeks

	Ratios of 2020 to 2019 payments in week ending		
State	5 JAN 2020	8 APR 2020	1 JUL 2020
Alaska	1.19	0.66	0.97
Alabama	0.94	0.59	0.95
Arkansas	0.99	0.62	0.97
Arizona	1.01	0.62	1.00
California	1.01	0.63	0.97
Colorado	0.97	0.56	0.96
Connecticut	0.93	0.66	0.89
District of Columbia	1.06	0.75	0.87
Delaware	1.02	0.56	0.97
Florida	0.99	0.60	1.03
Georgia	0.99	0.63	0.98
Hawaii	1.01	0.59	1.02
Iowa	1.00	0.56	0.99
Idaho	0.98	0.60	1.01
Illinois	0.98	0.58	0.92
Indiana	1.00	0.59	0.96
Kansas	1.01	0.61	1.02
Kentucky	0.94	0.59	0.89
Louisiana	0.95	0.61	1.00
Massachusetts	0.99	0.62	0.90
Maryland	1.07	0.60	0.98
Maine	0.95	0.53	0.84
Michigan	0.91	0.56	0.89
Minnesota	0.95	0.53	0.92
Missouri	0.98	0.59	0.97
Mississippi	0.97	0.63	0.98
Montana	1.00	0.55	1.00
North Carolina	0.99	0.58	0.94
North Dakota	1.05	0.61	1.00
Nebraska	0.99	0.63	1.04
New Hampshire	0.99	0.53	0.90
New Jersey	0.98	0.64	0.92
New Mexico	1.00	0.61	0.95
Nevada	0.99	0.65	0.95
New York	1.03	0.78	0.90
Ohio	0.98	0.56	0.97
Oklahoma	0.94	0.59	0.97
Oregon	1.00	0.58	0.99
Pennsylvania	0.98	0.58	0.96
Rhode Island	0.96	0.56	0.90
South Carolina	1.00	0.63	1.01
South Dakota	1.03	0.56	1.02
Tennessee	0.99	0.61	0.98

Texas	0.98	0.61	0.97
Utah	0.98	0.62	1.00
Virginia	1.01	0.60	0.99
Vermont	1.01	0.53	0.92
Washington	0.92	0.61	0.98
Wisconsin	1.02	0.54	0.97
West Virginia	1.09	0.55	0.97
Wyoming	1.08	0.62	1.00

Source: Data from Medicare's common working file as of claims submitted by August 11, 2020

APPENDIX B: Diagnosis codes included in service utilization measures

Service	Code Type	Codes
Primary care*	CPT	99441; 99442; 99443; 99444; 99421; 99422; 99423; 98966; 98967; 98968; 99201; 99202; 99203; 99204; 99205; 99211; 99212; 99213; 99214; 99215; 99497; 99498; 99401; 99402; 99403; 99404; 99406; 99407; 99408; 99409; 99411; 99412
	HCPCS	G0466; G0467; G0506; G0511; G0512; G0402; G0438; G0439; G0468; G0513; G0514
Total hip arthroplasty (THA)	CPT	27130; 27125; 27132; 27134; 27137; 27138
	ICD-10	0SR9019; 0SR901A; 0SR901Z; 0SR9029; 0SR902A; 0SR902Z; 0SR9039; 0SR903A; 0SR903Z; 0SR9049; 0SR904A; 0SR904Z; 0SR9069; 0SR906A; 0SR906Z; 0SR907Z; 0SR90EZ; 0SR90J9; 0SR90JA; 0SR90JZ; 0SR90KZ; 0SRB019; 0SRB01A; 0SRB01Z; 0SRB029; 0SRB02A; 0SRB02Z; 0SRB039; 0SRB03A; SRB03Z; 0SRB049; 0SRB04A; 0SRB04Z; 0SRB069; 0SRB06A; 0SRB06Z; 0SRB07Z; 0SRB0EZ; 0SRB0J9; 0SRB0JA; 0SRB0JZ; 0SRB0KZ; 0SRA009; SRA00A; 0SRA00Z; 0SRA019; 0SRA01A; 0SRA01Z; 0SRA039; 0SRA03A; 0SRA03Z; 0SRA07Z; 0SRA0J9; 0SRA0JA; 0SRA0JZ; 0SRA0KZ; 0SRE009; 0SRE00A; 0SRE00Z; 0SRE019; 0SRE01A; 0SRE01Z; 0SRE039; 0SRE03A; 0SRE03Z; 0SRE07Z; 0SRE0J9; 0SRE0JA; 0SRE0JZ; 0SRE0KZ; 0SRR019; 0SRR01A; 0SRR01Z; 0SRR039; 0SRR03A; 0SRR03Z; 0SRR07Z; 0SRR0J9; 0SRR0JA; 0SRR0JZ; 0SRR0KZ; 0SRS0KZ; 0SU90BZ; 0SUB0BZ; 0SUA0BZ; 0SUE0BZ; 0SUR0BZ; 0SUS0BZ; 0SWA0JZ; 0SWE0JZ; 0SWR0JZ; 0SWS0JZ; 0SW90JZ; 0SWB0JZ
Total knee arthroplasty (TKA)	CPT	27447; 27445; 27446; 27486; 27487
	ICD-10	0SRC0NZ; 0SRC069; 0SRC06A; 0SRC06Z; 0SRC07Z; 0SRC0EZ; 0SRC0J9; 0SRC0JA; 0SRC0JZ; 0SRC0KZ; 0SRC0L9; 0SRC0LA; 0SRC0LZ; 0SRC0M9; 0SRC0MA; 0SRC0MZ; 0SRC0N9; 0SRC0NA; 0SRD069; 0SRD06A; 0SRD06Z; 0SRD07Z; 0SRD0EZ; 0SRD0J9; 0SRD0JA; 0SRD0JZ; 0SRD0KZ; 0SRD0L9; 0SRD0LA; 0SRD0LZ; 0SRD0M9; 0SRD0MA; 0SRD0MZ; 0SRD0N9; 0SRD0NA; 0SRD0NZ; 0SRT0KZ; 0SRU0KZ; 0SRV0KZ; 0SRW0KZ; 0SRT0J9; 0SRT0JA; 0SRT0JZ; 0SRU0J9; 0SRU0JA; 0SRU0JZ; 0SRV0J9; 0SRV0JA; 0SRV0JZ; 0SRW0J9; 0SRW0JA; 0SRW0JZ; 0SWT0JZ; 0SWU0JZ; 0SWV0JZ; 0SWW0JZ; 0SWC0KZ; 0SWD0KZ; 0SWC0JC; 0SWD0JZ
Coronary artery bypass graft (CABG)	CPT	33510; 33511; 33512; 33513; 33514; 33516; 33517; 33518; 33519; 33521; 33522; 33523; 33530; 33533; 33534; 33535; 33536
	ICD-10	0210093; 02100A3; 02100J3; 02100K3; 02100Z3; 0210493; 02104A3; 02104J3; 02104K3; 02104Z3; 021008W; 021009W; 02100AW; 02100JW; 02100KW; 021048W; 021049W; 02104AW; 02104JW; 02104KW; 021108W; 021109W; 02110AW; 02110JW; 02110KW; 021148W; 021149W; 02114AW; 02114JW; 02114KW; 021208W; 021209W; 02120AW; 02120JW; 02120KW; 021248W; 021249W; 02124AW; 02124JW; 02124KW; 021308W; 021309W; 02130AW; 02130JW; 02130KW; 021348W; 021349W; 02134AW; 02134JW; 02134KW; 0210088; 0210089; 021008C; 0210098; 0210099; 021009C; 02100A8; 02100A9; 02100AC; 02100J8; 02100J9; 02100JC; 02100K8; 02100K9; 02100KC; 02100Z8; 02100Z9; 02100ZC; 0210488; 0210489; 021048C; 0210498; 0210499; 021049C; 02104A8; 02104A9; 02104AC; 02104J8; 02104J9; 02104JC; 02104K8; 02104K9; 02104KC; 02104Z8; 02104Z9; 02104ZC; 0211088; 0211089; 021108C; 0211098; 0211099; 021109C; 02110A8; 02110A9; 02110AC; 02110J8; 02110J9; 02110JC; 02110K8; 02110K9; 02110KC; 02110Z8; 02110Z9; 02110ZC; 0211488; 0211489; 021148C; 0211498; 0211499; 021149C; 02114A8; 02114A9; 02114AC; 02114J8; 02114J9; 02114JC; 02114K8; 02114K9; 02114KC; 02114Z8; 02114Z9; 02114ZC; 021208C; 021209C; 02120AC; 02120JC; 02120KC; 02120ZC; 021248C; 021249C; 02124AC; 02124JC; 02124KC; 02124ZC; 021308C; 021309C; 02130AC; 02130JC; 02130KC; 02130ZC; 021348C; 021349C; 02134AC; 02134JC; 02134KC; 02134ZC; 021008F; 021009F; 02100AF; 02100JF; 02100KF; 02100ZF; 021048F; 021049F; 02104AF; 02104JF; 02104KF; 02104ZF; 0210083; 0210483; 211093; 212093; 212098; 212099; 213093; 213099; 213098; 02110A3; 02120A3; 02120A8; 02120A9; 02130A3; 02130A8; 02130A9
Cardiac valve surgery	CPT	33361; 33362; 33363; 33364; 33365; 33366; 33390; 33391; 33405; 33406; 33410; 33411; 33412; 33413; 33414; 33415; 33416; 33417; 33418; 33419; 33420; 33422; 33425; 33426; 33427; 33430; 33440; 33460; 33463; 33464; 33465; 33468; 33470; 33471; 33472; 33474; 33475; 33476; 33477

Service	Code Type	Codes
Cardiac valve surgery	ICD-10	027F0DZ; 027F0ZZ; 027F3DZ; 027F3ZZ; 027G0DZ; 027G0ZZ; 027G3DZ; 027G3ZZ; 027H0DZ; 027H0ZZ; 027H3DZ; 027H3ZZ; 027J0DZ; 027J0ZZ; 027J3DZ; 027J3ZZ; 02RF07Z; 02RF08Z; 02RF0JZ; 02RF0KZ; 02RF37Z; 02RF38Z; 02RF3JZ; 02RF3KZ; 02RG07Z; 02RG08Z; 02RG0JZ; 02RG0KZ; 02RG37Z; 02RG38Z; 02RG3JZ; 02RG3KZ; 02RH07Z; 02RH08Z; 02RH0JZ; 02RH0KZ; 02RH37Z; 02RH38Z; 02RH3JZ; 02RH3KZ; 02RJ07Z; 02RJ08Z; 02RJ0JZ; 02RJ0KZ; 02RJ37Z; 02RJ38Z; 02RJ3JZ; 02RJ3KZ
Colonoscopy	CPT	45305; 45308; 45309; 45315; 45320; 45331; 45380; 45384; 45385; 45300; 45303; 45330; 45333; 45335; 45338; 45341; 45342; 45346; 45349; 45350; 45378; 45381; 45388
	ICD-10	0D5C8ZZ; 0D5E8ZZ; 0D5F8ZZ; 0D5G8ZZ; 0D5H8ZZ; 0D5K8ZZ; 0D5L8ZZ; 0D5M8ZZ; 0D5N8ZZ; 0D5P8ZZ; 0D5Q8ZZ; 0DJD8ZZ; 0DBC8ZZ; 0DBE8ZZ; 0DBF8ZZ; 0DBG8ZZ; 0DBH8ZZ; 0DBK8ZZ; 0DBL8ZZ; 0DBM8ZZ; 0DBN8ZZ; 0DBP8ZZ; 0DBQ8ZZ
Screening mammogram	CPT	77065; 77066; 77067
	HCPCS	G0202
	ICD-10	BH00ZZZ; BH01ZZZ; BH02ZZZ
Breast cancer surgery	CPT	19180; 19220; 19240; 19120; 19125; 19160; 19162; 38745; 38525; 19081; 19082; 19083; 19084; 19085; 19086; 19100; 19101; 19281; 19282; 19283; 19284; 19285; 19286; 19287; 19288; 19301; 19302; 19303; 19304; 19305; 19306; 19307; 19342; 19357; 19361; 19364; 19366; 19367; 19368; 19369; 19294; 19296; 19297; 19298
	ICD-10	0HBV0ZZ; 0HBT0ZZ; 0HBU0ZZ; 0HBV0ZX; 0HBT0ZX; 0HBU0ZX; 0HRT0JZ; 0HRU0JZ; 0HRT075; 0HRT076; 0HRT077; 0HRT078; 0HRT079; 0HRT07Z; 0HRU075; 0HRU076; 0HRU077; 0HRU078; 0HRU079; 0HRU07Z; 0HRV075; 0HRV076; 0HRV077; 0HRV078; 0HRV079; 0HRV07Z; 0HTT0ZZ; 0HTV0ZZ

*For more information about primary care visit codes, see ASPE's telehealth brief.[2]

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ABOUT THE AUTHORS
Arielle Bosworth, Joel Ruhter, Steven Sheingold, and Rachael Zuckerman work for the Office of Health Policy in the Office of the Assistant Secretary for Planning and Evaluation.

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