CHAPTER 4

Physician and other health professional services

RECOMMENDATION

4 For calendar year 2021, the Congress should update the calendar year 2020 Medicare payment rates for physician and other health professional services by the amount determined under current law.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

CHAPTER 4

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Chapter summary

Physicians and other health professionals deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. In 2018, Medicare paid $70.5 billion for clinician services, accounting for 17 percent of fee-for-service (FFS) Medicare benefit spending. Medicare pays for clinician services using a fee schedule. In the same year, more than 1.2 million clinicians billed according to the fee schedule, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Under current law, there is no update to the conversion factor (a fixed dollar amount) for Medicare's fee schedule for 2021. However, clinicians are eligible for performance-based payment adjustments ranging from –7 percent to +7 percent or can receive an incentive payment worth 5 percent of their professional services payments if they participate in an advanced alternative payment model.

Assessment of payment adequacy

To assess the adequacy of current payment rates for clinicians, we assess beneficiaries' access to care, the quality of their care, and providers' payments and costs.

In this chapter

Beneficiaries' access to care—Overall, beneficiary access to clinician services is comparable with prior years.

- **Beneficiaries report relatively good access to care.** Most beneficiaries continue to report that they are able to find a new doctor without a problem. A small number of beneficiaries report more difficulty, with a higher share reporting problems obtaining a new primary care doctor than reporting problems obtaining a new specialist. The vast majority of beneficiaries report being satisfied with their care, describe using an appropriate usual source of care, and report no trouble accessing timely care.
- **The supply of clinicians continues to grow.** Growth in the number of clinicians billing under the fee schedule outpaced Medicare beneficiary growth from 2013 to 2018. However, during this time, the mix of clinicians changed: The number of primary care physicians decreased slightly, while the number of advanced practice registered nurses and physician assistants grew rapidly. The share of providers billing Medicare who are enrolled in Medicare's participating provider program—meaning they accept fee schedule amounts as payment in full—remains very high.
- **The number of clinician encounters per beneficiary is growing.** The number of clinician encounters per beneficiary increased modestly over time, with faster growth from 2017 to 2018 (1.5 percent) compared with the average annual growth rate from 2013 to 2017 (0.9 percent). Growth rates varied by specialty and type of provider. From 2017 to 2018, the number of encounters per beneficiary with primary care physicians declined by 2.7 percent, while encounters per beneficiary with advanced practice registered nurses and physician assistants increased by 10.8 percent. These findings suggest that beneficiaries are able to access care even though different clinicians may be furnishing it.

Quality of care—Patient experience scores in FFS Medicare remain stable. Geographic variation in FFS beneficiaries' ambulatory care–sensitive hospitalizations and emergency department visits signals opportunities to improve the quality of ambulatory care.

Medicare payments and providers' costs—Clinicians' Medicare payments and input costs continue to rise.

- **Medicare payments per beneficiary are growing.** Between 2017 and 2018, Medicare FFS allowed charges for clinician services (including beneficiary cost-sharing) per beneficiary grew 2.3 percent, a higher growth rate than in prior years. Among broad service categories, growth rates between 2017 and

2018 were 1.9 percent for evaluation and management services, 2.4 percent for imaging services, 2.7 percent for major procedures, 3.5 percent for other procedures, 2.4 percent for tests, and 1.3 percent for anesthesia services.

- **Commercial payment rates continue to be higher than Medicare payment rates.** In 2018, commercial payment rates for preferred provider organizations were 135 percent of Medicare FFS rates for clinician services, compared with 134 percent in 2017. The growth of commercial prices could be a result of increased consolidation of physician practices, which gives physicians greater leverage to negotiate higher prices with commercial plans.
- **Physician compensation is rising.** From 2014 to 2018, median physician compensation from all payers grew by 18.6 percent. However, median compensation in 2018 remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and nonsurgical, procedural specialties—continuing to raise concerns about the mispricing of fee schedule services and its impact on primary care.
- **Clinicians' input costs are growing.** The Medicare Economic Index—which measures input costs—grew by 1.7 percent in 2018. CMS currently projects that it will increase by 1.7 percent in 2019, 2.4 percent in 2020, and 2.6 percent in 2021.

How should payment rates change in 2021?

The Commission's analyses suggest that Medicare's payments for physicians and other health professionals are adequate. The Medicare Access and CHIP Reauthorization Act of 2015 mandates no update for clinicians for 2021. The Commission recommends that the Congress update the 2021 Medicare payment rates for physician and other health professional services by the amount determined under current law. ■

Background

Physicians and other health professionals billing under Medicare's fee schedule deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. The Medicare program paid $70.5 billion for clinician services in 2018, or 17 percent of spending in Medicare's traditional fee-for-service (FFS) program (Boards of Trustees 2019). In 2018, more than 1.2 million clinicians, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners, billed the fee schedule for at least one beneficiary.

Medicare uses a fee schedule to pay for clinician services, which consists of about 8,000 services and their payment rates. In determining payment rates for each service, CMS considers the amount of clinician work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. These three factors are adjusted for variation in the input prices in different markets, and the sum is multiplied by the fee schedule's conversion factor (a fixed dollar amount) to produce a total payment amount.[1] The conversion factor is $36.09 in 2020, up slightly from $36.04 in 2019.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a set of updates for clinicians billing under the fee schedule. MACRA established two paths: (1) a payment path for clinicians who participate in advanced alternative payment models (A–APMs), such as the Comprehensive Primary Care Plus (CPC+) model or certain accountable care organization (ACO) models, and (2) the Merit-based Incentive Payment System (MIPS) for other clinicians (Table 4-1). For 2021, there is no statutory update for clinicians. However, clinicians qualifying for the A–APM incentive payment will receive a payment worth 5 percent of their professional services payments in a lump sum. Clinicians remaining in MIPS can receive payment adjustments of –7 percent to +7 percent (or higher) in 2021, based on performance.

Are Medicare fee schedule payments adequate in 2020?

We assess payment adequacy by reviewing beneficiaries' access to care (including beneficiaries' reports of their experience accessing care, growth in the supply of clinicians, and growth in the number of clinician

TABLE 4–1 **Clinicians are eligible for performance-based payment adjustments and incentive payments but not updates to their base payments from 2020 to 2025**

	2020	2021	2022	2023	2024	2025	2026 and later
A–APM clinicians							
Update	0%	0%	0%	0%	0%	0%	0.75%
APM bonus	5%	5%	5%	5%	5%	N/A	N/A
Other clinicians							
Update	0%	0%	0%	0%	0%	0%	0.25%
Potential MIPS adjustments	(–5% to +5%)	(–7% to +7%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)

Note: A–APM (advanced alternative payment model), N/A (not applicable), MIPS (Merit-based Incentive Payment System). The annual change to the conversion factor (a fixed dollar amount) for Medicare's fee schedule is based on the statutory payment update and an adjustment to ensure that changes to the fee schedule's work relative value units are budget neutral. The 5 percent incentive payment for A–APM participation expires after 2024. The basic MIPS adjustments are budget neutral; an additional $500 million per year from 2019 to 2024 is available for exceptional performance under MIPS.

Source: Medicare Access and CHIP Reauthorization Act of 2015 and Bipartisan Budget Act of 2018, www.congress.gov.

Beneficiary surveys and focus groups used to assess access to care

We used three data sources to assess beneficiaries' reported access to timely, appropriate care:

- The Commission sponsored a telephone survey of approximately 4,000 Medicare beneficiaries ages 65 and over and 4,000 privately insured individuals ages 50 to 64. The goal in surveying these two populations is to assess whether access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year's survey was fielded from April through October of 2019.
- We analyzed 2017 findings from CMS's Medicare Current Beneficiary Survey (MCBS), which is a nationally representative in-person survey of 14,000 Medicare beneficiaries. Findings from the MCBS are not as recent as those from the Commission's survey, but the data are more comprehensive. Therefore, we use the MCBS to confirm and supplement the trends we observe in our phone survey. The MCBS's large sample—which includes both aged and disabled beneficiaries and beneficiaries in fee-for-service Medicare and Medicare Advantage—allows us to examine differences among numerous subgroups of beneficiaries.
- The Commission conducted focus groups in markets around the country to gain an in-depth understanding of beneficiary and provider experiences with the Medicare program. This year, we conducted six focus groups of Medicare beneficiaries in three markets. We also conducted focus groups with primary care and specialist physicians in those locations. ■

encounters per beneficiary). We also assess the quality of beneficiaries' care (including patient experience measures and rates of ambulatory care–sensitive hospitalizations and emergency department visits). Finally, we assess Medicare payments and providers' costs (including growth in Medicare payments per beneficiary, the ratio of commercial payment rates to Medicare's rates for clinician services, growth in physician compensation from all payers, and the change in input costs for clinician services). Overall, most indicators are positive and show no significant change from prior years.

Beneficiaries' access to care

Beneficiaries' access to care is largely comparable with (or in some cases, better than) access for privately insured individuals. Most beneficiaries report no difficulty accessing care, the number of clinicians billing under the fee schedule is growing faster than beneficiary enrollment in Medicare, and the number of clinician encounters per beneficiary is growing.

Beneficiaries report relatively good access to care

Overall, findings from the surveys and focus groups we use to assess Medicare beneficiaries' access to care (see text box) are consistent with one another and similar to prior years. The vast majority of beneficiaries report being satisfied with their care and not experiencing any trouble accessing care.

Medicare beneficiaries' overall satisfaction with care is higher than satisfaction among privately insured patients
In our 2019 telephone survey, a higher share of Medicare beneficiaries reported that they were very or somewhat satisfied with the overall quality of their care (87 percent) compared with those who have private insurance (80 percent) (Table 4-2). Similarly, CMS's Medicare Current Beneficiary Survey (MCBS) found that, in 2017, 93 percent of Medicare beneficiaries were satisfied or very satisfied with the overall quality of the care they received in the past year.

Most beneficiaries report that they are able to see a doctor when they need to Most beneficiaries report that they are able to see a doctor when they need to for both routine care and for care related to an illness or injury. In the beneficiary focus groups we conducted, most beneficiaries reported that they were able to access their primary care provider on a timely basis. In our 2019 telephone survey, 72 percent of Medicare beneficiaries reported that they never had to wait longer than they wanted for routine care, and 80 percent reported the same for illness or injury care (Table 4-3, p. 114). Medicare beneficiaries' ability to obtain either type of care when needed was statistically no different compared with privately insured individuals (the comparable rates for privately insured individuals were 74 percent for routine care and 81 percent for illness or injury care).

The MCBS found that a majority (55 percent) of beneficiaries got their last appointment with a doctor in less than 10 days. About a quarter of beneficiaries reported getting a same-day appointment, while another quarter reported waiting more than three weeks for their last appointment (Figure 4-1, p. 115).[2] We note that long waits for appointments do not necessarily mean beneficiaries are experiencing access problems because physicians sometimes instruct patients to schedule a follow-up appointment for several months from the time of their last appointment.

According to the MCBS, Medicare beneficiaries waited longer for visits with specialists than for visits with primary care providers. Among beneficiaries whose last doctor's appointment was with a primary care provider, 45 percent were seen within three days, while only 32 percent of beneficiaries seeing a specialist were seen that quickly. In addition, 30 percent of beneficiaries seeing a specialist waited more than three weeks for their last appointment, while only 24 percent of beneficiaries seeing a primary care provider waited that long. This finding is consistent with reports from our focus groups at which beneficiaries generally responded that they could access their primary care provider that day or within a few days, but some reported longer wait times to access some specialty care, including psychiatry, urology, gynecology, and dermatology. The vast majority (94 percent) of beneficiaries reported that appointments themselves were long enough, according to the MCBS.

Beneficiaries report little difficulty accessing care The MCBS found that 92 percent of beneficiaries reported no trouble accessing care in 2017. Among the 7 percent of beneficiaries who reported trouble accessing care, the cost of care was the most commonly cited barrier to care; of this subset of beneficiaries, 27 percent cited cost. Thus, on net, only 2 percent of total respondents reported that the cost of care was a barrier to access. Among the 7 percent of beneficiaries who reported trouble accessing care, only 6 percent of this subset said the trouble stemmed from providers not accepting Medicare—translating to only 0.4 percent of total respondents who encountered a provider that did not accept Medicare.

Our telephone survey asks respondents whether, when they are looking for a new doctor, they are able to find one without difficulty. Most beneficiaries reported that they were able to find a new doctor without a problem. However, consistent with prior years, beneficiaries looking for a new doctor generally reported more problems finding one when seeking a new primary care doctor than when seeking a new specialist (Table 4-3, p. 114). Specifically, among those looking, 85 percent of beneficiaries had no problem finding a specialist and 72 percent of beneficiaries had no problem finding a primary care doctor. This pattern of greater difficulty among Medicare beneficiaries in finding a new primary care doctor relative to finding a specialist is consistent with prior years, other surveys, and our beneficiary focus groups.

In addition, because relatively few beneficiaries were looking for a new physician and most of those looking

TABLE 4–2

More Medicare beneficiaries are satisfied with the overall quality of their care in the past 12 months than are privately insured individuals, 2019

	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Very satisfied	68%	59%
Somewhat satisfied	19	22
Somewhat dissatisfied	3	3
Very dissatisfied	1	2

Note: Table excludes the following responses: "Did not receive health care in past 12 months," "Don't know," and "Refused." It does not include Medicare beneficiaries under the age of 65. Components may not sum to 100 percent due to rounding and excluded data.

Source: MedPAC-sponsored telephone survey conducted in 2019.

TABLE 4–3

Most aged Medicare beneficiaries and older privately insured individuals had good access to physician care, 2015–2019

	Medicare (ages 65 and older)					Private insurance (ages 50–64)				
Survey question	**2015**	**2016**	**2017**	**2018**	**2019**	**2015**	**2016**	**2017**	**2018**	**2019**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"										
For routine care										
Never	72%[a]	68%[b]	73%[a]	70%[ab]	72%	69%[ab]	67%[b]	69%[ab]	64%[ab]	74%
Sometimes	19[a]	22	20[a]	20[a]	20	23[ab]	23[b]	22[ab]	26[ab]	19
Usually	4[b]	4[b]	3	5[b]	3	4	5	4	5	4
Always	3	3	3	3[a]	3	3	4[b]	3	4[ab]	3
For illness or injury										
Never	82[a]	79[a]	80[a]	79[a]	80	77[ab]	75[ab]	76[ab]	74[ab]	81
Sometimes	13[a]	16[a]	15[a]	15[a]	14	17[ab]	19[ab]	18[ab]	19[ab]	15
Usually	3	2[a]	2	2	2	3	3[ab]	2	3[b]	2
Always	2	2[a]	1[a]	2	2	2	3[ab]	2[a]	2	1
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"										
Share answering "Yes"	11	11[a]	11[b]	11[ab]	9	12[b]	12[ab]	12[b]	14[ab]	10
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")										
Primary care doctor	7[a]	8[a]	9[a]	10[b]	8	9[a]	10[a]	11[ab]	10	9
Specialist	16	18	17[a]	19[ab]	17	18[b]	18[b]	20[ab]	21[ab]	15
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."										
Primary care physician										
No problem	67	64	69[a]	71	72[a]	63	63	59[a]	67	62[a]
Share of total insurance group	*4.7*	*5.1*	*6.2*	*7.1*[b]	*5.5*	*5.7*	*6.1*	*6.5*	*6.7*[b]	*5.4*
Small problem	18	15	13	13	13[a]	18	16	18	16	20[a]
Share of total insurance group	*1.2*	*1.2*	*1.2*[a]	*1.3*	*1.0*[a]	*1.7*	*1.5*	*2.0*[a]	*1.6*	*1.7*[a]
Big problem	14	20	14[a]	14	14	17	20	22[a]	16	17
Share of total insurance group	*1.0*	*1.6*	*1.3*[a]	*1.4*	*1.1*	*1.5*	*1.9*	*2.4*[ab]	*1.7*	*1.5*
Specialist										
No problem	87[a]	82	83	84	85[a]	82[a]	79	81	80	79[a]
Share of total insurance group	*14.2*	*14.7*	*14.1*	*16.1*	*14.2*[a]	*14.8*[b]	*14.4*[b]	*16.2*[b]	*17.1*[b]	*12.0*[a]
Small problem	7	10[b]	11[b]	7	6[a]	8	9	11	9	11[a]
Share of total insurance group	*1.1*	*1.8*[b]	*1.9*[b]	*1.4*	*1.1*	*1.5*	*1.6*	*2.2*	*2.0*	*1.7*
Big problem	6	8[a]	5[ab]	8	8	9	11[a]	8[a]	10	9
Share of total insurance group	*1.0*[a]	*1.4*	*0.9*[a]	*1.5*	*1.4*	*1.7*[a]	*2.0*	*1.6*[a]	*2.0*	*1.4*

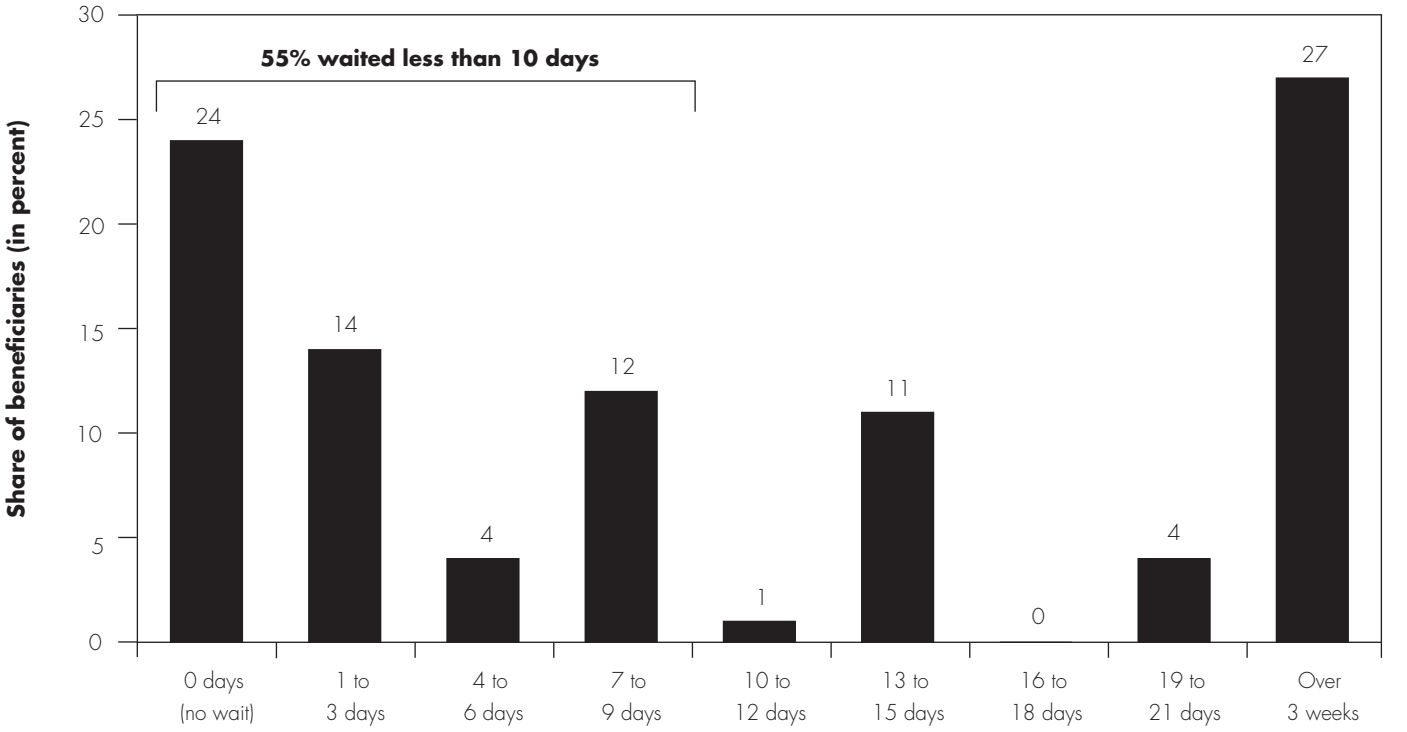
Note: Components may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample sizes for each group (Medicare and privately insured) are approximately 4,000. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.

[a] Statistically significant difference between the Medicare and privately insured groups in the given year (at a 95 percent confidence level).

[b] Statistically significant difference from 2019 within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted from 2015 to 2019.

FIGURE 4–1 **A majority of beneficiaries waited less than 10 days for their last doctor's appointment**



Note: In addition, 3 percent of beneficiaries reported that they "don't know" how long they waited for their last doctor's appointment, and a response to this question could not be ascertained from another 0.2 percent of respondents. This question was asked of noninstitutionalized beneficiaries with a doctor's appointment in the past year. Percentages do not sum to total due to rounding.

Source: MedPAC analysis of CMS's 2017 Medicare Current Beneficiary Survey.

had no problem finding one, the share of Medicare beneficiaries who had a problem finding a new physician was very small. About 8 percent of Medicare beneficiaries were looking for a new primary care doctor, and of those looking, 14 percent reported a big problem—meaning that, on net, only 1.1 percent of beneficiaries reported a big problem. In addition, about 17 percent of beneficiaries were looking for a new specialist doctor; of those looking, 8 percent reported a big problem—meaning that, on net, only 1.4 percent of beneficiaries reported a big problem.

Relative to individuals with private insurance, Medicare beneficiaries continue to be less likely to report problems finding a new doctor. For example, among those who tried to get an appointment with a new primary care doctor in the last 12 months, 72 percent of Medicare beneficiaries said they had no problem finding a doctor who would treat them compared with 62 percent among individuals ages 50–64 with private insurance (Table 4-3).

Minority beneficiaries reported more difficulty receiving care as soon as they wanted and higher rates of forgoing care Consistent with general trends in poorer access to health care among racial and ethnic minority groups, we continue to find through the Commission's telephone survey that Medicare beneficiaries who belong to racial or ethnic minority groups are more likely to face difficulties finding a new physician and to wait longer than they want for care compared with White beneficiaries.[3] For example, among those looking for a new specialist, a higher share of minority Medicare beneficiaries reported that they had a big problem finding a new one compared with non-Hispanic White beneficiaries (16 percent vs. 7 percent) (Table 4-4, p. 116). A similar pattern (of more difficulty

TABLE 4–4

Medicare beneficiaries had similar access to physicians compared with privately insured individuals, but minorities in both groups reported problems more frequently, 2019

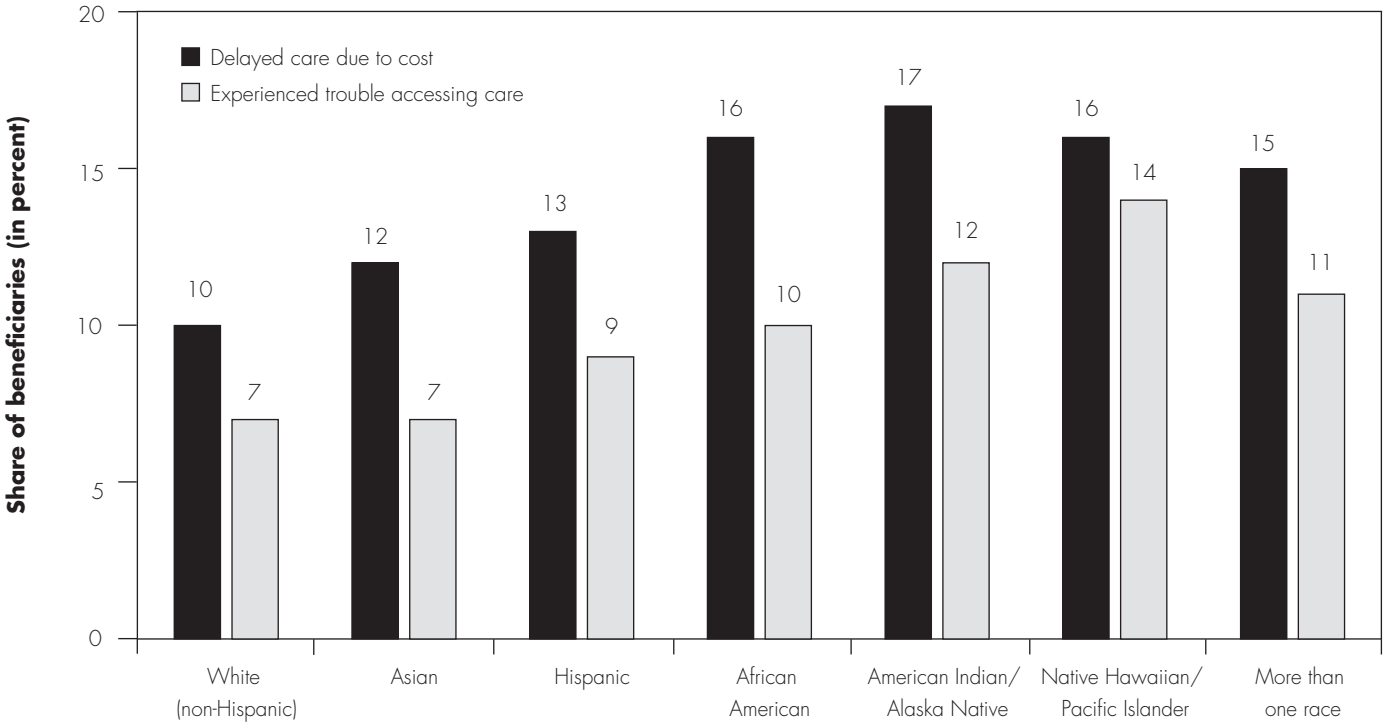
	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	**All**	**White**	**Minority**	**All**	**White**	**Minority**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	72%	74%[b]	68%[b]	74%	76%[b]	68%[b]
Sometimes	20	19	22	19	18[b]	22[b]
Usually	3	3	3[a]	4	3[b]	6[ab]
Always	3	2	3	3	2	3
For illness or injury						
Never	80	82[b]	76[b]	81	83[b]	77[b]
Sometimes	14	13[b]	18[b]	15	14[b]	18[b]
Usually	2	2	3	2	2	2
Always	2	2	1	1	1[b]	3[b]
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Share answering "Yes"	9	9	11	10	9[b]	12[b]
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care physician	8	8	8	9	9	9
Specialist	17	18[b]	14[b]	15	16	13
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."						
Primary care physician						
No problem	*72*[a]	*74*	*66*	*62*[a]	*65*	*56*
Share of total insurance group, by race	*5.5*	*5.6*	*5.3*	*5.4*	*5.6*	*5.2*
Small problem	13[a]	12	14	20[a]	19	23
Share of total insurance group, by race	*1.0*[a]	*0.9*	*1.1*	*1.7*[a]	*1.6*	*2.1*
Big problem	14	12	20	17	16	20
Share of total insurance group, by race	*1.1*	*0.9*	*1.6*	*1.5*	*1.4*	*1.9*
Specialist						
No problem	85[a]	88[ab]	*75*[b]	*79*[a]	81[ab]	*72*[b]
Share of total insurance group, by race	*14.2*[a]	*15.4*[ab]	*10.4*[b]	*12.0*[a]	*12.7*[ab]	*9.4*[b]
Small problem	6[a]	6	9	11[a]	9[b]	18[b]
Share of total insurance group, by race	*1.1*	*1.0*	*1.3*	*1.7*	*1.5*	*2.3*
Big problem	8	*7*[b]	16[b]	9	9	10
Share of total insurance group, by race	*1.4*	*1.1*	*2.2*	*1.4*	*1.4*	*1.3*

Note: Components may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Respondents who did not report race or ethnicity were not included in "White" or "Minority" results, but were included in "All" results. "White" in the table refers to non-Hispanic White respondents. Sample sizes for each group (Medicare and privately insured) were approximately 4,000 in 2019. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.
[a] Statistically significant difference between the Medicare and privately insured populations in the given year (at a 95 percent confidence level).
[b] Statistically significant difference by race within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2019.

FIGURE 4–2

Higher shares of racial and ethnic minority beneficiaries reported trouble accessing care and delaying care due to cost than White beneficiaries, 2017



Note: Figure excludes institutionalized beneficiaries.

Source: MedPAC analysis of CMS's 2017 Medicare Current Beneficiary Survey.

among minorities finding a specialist) existed for privately insured individuals.

Similar trends were observed in CMS's MCBS. Larger shares of most racial and ethnic minorities reported having trouble accessing care than non-Hispanic White beneficiaries, and all minorities reported higher rates of delaying care due to cost than non-Hispanic White beneficiaries (Figure 4-2). (Both of these questions ask about accessing care in general and are not specific to accessing clinician care.)

No meaningful differences in access between urban and rural beneficiaries Similar to prior years, the Commission's telephone survey showed no substantive differences in access between urban and rural beneficiaries (Table 4-5, p. 118). For example, there was no significant difference between the share of urban and rural beneficiaries experiencing an unwanted delay in getting an appointment for routine care or for an illness or injury. The MCBS also found no meaningful differences between urban and rural beneficiaries' access to care.

Nearly all beneficiaries have a regular source of care, with more use of nurse practitioners and physician assistants in rural areas In 2019, nearly all beneficiaries—94 percent—in the Commission's telephone survey reported that they had a regular source of primary care (data not shown). This finding is consistent with the MCBS data: 92 percent of beneficiaries reported having a usual source of care. Among Medicare beneficiaries with a usual source of care, the MCBS found that the vast majority used appropriate care settings as their usual source of care; only 1 percent used a hospital emergency room or an urgent care clinic as their usual source of care.

TABLE 4–5

Access to physician care for Medicare beneficiaries was similar to or slightly better than access for privately insured individuals, urban and rural areas, 2019

	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	**All**	**Urban**	**Rural**	**All**	**Urban**	**Rural**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	72%	74%	70%	74%	74%	76%
Sometimes	20	20	21	19	19	17
Usually	3	3[a]	4	4	4[a]	3
Always	3	3	2	3	2	3
For illness or injury						
Never	80	80	80	81	81	82
Sometimes	14	14	12	15	15	13
Usually	2	2	2	2	2	2
Always	2	2	2	1	1	2
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Share answering "Yes")	9	10[b]	7[ab]	10	9[b]	12[ab]
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care physician	8	8	6	9	8	9
Specialist	17	17	19[a]	15	15	13[a]
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."						
Primary care physician						
No problem	72[a]	69	68	62[a]	64	63
Share of total insurance group, by area	*5.5*	*5.3*	*4.2*	*5.4*	*5.1*	*5.6*
Small problem	13[a]	14	13	20[a]	19	17
Share of total insurance group, by area	*1.0[a]*	*1.1*	*0.8*	*1.7[a]*	*1.5*	*1.6*
Big problem	14	15	18	17	16	20
Share of total insurance group, by area	*1.1*	*1.2*	*1.1*	*1.5*	*1.3*	*1.8*
Specialist						
No problem	85[a]	86[a]	92[a]	79[a]	80[a]	78[a]
Share of total insurance group, by area	*14.2[a]*	*14.6[a]*	*17.3[a]*	*12.0[a]*	*12.2[a]*	*10.1[a]*
Small problem	6[a]	6	4	11[a]	10	11
Share of total insurance group, by area	*1.1*	*1.1*	*0.6*	*1.7*	*1.6*	*1.3*
Big problem	8	8	4	9	10	11
Share of total insurance group, by area	*1.4*	*1.3*	*0.8*	*1.4*	*1.5*	*1.3*

Note: Components may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample sizes for each group (Medicare and privately insured) were approximately 4,000 in 2019. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65. The Commission uses the Census Bureau definitions of "urban" and "rural." The Census Bureau classifies as "urban" all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census block groups or blocks that have a population density of at least 1,000 people per square mile, and surrounding census blocks that have an overall density of at least 500 people per square mile. In addition, under certain conditions, less densely settled territory may be part of each UA or UC. The Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of UAs and UCs.

[a] Statistically significant difference between the Medicare and privately insured populations in a given year (at a 95 percent confidence level).

[b] Statistically significant difference by area type within the same insurance category in a given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2019.

TABLE 4–6

The number of clinicians billing under the fee schedule has increased, but the mix of clinicians has changed, 2013–2018

	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
Year	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total
2013	140	426	146	148	861	2.9	8.9	3.1	3.1	17.9
2014	141	432	161	152	886	2.9	8.8	3.2	3.1	17.9
2015	141	439	178	157	915	2.8	8.7	3.5	3.1	18.0
2016	141	447	198	162	948	2.7	8.6	3.8	3.1	18.2
2017	140	455	218	168	981	2.6	8.5	4.1	3.1	18.4
2018	139	461	237	177	1,012	2.6	8.5	4.3	3.2	18.5

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialties" include family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists (see text box on identifying hospitalists, pp. 120–121). Hospitalists are counted in "other specialties." "Other practitioners" include clinicians such as physical therapists, psychologists, social workers, and podiatrists. The number of clinicians billing Medicare includes those with a caseload of more than 15 beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in Part B in fee-for-service or Medicare Advantage based on the assumption that clinicians generally furnish services to beneficiaries in both programs. Numbers vary from those that appeared in prior reports due to changes in how hospitalists are counted and other technical changes. Numbers exclude nonperson providers such as clinical laboratories and independent diagnostic testing facilities.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2019 annual report of the Boards of Trustees of the Medicare trust funds.

In our beneficiary focus groups, nearly all beneficiaries reported a regular source of primary care, including physicians, nurse practitioners (NPs), or physician assistants (PAs). In the Commission's telephone survey, more than 40 percent of beneficiaries responded that they saw an NP or PA for at least some of their primary care. Similar to prior years, rural beneficiaries were more likely than urban beneficiaries to report seeing NPs and PAs for all or most of their primary care.

Growth in the supply of clinicians billing Medicare has outpaced enrollment growth, but the mix of clinicians is changing

From 2013 to 2018, the number of clinicians billing Medicare under the fee schedule grew faster than the Medicare population. However, the mix of clinicians has changed over time.

We limited our analysis of clinicians to those who billed Medicare for more than 15 beneficiaries in a given year. This minimum threshold helps us to (1) better measure clinicians who substantially participate in Medicare and are therefore likely critical to ensuring beneficiary access to care and (2) avoid year-to-year variability in clinician counts (e.g., physicians entering and exiting our analysis because they billed for one or two beneficiaries in one year but no beneficiaries the following year).[4]

Using the 15-beneficiary threshold, from 2013 to 2018, we found that the number of clinicians billing Medicare grew from about 861,000 to 1,012,000 (Table 4-6). Over the same period, the total number of clinicians per 1,000 beneficiaries increased from 17.9 to 18.5.[5]

While the number of clinicians billing Medicare has increased, trends varied by type and specialty of clinicians. From 2013 to 2016, the number of primary care physicians billing the fee schedule increased modestly, but declined in 2017 and 2018. On net, these changes resulted in about 1,000 fewer primary care physicians billing Medicare in 2018 compared with 2013. In contrast, the number of advanced practice registered nurses (APRNs) and PAs billing Medicare increased rapidly; from 2013 to

Identifying hospitalists in Medicare claims data

Hospitalists are physicians whose primary focus is the general medical care of hospitalized patients. Organized hospitalist programs first emerged in the mid-1990s. Under these programs, hospitalists cared for patients instead of primary care physicians rounding in hospitals to see their admitted patients. The number of hospitalists in the U.S. has grown rapidly. According to one estimate, from 2010 to 2016, the number of hospitalists in the United States grew from about 30,000 to over 50,000 (Wachter and Goldman 2016).

In the second quarter of 2017, CMS established a new specialty code for hospitalists. Before that, hospitalists billed Medicare under some other self-selected specialty. Historically, the Commission defined primary care physicians as those who billed a plurality of their fee schedule allowed charges under one of four specialties—internal medicine, family medicine, geriatrics, or pediatrics—and included all other physicians in the "other specialties" category. Because nearly all hospitalists historically billed under the internal medicine or family medicine specialties, the Commission's methodology has, in prior years, counted many hospitalists as primary care physicians.

While some hospitalists may provide primary care services, including them in the count of primary care physicians is problematic because the care they furnish generally does not meet the criteria that are commonly used to define primary care. *Primary care* is commonly defined in the literature as including five core elements: first-contact accessibility, continuity over time, comprehensiveness of care, accountability for the whole person, and coordination of care across providers and settings (O'Malley et al. 2015). The services hospitalists furnish generally do not meet all five of these criteria. For example, hospitalists usually do not serve as the first contact point for patients and do not provide longitudinal care.

The Commission used the introduction of the hospitalist specialty code in 2017 to more fully understand the billing patterns of hospitalists and to establish a methodology to retrospectively identify hospitalists in claims data and exclude them from our count of primary care physicians. We found, based on the billing patterns of all self-identified hospitalists from the fourth quarter of 2017 (about 8,000 physicians):

- of those who billed Medicare in 2016, about 96 percent billed under the internal medicine (88 percent) or family medicine (9 percent) specialties;
- nearly all (99 percent) of the allowed charges billed by self-identified hospitalists were for evaluation and management (E&M) services;
- nearly all (95 percent) of the allowed charges billed by self-identified hospitalists were in the hospital

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2018, the number of APRNs and PAs grew from about 146,000 to 237,000. The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed Medicare increased modestly. (The methodology used to calculate the numbers in Table 4-6 differs from previous years. See the text box for more information.)

Most clinicians who bill Medicare are participating providers

In 2018, 97 percent of clinicians billing under the fee schedule were participating providers. Participating providers agree to take assignment for all claims, which means that they accept the fee schedule amount (which includes Medicare's payment plus beneficiary cost sharing) as payment in full. Nonparticipating providers

Identifying hospitalists in Medicare claims data (cont.)

inpatient (85 percent) or hospital outpatient (11 percent) settings; and

- a large majority (91 percent) of the allowed charges billed by hospitalists in the hospital outpatient setting were for hospital observation services.

Based on the billing patterns of self-identified hospitalists in the last quarter of 2017, we defined a set of criteria to identify hospitalists in Medicare claims data for the years before physicians could self-identify as hospitalists and before the hospitalist specialty code is fully adopted by physicians. Specifically, we consider physicians to be hospitalists in a given year if they meet any one of these three criteria:

- billed a plurality of their allowed charges under the hospitalist specialty;
- billed a plurality of their allowed charges as a primary care physician, 75 percent or more of all their allowed charges for E&M services, and 75 percent or more of their allowed charges for E&M services in the hospital inpatient setting;[6] or
- billed a plurality of their allowed charges as a primary care physician, 75 percent or more of all their allowed charges for E&M services, 50 percent to 75 percent of their allowed charges for E&M services in the hospital inpatient setting, and 90 percent or more of their allowed charges for E&M services in the hospital inpatient setting or for hospital observation care.

Using this methodology, we found that the number of hospitalists billing Medicare increased substantially over time. For example, from 2013 to 2018, the total number of hospitalists who billed Medicare for at least one beneficiary increased from about 40,000 to 51,000. We also found that, even after the introduction of the new hospitalist specialty code in 2017, most hospitalists continued to bill under other specialties. For example, in 2018, we found that only about 12,000 physicians billed a plurality of their allowed charges as a hospitalist. Other researchers have also noted the slow uptake of the new specialty code (Flansbaum et al. 2020).

CMS's introduction of the new specialty code for hospitalists has enabled easier identification of these clinicians and, in turn, has allowed the Commission to more accurately identify primary care physicians. Nonetheless, because full uptake of the new hospitalist specialty code will likely take several years, the Commission will continue to analyze trends in the number of physicians billing the program using the methodology we developed to identify hospitalists. While any claims-based count of hospitalists is necessarily an approximation, netting out the fast-growing hospitalist specialty from our historical counts of primary care physicians reveals slower growth (or slight declines) in the number of primary care physicians billing the fee schedule.[7] The Commission has a long-standing concern about the future pipeline of primary care physicians and will continue to monitor beneficiaries' access to primary care. ■

can choose whether to take assignment for their claims on a claim-by-claim basis. Nonparticipating providers who take assignment on a claim receive 95 percent of the fee schedule amount. Nonparticipating providers who do not take assignment on a claim may "balance bill" beneficiaries up to 109.25 percent of the fee schedule amount.[8] While balance billing is allowed, clinicians rarely balance bill beneficiaries for fee schedule services; in 2018, 99.6 percent of fee schedule claims were paid on assignment.

Clinicians can also sign up as an opt-out provider if they wish to bill beneficiaries for services directly, outside of the Medicare benefit. The 25,000 clinicians who had chosen to opt out of Medicare as of October 2019 were concentrated in the specialties of behavioral health (40

TABLE 4–7

Total encounters per beneficiary increased, but mix of clinicians furnishing care changed from 2013 to 2018

	Encounters per beneficiary			Percent change in encounters per beneficiary	
Specialty category	2013	2017	2018	Average annual (2013–2017)	2017–2018
Total (all clinicians)	20.8	21.6	21.9	0.9%	1.5%
Primary care physicians	4.1	3.7	3.6	–3.0	–2.7
Specialists	12.5	12.7	12.8	0.3	0.7
APRNs/PAs	1.3	2.0	2.2	11.6	10.8
Other practitioners	2.8	3.2	3.3	2.7	3.5

Note: APRN (advanced practice registered nurse), PA (physician assistant). We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the services. Figures do not account for "incident to" billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare's "incident to" rules are included in the physician totals. We use the number of fee-for-service beneficiaries enrolled in Part B to define encounters per beneficiary.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2019 annual report of the Boards of Trustees of the Medicare trust funds.

percent of clinicians who opted out),[9] oral health (30 percent),[10] and primary care (11 percent)[11] (Centers for Medicare & Medicaid Services 2018a). The number of clinicians who opted out in 2019 was comparable with the number who did so in 2018.

Total number of clinician encounters per beneficiary grew faster from 2017 to 2018 than in recent years

We use encounters between beneficiaries and clinicians as another measure of access to care (see text box on pp. 124–125). Encounters are a measure of entry into the health care system. Entry can be a first step toward timely use of services (Office of Disease Prevention and Health Promotion 2019).

We developed a claims-based definition of encounters.[12] Clinicians submit a claim when they furnish one or more services to a Medicare FFS beneficiary. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would count that as one encounter.

We found that the number of encounters per FFS beneficiary increased modestly over time, with faster growth from 2017 to 2018 than in recent years. Specifically, from 2013 to 2017, the number of total encounters per beneficiary increased from 20.8 to 21.6, an average annual increase of 0.9 percent (Table 4-7). From 2017 to 2018, the number of encounters per beneficiary increased from 21.6 to 21.9, an increase of 1.5 percent.

Growth rates in the number of encounters per beneficiary varied by specialty and type of provider From 2017 to 2018, the number of encounters per beneficiary with primary care physicians declined by about 2.7 percent (Table 4-7). Over the same period, the number of encounters per beneficiary with APRNs or PAs increased by about 10.8 percent, the number of encounters with specialist physicians (who account for a majority of all encounters) increased slightly (0.7 percent), and encounters with other practitioners (e.g., physical therapists) increased moderately (3.5 percent). The changes from 2017 to 2018 are part of a longer-term trend. For example, from 2013 to 2017, we also found declines in encounters per beneficiary with primary care physicians, rapid growth in encounters with APRNs or PAs, and slow or moderate growth in encounters with all other clinicians.

The decline in beneficiary encounters with primary care physicians occurred across a broad range of services. For example, from 2013 to 2018, the average annual change in the number of encounters per beneficiary with primary

TABLE 4–8 **Encounters grew modestly across all service types, 2013–2018**

Type of service	Encounters per beneficiary			Percent change in encounters per beneficiary	
	2013	2017	2018	Average annual (2013–2017)	2017–2018
Total (all services)	20.8	21.6	21.9	0.9%	1.5%
Evaluation and management	12.4	12.8	13.0	0.9	1.2
Major procedures	0.2	0.2	0.2	0.3	1.5
Other procedures	4.2	4.5	4.7	2.0	2.8
Imaging	3.9	4.0	4.1	0.7	0.7
Tests	2.1	2.1	2.1	0.2	0.9
Anesthesia	0.5	0.5	0.5	3.1	2.7

Note: We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the services. We use the number of fee-for-service beneficiaries enrolled in Part B to define encounters per beneficiary. Values by type of service do not sum to the total because encounters that include multiple service types are counted separately for each type of service but counted only once for the total. For example, if an imaging service and a test were billed in the same encounter, we count that as one encounter for imaging and one for tests (for a total of two encounters), but we count the services as one encounter for the total row.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2019 annual report of the Boards of Trustees of the Medicare trust funds.

care physicians for E&M services, other procedures, imaging services, and tests was –2.3 percent, –3.3 percent, –4.2 percent, and –5.5 percent, respectively (data not shown).[13]

The decline in beneficiary encounters with primary care physicians was driven mostly by a decline in the number of encounters per beneficiary rather than a decline in the number of beneficiaries with at least one encounter. From 2013 to 2018, while the total number of primary care physician encounters decreased by more than 13 percent, the number of beneficiaries who had at least one encounter with a primary care physician fell by less than 3 percent (data not shown).

Further, recent research has documented that similar decreases in encounters with primary care physicians also have occurred among the commercially insured population (Ganguli et al. 2019). This trend suggests that primary care physicians are not filling their patient panels with commercially insured patients in lieu of Medicare beneficiaries. Rather, the consistent declines across patient populations suggest that more systematic changes in primary care encounters are occurring.

One likely factor in the decrease in encounters with primary care physicians is the increasing prevalence of APRNs and PAs. While only a portion of APRNs and PAs work in primary care, our analysis found that the decline in beneficiary encounters with primary care physicians coincided with a dramatic rise in encounters with APRNs or PAs, suggesting that these clinicians increasingly furnish some services once performed by physicians.[14] These findings could also help explain why the Commission's annual telephone survey has not indicated a decline in access to primary care, even though encounters with primary care physicians declined substantially; beneficiaries are still able to access care, but different clinicians may be furnishing it.

Encounters per beneficiary grew across service types

Examining beneficiary encounters by service type, we found that encounters grew modestly, with some differences across categories. From 2017 to 2018, the number of E&M encounters per beneficiary provided by all clinicians rose 1.2 percent, from 12.8 to 13.0 (Table 4-8). Over the same time period, imaging encounters grew the slowest (0.7 percent), and encounters involving

Changes to how the Commission uses claims-based measures of service use as part of its assessment of payment adequacy

Historically, the Commission measured changes in service use as changes in the number of services (i.e., counts of services on claims) and changes in the complexity or intensity of services (e.g., substituting a computed tomography (CT) scan for an X-ray increases the intensity of care). While this methodology provided insight into the drivers of increased spending (e.g., more services or an increase in service intensity), one key disadvantage was that it was sensitive to shifts in the site of service. For example, in 2019, when a CT of the head (Healthcare Common Procedure Coding System code 70450) was performed in a hospital outpatient department instead of a physician office, the number of relative value units (RVUs) (a measure of intensity) billed under the fee schedule was 63 percent lower because of the way Medicare treats physician practice expense payments when clinicians provide services in hospital outpatient departments.

Because many services once billed in physician offices have shifted (and continue to shift) to hospital outpatient departments, relying on RVUs to measure service use has translated into apparent negative volume trends for many categories of services in the Commission's annual assessments. While these shifts have important ramifications for total Medicare spending (because Medicare pays more overall for services performed in hospitals than physician offices), they also confound our ability to measure volume trends. For example, if volume declined for a particular category of services, the trend could be driven by actual reductions in service use or a shift to hospital outpatient departments. (The Commission discussed this issue extensively in its June 2019 report to the Congress (Medicare Payment Advisory Commission 2019).)

Because of these issues, the Commission now calculates new measures of service use to more clearly differentiate access and spending trends. To inform our assessment of beneficiary access to care, we now calculate beneficiary encounters with clinicians. We define *encounters* as unique combinations of beneficiary identification numbers, claim identification

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a procedure other than a major procedure (i.e., "other" procedures) grew most rapidly (2.8 percent). Other procedures include skin procedures and various forms of outpatient therapy (physical therapy, occupational therapy, and speech language pathology). With the exception of anesthesia services, growth in encounters per beneficiary from 2017 to 2018 was similar to or faster than the average annual growth rate from 2013 to 2017.

Quality of care

We assess the quality of the ambulatory care environment for Medicare FFS beneficiaries using patient experience measures (measured using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey) and population-based outcome measures assessing ambulatory care–sensitive (ACS) hospitalizations and emergency department visits.[15] This approach is consistent with the Commission's principle that Medicare's quality incentive programs should use a small set of population-based outcome, patient experience, and value measures to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, ACOs, and FFS in defined market areas as well as those cared for by particular hospitals, groups of clinicians, and other providers (Medicare Payment Advisory Commission 2018a). By contrast, CMS primarily measures the performance of clinicians in the Merit-based Incentive Payment System (MIPS) using clinician-reported and clinician-attested individual quality measures and clinician attestation of participation in

Changes to how the Commission uses claims-based measures of service use as part of its assessment of payment adequacy (cont.)

numbers (for paid claims), and national provider identifiers of the clinicians who billed for the services. Our measure of encounters is less sensitive to shifts in the settings where services are furnished than our old measure of RVUs. For example, we count an office visit as one encounter regardless of whether it takes place in a physician office or hospital outpatient department.

Data on the number of encounters per beneficiary help the Commission assess whether there has been a change in beneficiary access to care. Interpreted together with other indicators, such as those derived from the Commission's telephone survey and data on the number of clinicians billing the fee schedule, growth in the number of encounters provides perspective on the frequency of beneficiary interactions with clinicians and thus measures clinicians' willingness to furnish services to Medicare beneficiaries.

Our other two measures—changes in units of service and allowed charges (which includes beneficiary and program spending)—are critical to understand spending trends but are less useful as indicators of access. Units of service, for example, are influenced not just by changes in service use but also by the way services are defined (e.g., bundling of multiple billing codes into one). Therefore, we use growth in units of service and allowed charges to aid our understanding of spending trends. When analyzed by type of service, our analysis shows which services contribute the most to growth in total spending. Moreover, when compared with each other, growth in units of service and allowed charges can indicate the need for further investigation. For example, if units of service grow more slowly than allowed charges for a particular type of service, further analysis would show whether spending has changed because of a change in service mix (e.g., a shift within the type of service from services with lower RVUs to ones with higher RVUs). By contrast, if units of service and allowed charges increase at similar rates (after accounting for any updates to the conversion factor), growth in spending is likely due to growth in the number of services. ■

certain activities (see text box for second-year results of MIPS, pp. 126–127).

Patient experience scores remain stable

The Agency for Healthcare Research and Quality's CAHPS survey initiative develops a variety of standardized patient surveys that ask well-tested questions using a consistent methodology across a large sample of respondents. CAHPS surveys generate standardized and validated measures of patient experience that enable health care providers, purchasers, and policymakers to track, compare, and improve patients' experiences in different health care settings. CAHPS surveys measure a key component of quality of care because they assess whether something that should happen in a health care setting (such as clear communication with a provider) actually happened or how often it happened. When patients have a better experience, they are more likely to adhere to treatments, return for follow-up appointments, and engage with the health care system by seeking appropriate care.

CMS annually fields a CAHPS survey among a subset of FFS beneficiaries. The questions on the survey relate to the beneficiary's experience of care with Medicare and their FFS providers. Overall, how Medicare FFS beneficiaries rated their health care quality and reported their ability to get care quickly was generally stable between 2014 and 2018 (Table 4-10, p. 128).

Medicare's Quality Payment Program: Year 2 results

In 2019 and 2020, about a million clinicians will receive additional payments from Medicare, in the form of either positive adjustments to their payment rates under the Merit-based Incentive Payment System (MIPS) or advanced alternative payment model (A–APM) incentive payments. MIPS adjustments (which can be positive or negative) are based on clinician performance in four areas: quality; promoting interoperability (formerly "meaningful use" of electronic health records); improvement activities; and cost. Clinicians are exempt from MIPS and instead receive an annual incentive payment worth 5 percent of their Medicare professional services payments if they substantially participate in an A–APM. Together, MIPS and A–APM incentive payments are known as Medicare's Quality Payment Program.

MIPS payment adjustments are based on clinician performance from two years prior (e.g., in 2020, adjustments are based on clinicians' 2018 performance). In 2020, about 890,000 clinicians are subject to MIPS. Of these clinicians, about 97 percent are receiving a positive adjustment (Table 4-9)—up from the 93 percent in 2019 (data not shown). About 2 percent are receiving a negative adjustment (Table 4-9)—down from 5 percent in 2019 (data not shown) (Centers for Medicare & Medicaid Services 2020a, Centers for Medicare & Medicaid Services 2020b, Centers for Medicare & Medicaid Services 2019b). CMS has set low performance thresholds in the initial years of MIPS: Clinicians needed only 3 points out of 100 to avoid a negative payment adjustment in the first year of MIPS and needed only 15 points in the second year. That being said, the median clinician score ended up being well above these thresholds in both years—at 89 points and 99.6 points, respectively.

By law, positive adjustments (which are budget neutral and offset by negative payment adjustments) can reach as high as 5 percent for top-performing MIPS clinicians in 2020; an additional $500 million is also available to distribute to clinicians with "exceptional" performance (and is not budget neutral). In 2020, actual positive MIPS adjustments are as high as 0.2 percent, and the additional "exceptional" performance adjustment brings the maximum MIPS payment adjustment to 1.68 percent. These adjustments are smaller than the maximum adjustment legally allowed because only 2

TABLE 4–9

The vast majority (97 percent) of clinicians subject to MIPS are receiving a positive payment adjustment in 2020

	Percentage of clinicians subject to MIPS	Payment adjustment
Clinicians subject to MIPS		
Above the "exceptional" performance threshold	84%	+0.21% to +1.68%
Above the performance threshold	13	>0% to +0.20%
At the performance threshold	0	0%
Below the performance threshold	2	–5% to <0%

Note: MIPS (Merit-based Incentive Payment System). Components do not sum to 100 percent due to rounding.

Source: Centers for Medicare & Medicaid Services. 2020. 2018 Quality Payment Program (QPP) performance results. January 6. https://www.cms.gov/blog/2018-quality-payment-program-qpp-performance-results.

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Medicare's Quality Payment Program: Year 2 results (cont.)

percent of eligible clinicians are receiving a negative adjustment in 2020, so a relatively small amount of funds are available to distribute to the 97 percent of eligible clinicians qualifying for positive adjustments. This phenomenon was also observed in 2019, when positive payment adjustments were legally allowed to reach as high as 4 percent, but in actuality reached only 0.2 percent; the additional $500 million available for "exceptional" performance brought the maximum MIPS adjustment in 2019 to 1.88 percent (Centers for Medicare & Medicaid Services 2018b).

About 183,000 clinicians are exempt from MIPS in 2020 because they participated in an A–APM in 2018, and instead receive a 5 percent incentive payment. This number is nearly double the number of clinicians in A–APMs in the prior year (99,000) (Centers for Medicare & Medicaid Services 2019b).

CMS has estimated that another 540,000 clinicians are exempt from MIPS in 2020 because they fell under CMS's low-volume threshold in 2018—meaning they did not bill more than $90,000 in Medicare Part B covered professional services or did not see more than 200 Part B patients that year (Centers for Medicare & Medicaid Services 2017).

In March 2018, the Commission recommended eliminating MIPS, because it is based on predecessor programs that have generally not been successful, exempts many clinicians, allows clinicians to choose which quality measures are used to assess their performance, and imposes a significant reporting burden on clinicians. In addition, MIPS adjustments will be small in the program's early years, then arbitrary and possibly very large in later years, creating financial uncertainty for clinicians. In place of MIPS, the Commission has recommended a Voluntary Value Program in which clinicians could elect to be measured as part of a group, and clinicians in those groups could qualify for a value payment based on their group's performance on a set of population-based measures (Medicare Payment Advisory Commission 2018b). ■

Measures of ambulatory care–sensitive hospitalizations and emergency department visits signal opportunities for improvement

The Commission has discussed the use of two claims-based outcome measures—ACS hospitalizations and emergency department (ED) visits—to compare quality of care within and across different populations (e.g., FFS Medicare in different local market areas), given the adverse impact on beneficiaries and high cost of these events. (These measures were not designed to assess the quality of individual clinicians.) Conceptually, an ACS hospitalization or ED visit refers to hospital use that could have been prevented with appropriate, high-quality, and timely care in ambulatory care settings. Two categories of ACS conditions are included in the measures: chronic (e.g., diabetes, asthma, hypertension) and acute (e.g., bacterial pneumonia, cellulitis). Although payers often examine total hospital utilization or measures of total spending in cost containment efforts, identification of potentially avoidable hospital admissions or ED visits for ACS conditions can offer more useful insights into the quality of care provided to beneficiaries in a market area and may inform quality improvement initiatives in Medicare.

We find variation in the distribution of risk-standardized rates of avoidable hospitalizations and ED visits per 1,000 FFS beneficiaries for the Dartmouth-defined hospital service areas (HSAs), which signals opportunities to improve the quality of FFS ambulatory care (Table 4-11, p. 129).[16] The HSA at the 90th percentile of ACS hospitalizations had a rate that was 1.9 times the HSA

TABLE 4–10 **Medicare FFS CAHPS® performance rates, 2014–2018**

CAHPS composite measure	2014	2015	2016	2017	2018
Getting needed care and seeing specialists	86%	85%	84%	84%	83%
Getting appointments and care quickly	76	75	77	77	77
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical records, helps with managing care)	86	85	86	86	85
Rating of health plan (FFS Medicare)	84	82	84	83	83
Rating of health care quality	86	86	85	85	85

Note: FFS (fee-for-service), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). Questions in rows 1 to 3 have responses of "Never," "Sometimes," "Usually," and "Always." CMS converts these to a linear mean score on a 0 to 100 scale. Questions in rows 4 and 5 have responses of 1 to 10 (which CMS converts to a linear mean score on a 0 to 100 scale). "Plan" in the fourth row refers to the Medicare FFS program.

Source: FFS CAHPS mean scores provided by CMS.

at the 10th percentile. The HSA at the 90th percentile of ACS ED visits had a rate that was 2.4 times the HSA in the 10th percentile. Relatively poor performance on a local market's ACS hospitalization and ED visit measures can identify opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can identify best practices for ambulatory care systems.

The Commission plans to continue to refine a set of population-based outcome measures—such as readmissions and ACS hospitalizations and ED visits—that Medicare can calculate using administrative data and use to compare quality across Medicare populations.

Medicare payments and providers' costs

Because clinicians do not report their costs to the Medicare program, we use other measures to assess Medicare payments to clinicians and the projected increase in clinicians' costs. The first measure is growth in Medicare FFS allowed charges (payments to providers, including beneficiary cost sharing) for fee schedule services. The second measure is how commercial rates paid by preferred provider organizations (PPOs) for clinician services compare with Medicare's rates. The third measure examines growth in all-payer physician compensation and compares compensation across specialties. The fourth measure assesses the change in input prices for clinician services using the Medicare Economic Index (MEI).

We found that allowed charges per beneficiary for clinician services between 2017 and 2018 grew 2.3 percent, a higher growth rate than in prior years. In 2018, commercial payment rates for PPOs were 135 percent of Medicare FFS rates for clinician services, compared with 134 percent in 2017. From 2014 to 2018, median physician compensation from all payers grew by 18.6 percent, but median compensation in 2018 remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and nonsurgical, procedural specialties. Meanwhile, the MEI increased by 1.7 percent in 2018, and CMS projects that it will increase by 2.6 percent in 2021.

Allowed charges grew faster from 2017 to 2018 than in recent years

The allowed charges for a clinician service are the payment amount specified for a given service under the physician fee schedule multiplied by the units of the service billed by clinicians. Allowed charges are the total payments a provider receives (including beneficiary cost sharing) and are a function of the fee schedule's RVUs, the fee schedule's conversion factor, and other payment

TABLE 4–11

Distribution of risk-standardized ambulatory care–sensitive hospitalizations and emergency department visits rates across hospital service areas signals opportunities for improvement, 2018

	Risk-standardized rate per 1,000 FFS beneficiaries			
	10th percentile (high performing)	50th percentile	90th percentile (low performing)	Ratio of 90th to 10th percentile
Ambulatory care–sensitive hospitalizations	36.1	50.2	68	**1.9**
Ambulatory care–sensitive ED visits	64.4	102.3	154.6	**2.4**

Note: FFS (fee-for-service), ED (emergency department). Lower rates are better. To measure population-based outcomes for FFS beneficiaries, we calculated the risk-standardized rates of admissions and ED visits tied to a set of acute and chronic conditions per 1,000 FFS beneficiaries in hospital service areas (HSAs). There are about 3,400 Dartmouth-defined HSAs. The average FFS population in each HSA is about 10,000 beneficiaries. We excluded any HSA with fewer than 1,000 FFS beneficiaries.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries.

adjustments such as those determined by geographic practice cost indexes.

We used claims data from 2013, 2017, and 2018 to analyze changes in allowed charges for the services furnished by clinicians billing under Medicare's fee schedule. We grouped individual service codes into broad service categories that are clinically meaningful (e.g., E&M, major procedures). Most broad service categories contain multiple subcategories of similar services (e.g., E&M includes office/outpatient services, hospital inpatient services, and other subcategories).

We also present changes in units of service per beneficiary. A difference between a change in allowed charges and a change in units of service means that one of the factors influencing allowed charges—other than units of service—has changed. For example, if providers substitute higher-RVU computed tomography (CT) scans for lower-RVU X-rays, the allowed charges for imaging services would increase at a higher rate than would units of service. However, we recommend caution in interpreting such data. Evidence indicates that decreases in allowed charges could be related to the movement of services from freestanding offices to hospitals (see text box, p. 131).

Between 2017 and 2018, across all services, allowed charges per beneficiary grew by 2.3 percent (Table 4-12, p. 130). Among broad service categories, growth rates were 1.9 percent for E&M services, 2.4 percent for imaging services, 2.7 percent for major procedures, 3.5 percent for other procedures, 2.4 percent for tests, and 1.3 percent for anesthesia services. Growth in allowed charges from 2017 to 2018 was faster than the average annual growth rates from 2013 to 2017 for all services (combined) and for each broad service category except anesthesia.

Subcategories of services sometimes experienced more rapid growth in allowed charges than the broad service category. For example, from 2017 to 2018, growth in the other procedures category was 3.5 percent, but growth in the subcategory of physical, occupational, and speech therapy was 8.8 percent.

Among the service subcategories, care management/coordination had the highest rate of growth in allowed charges: 33.7 percent per year from 2013 to 2017 and 12.4 percent from 2017 to 2018. CMS created new billing codes for transitional care management (TCM) in 2013 and chronic care management (CCM) in 2015 and 2017.[17] The CCM and TCM services accounted for most of the growth in allowed charges for care management/coordination from 2017 to 2018, increasing by 27.4 percent and 14.5 percent, respectively (data not shown). At the same time, the allowed charges for other care management/coordination services (e.g., physician certification and recertification of home health care, home health care supervision, and hospice care supervision)

TABLE 4–12

Allowed charges per beneficiary continued to grow, 2013–2018

Type of service	Change in units of service per beneficiary		Change in allowed charges per beneficiary		Share of 2018 allowed charges
	Average annual 2013–2017	2017–2018	Average annual 2013–2017	2017–2018	
All services	**0.7%**	**1.9%**	**1.1%**	**2.3%**	**100.0%**
Evaluation and management	**0.5**	**1.1**	**1.5**	**1.9**	**50.4**
Office/outpatient services	0.5	0.8	1.4	1.9	25.6
Hospital inpatient services	–1.4	–0.7	–0.1	0.5	10.8
Emergency department services	0.6	–2.0	2.3	–1.4	3.0
Nursing facility services	0.9	3.2	2.2	4.2	2.9
Ophthalmological services	–0.1	1.1	0.0	3.8	2.8
Behavioral health services	2.3	2.6	5.0	5.0	1.9
Critical care services	1.9	2.2	2.6	2.1	1.4
Care management/coordination	27.0	23.6	33.7	12.4	0.9
Observation care services	5.0	3.3	6.1	4.2	0.7
Home services	–1.4	–1.1	–1.4	–0.4	0.3
Imaging	**–0.3**	**1.3**	**0.3**	**2.4**	**11.0**
Standard X-ray	–2.1	0.5	–1.3	1.5	3.1
Ultrasound	0.2	1.2	1.9	1.4	2.9
CT	4.1	3.8	3.7	4.7	2.0
Nuclear	–2.5	–2.0	–0.2	2.6	1.3
MRI	2.4	2.1	–3.6	2.0	1.3
Major procedures	**–0.1**	**1.8**	**1.7**	**2.7**	**7.5**
Musculoskeletal	0.3	3.4	1.4	3.5	2.8
Vascular	0.4	–1.4	8.7	4.8	1.4
Cardiovascular	1.2	1.9	1.8	1.9	1.0
Other organ systems	–0.8	2.1	–0.1	1.3	0.9
Digestive/gastrointestinal	–2.5	–0.6	–1.8	–0.3	0.8
Skin	0.2	0.9	–0.3	1.7	0.5
Eye	–0.6	0.4	–4.5	0.8	0.2
Other procedures	**2.6**	**3.7**	**0.6**	**3.5**	**22.6**
Skin	1.6	1.3	1.0	3.5	4.4
Physical, occupational, and speech therapy	7.3	7.9	7.8	8.8	4.0
Musculoskeletal	0.2	1.3	2.0	2.7	2.5
Eye	1.6	3.5	–0.1	2.8	2.4
Radiation oncology	–0.8	1.8	–1.2	3.3	2.0
Other organ systems	1.0	1.9	1.4	2.7	1.7
Digestive/gastrointestinal	–0.5	0.7	–3.8	0.8	1.3
Dialysis	–1.7	–0.7	0.5	1.3	1.1
Vascular	–5.5	0.6	–4.8	3.8	1.0
Chiropractic	–1.9	0.8	0.7	2.6	0.8
Chemotherapy administration	–3.4	–0.9	–4.3	3.6	0.5
Injections and infusions: non-oncologic	–1.7	–1.7	–2.5	–13.0	0.4
Tests	**0.3**	**1.3**	**0.1**	**2.4**	**5.1**
Anatomic pathology	–0.4	2.1	–1.5	1.9	2.2
Cardiography	0.2	1.5	3.1	6.4	1.3
Neurologic	0.0	1.2	0.8	2.4	0.9
Anesthesia	**3.2**	**2.7**	**1.4**	**1.3**	**2.9**

Note: CT (computed tomography), MRI (magnetic resonance imaging). Some low-spending categories are not shown but are included in the calculations. We use the number of fee-for-service beneficiaries enrolled in Part B to define allowed charges per beneficiary.

Source: MedPAC analysis of claims data for 100 percent of Medicare fee-for-service beneficiaries.

Shifts in billing from freestanding offices to hospitals reduce fee schedule–allowed charges but raise overall Medicare spending

Growth in allowed charges is sensitive to shifts in the site of care. Medicare makes both a physician fee schedule payment and a facility payment when a service is provided in a hospital outpatient department (HOPD). However, the program makes only a fee schedule payment when a service is furnished in a freestanding office. In 2019, for example, a common evaluation and management (E&M) office visit (Healthcare Common Procedure Coding System code 99213) had an average nonfacility (freestanding office) fee schedule payment rate of $75. By contrast, the average fee schedule payment rate for the visit when provided in an HOPD was $52, and the facility payment to the HOPD was $116 (for a combined payment of $168).[18] Thus, the shift of office visits from freestanding offices to HOPDs reduces the allowed charge billed under the fee schedule (from $75 to $52) but increases the total Medicare payment amount (from $75 to $168).

In recent years, there has been a trend toward billing for some services in hospitals instead of freestanding offices. From 2012 to 2018, for example, the number of E&M office visits performed in HOPDs grew by 37 percent, compared with a 2 percent decline in physician offices. During the same period, the number of chemotherapy administration services delivered in HOPDs grew 53 percent, while the number provided in physician offices declined 17 percent. This change in the billed setting increases overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in HOPDs than in freestanding offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012). For example, we estimate that in 2018, the Medicare program spent $2.2 billion more than it would have if payment rates for office visits in HOPDs were the same as freestanding office rates. In addition, in the same year, beneficiaries' cost sharing was $550 million more than it would have been had payment rates been the same in both settings.

To address the increased spending that results when services shift from freestanding offices to HOPDs, the Commission has recommended adjusting payment rates in the outpatient prospective payment system (OPPS) so that Medicare pays the same amount for E&M office/outpatient visits in freestanding offices and HOPDs (Medicare Payment Advisory Commission 2012). As of 2019, Medicare pays a comparable amount for E&M office/outpatient visits in freestanding offices and off-campus HOPDs; however, Medicare continues to pay a higher amount for these visits when provided in on-campus HOPDs.[19] The Commission also has recommended adjusting OPPS rates for services in ambulatory payment classification (APC) groups that meet certain criteria so that payment rates are equal or more closely aligned between HOPDs and freestanding offices (Medicare Payment Advisory Commission 2014).[20] APCs that meet these criteria are those that are unlikely to have costs associated with operating an emergency department, do not have extra costs associated with higher patient complexity in HOPDs, and include services that are frequently performed in physicians' offices (which indicates that these services are likely safe and appropriate to provide in a physician's office). ■

increased at a somewhat slower rate (4.1 percent) (data not shown). Although care management/coordination experienced high growth, it accounted for less than 1 percent of total fee schedule spending in 2018.

From 2017 to 2018, a few types of services experienced decreases in allowed charges. For example, the largest decrease (13.0 percent) was for nononcologic injections and infusions (Table 4-12). This decrease was greater than the 1.7 percent decrease in units of service. The difference is explained by a 19.4 percent decrease in RVUs implemented by CMS in 2018 for the most frequently billed service (which includes certain therapeutic, prophylactic, and diagnostic injections and infusions) in this category.

Commercial PPO payment rates remain higher than Medicare payment rates for clinician services

In 2018, commercial payment rates for PPOs for clinician services were 135 percent of Medicare's FFS payment rates, compared with 134 percent in 2017.[21] In 2011, commercial rates were 122 percent of Medicare rates. The ratio in 2018 varied by type of service. For example, commercial rates were 128 percent of Medicare rates for E&M office visits for established patients but 169 percent of Medicare rates for coronary artery bypass graft surgery. This analysis uses data on paid claims for PPO members of a large national insurer that covers a wide geographic area across the U.S. The payments reflect the insurer's allowed amount (including allowed cost sharing). The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments.

The gap between commercial rates and Medicare rates has grown in recent years as commercial rates have risen while Medicare rates have remained relatively stable. The growth of commercial prices could be a result of greater consolidation of physician practices and increased physician employment by hospitals, which give providers more leverage to negotiate higher prices with commercial plans (see Chapter 15 in this report on health care provider consolidation issues and 340B incentives). In recent years, an increasing number of physicians have joined larger groups, hospitals, and health systems. For example, between 2009 and 2014, the share of physicians working in practices with more than 50 physicians grew from 16 percent to 22 percent (Medicare Payment Advisory Commission 2017). A recent survey found that, from 2012 to 2018, the share of physicians who worked for hospitals increased from 29 percent to 35 percent (Kane 2019).

Studies show that commercial prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation (Baker et al. 2014, Clemens and Gottlieb 2017, Neprash et al. 2015). Our own research found that independent practices with larger market shares and hospital-owned practices received higher commercial prices for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). For example, independent practices with a large market share of E&M visits received an average commercial price for an E&M visit that was 141 percent of the Medicare FFS rate. By contrast, the average commercial price received by the smallest independent practices for an E&M visit was about equal to Medicare's rate. These findings indicate that the ratio of commercial rates to Medicare rates for physician services vary based on practice size and physician–hospital consolidation because larger practices can obtain higher prices from commercial payers than smaller practices can.

In addition to varying within markets, evidence suggests that commercial prices for physician services vary widely across markets. A study by the Congressional Budget Office (CBO) using data from 2014 found that the average ratio of commercial prices to Medicare FFS prices for 20 common physician services was at least 70 percent higher in the most costly market than in the least costly market (Congressional Budget Office 2018).

The CBO study found much less variation in the average ratio of Medicare Advantage (MA) prices to Medicare FFS prices across and within markets. MA plans paid much lower prices than commercial plans for the 20 services examined in the study, and the median MA prices for these services were almost the same as the median Medicare FFS prices. These results suggest that MA plans—but not commercial plans—can benchmark their prices to Medicare FFS rates. The similar payment rates may partly explain why CMS's MCBS found no meaningful difference in access to care for beneficiaries in MA compared with FFS Medicare.[22]

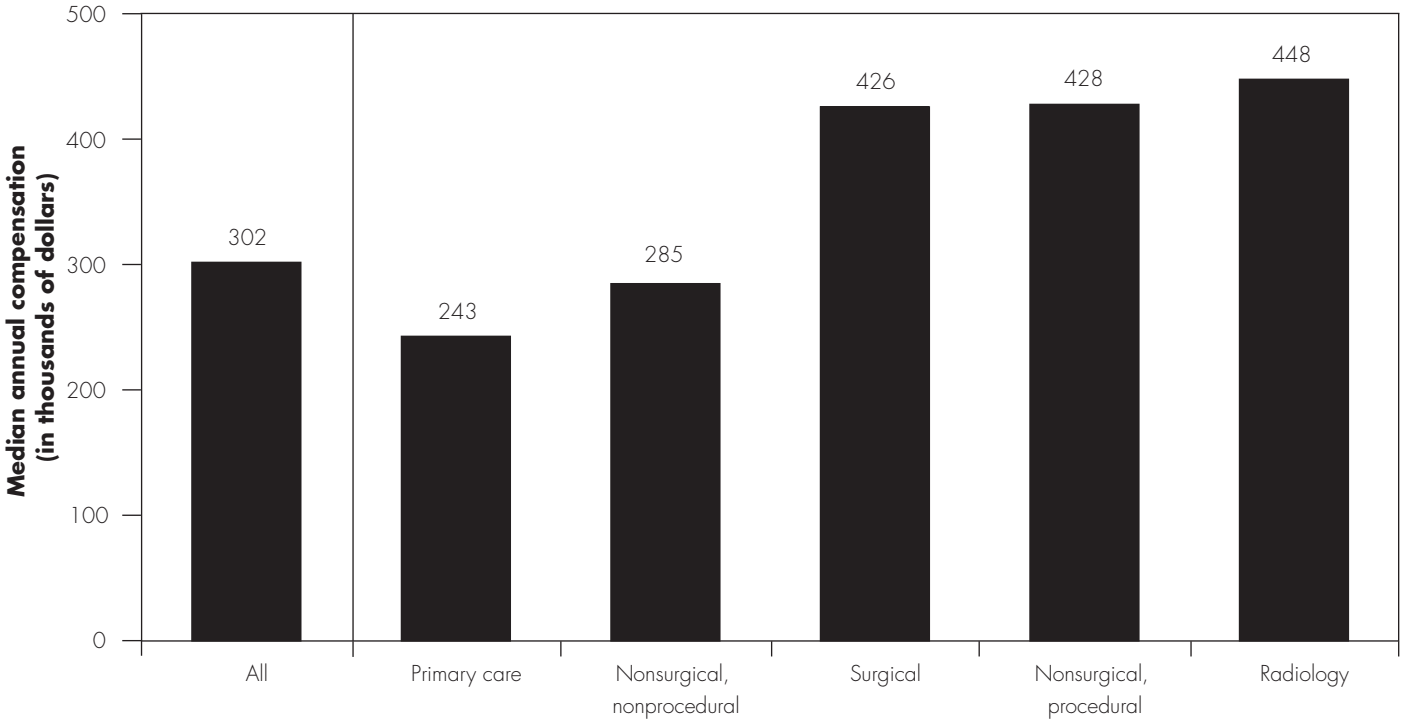
Compensation is much higher for certain specialties than for primary care

To examine compensation received from all payers by physicians, we analyzed 2018 data from SullivanCotter's Physician Compensation and Productivity Survey. Median compensation across all specialties grew rapidly—by 18.6 percent—from 2014 to 2018 and was $302,000 in 2018.

Compensation was much higher for some specialties than others. Specialties with the highest median compensation were radiology ($448,000); nonsurgical, procedural specialties ($428,000); and surgical specialties ($426,000) (Figure 4-3).[23] Median compensation for radiology was 85 percent higher than median compensation for primary care ($243,000), and median compensation for nonsurgical, procedural specialties was 77 percent higher than that of primary care. Psychiatry—which is in the nonsurgical, nonprocedural group—had median compensation of $244,000, slightly higher than that of primary care physicians.[24] A previous Commission analysis using data from the Medical Group Management Association (MGMA) showed that such disparities also

FIGURE 4–3

Disparities in physician compensation were widest when comparing primary care physicians with surgeons, nonsurgical proceduralists, and radiologists, 2018



Note: Figure includes all physicians who reported their annual compensation in the survey (n=81,851). The primary care group includes family medicine, internal medicine, and general pediatrics. The nonsurgical, nonprocedural group includes psychiatry, emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The nonsurgical, procedural group includes cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.

Source: SullivanCotter's Physician Compensation and Productivity Survey, 2019.

existed when compensation was observed on an hourly basis, thus accounting for variations in hours worked per week.[25] From 2014 to 2018, median compensation for primary care physicians increased by 17.6 percent, slower than nonsurgical, nonprocedural specialties (20.4 percent) and nonsurgical, procedural specialties (18.4 percent), but faster than surgical specialties (16.1 percent) and radiology (12.8 percent) (data not shown).[26]

Physician compensation from all payers reflects the structure of Medicare's fee schedule because many private insurers use a system of RVUs that is similar to Medicare's RVUs but negotiate a conversion factor (a fixed dollar amount) that is different from Medicare's (Congressional Budget Office 2018). According to a study of a large health plan, between 70 percent and 80 percent of the prices for specific services were benchmarked to Medicare's fee schedule (i.e., the plan paid prices that were a constant mark-up over Medicare's prices) (Clemens et al. 2017). Therefore, physician compensation from all payers probably reflects the underpricing of ambulatory E&M visits relative to other services, such as procedures, in Medicare's fee schedule (Medicare Payment Advisory Commission 2018a).[27] Ambulatory E&M visits make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology). The underpricing of these services in the fee schedule contributes to an income disparity between primary care physicians and certain specialists, which could influence the pipeline of primary care physicians.

CMS recently finalized a proposal to substantially increase the work RVUs for E&M office/outpatient visits—the

Previous Commission recommendations to improve the accuracy of prices for clinician services and establish a per beneficiary payment for primary care clinicians

The Commission has a long-standing concern that ambulatory evaluation and management (E&M) services, which make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology), are underpriced in the fee schedule for clinician services compared with other services, such as procedures (Medicare Payment Advisory Commission 2018a). Ambulatory E&M services include office visits, hospital outpatient department visits, nursing facility visits, and home visits.

In 2011, the Commission recommended that CMS use a streamlined method to regularly collect data—including service volume and work time—from a cohort of efficient practices to establish more-accurate work and practice expense RVUs (Medicare Payment Advisory Commission 2011a, Medicare Payment Advisory Commission 2011b). These data should be used to calculate the amount of time that a clinician worked over the course of a week or month and compare it with the time estimates in the fee schedule for all of the services that the clinician billed over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates—and, hence, the work RVUs—are too high. CMS could use this approach to identify groups of services that are likely overpriced, carefully review those services, and adjust the work RVUs accordingly.

Practice expense RVUs—which account for the cost of operating a practice—are partly based on data from a survey of total practice costs incurred by nearly all specialty groups. Because this survey was conducted in 2007 and 2008, practice expense RVUs probably do not reflect current practice costs. CMS has not developed a strategy for updating practice cost data. However, CMS could regularly collect data on total practice costs along with data on service volume and work time from a cohort of efficient practices, as the Commission

(continued next page)

most common type of ambulatory E&M visits; these changes will take effect in 2021 (Centers for Medicare & Medicaid Services 2019a). For example, the work RVUs for a Level 3 E&M visit for an established patient (Healthcare Common Procedure Coding System code 99213) will increase from 0.97 to 1.30 (34 percent). CMS will announce the final payment rates for E&M office/outpatient visits (which are a function of the conversion factor and the RVUs for clinician work, practice expense, and professional liability insurance) in the physician fee schedule final rule for 2021. Although increasing the work RVUs for E&M office/outpatient visits is an important first step to address the long-term devaluation of these services, CMS still needs to improve the overall accuracy of the fee schedule and further rebalance the fee schedule toward primary care. The Commission has previously recommended that CMS collect accurate, timely data to set RVUs and that the Congress establish a per beneficiary payment for primary care practitioners (see text box on the Commission's primary care payment recommendations).

Input costs for clinicians are projected to increase from 2020 to 2021

The Medicare Economic Index (MEI) measures the average annual price change in the market basket of inputs used by clinicians to furnish services (Centers for Medicare & Medicaid Services 2013). It is adjusted for economy-wide productivity growth. The MEI is comprised of two main categories: (1) physicians' compensation and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, capital, and professional liability insurance). The index's cost categories and cost weights (each category's share of total costs) are based on data on physicians' expenses from 2006, which raises questions

Previous Commission recommendations to improve the accuracy of prices for clinician services and establish a per beneficiary payment for primary care clinicians (cont.)

recommended in 2011 (Medicare Payment Advisory Commission 2011a).

In addition to concern about the mispricing of ambulatory E&M services, the Commission believes that the fee schedule—with its orientation toward discrete services that have a definite beginning and end—is not well designed to support primary care, which requires ongoing care coordination for a panel of patients. Consequently, in 2015 the Commission recommended that the Congress establish a per beneficiary payment for primary care clinicians to replace the expired Primary Care Incentive Payment (PCIP) program, which provided a 10 percent bonus payment on fee schedule payments for certain E&M visits provided by primary care clinicians (Medicare Payment Advisory Commission 2015). A monthly payment based on the total amount of PCIP payments in 2015 ($686 million) would initially amount to about $2.35 per beneficiary.[28]

The Commission recommended that the additional payments to primary care clinicians be in the form of a per beneficiary payment to move away from the approach of paying separately for each discrete service. The payment would provide funds to support the investment in infrastructure and staff that facilitate care management and care coordination. Funding for the per beneficiary payment would come from reducing payment rates for all services in the fee schedule other than ambulatory E&M visits provided by any clinician. This method of funding would be budget neutral and would help rebalance the fee schedule toward primary care clinicians.

In the future, the Commission plans to explore new ways of paying primary care clinicians. As part of this work, we plan to examine payment models for primary care clinicians that use a population-based approach, such as the Comprehensive Primary Care Plus model and the Primary Care First model developed by CMS's Center for Medicare & Medicaid Innovation. ■

about the continued accuracy of the MEI. However, CMS lacks a reliable, ongoing source of data to update the MEI. In 2011, the Commission recommended that CMS regularly collect data from a cohort of efficient practices to establish more-accurate work and practice expense RVUs. As part of this data collection, CMS could gather information on physicians' practice costs to update the MEI. The MEI increased by 1.7 percent in 2018. CMS's forecasted growth for the MEI (as of the third quarter of 2019) is 1.7 percent in 2019, 2.4 percent in 2020, and 2.6 percent in 2021. These projections are subject to change.

How should Medicare payments change in 2021?

The Commission's deliberations on payment adequacy for clinicians are informed by data assessing beneficiaries' access to services, the quality of their care, and Medicare payments and providers' costs. We find that, on the basis of these indicators, payments appear adequate.

On measures of access to clinician services, the Commission continues to find that beneficiaries' access to care appears generally stable. Overall, Medicare beneficiaries generally have comparable or slightly better access to clinician services than privately insured individuals ages 50 to 64. The vast majority of beneficiaries report that they are satisfied with their care, use an appropriate usual source of care, and do not have trouble accessing timely care. Growth in the number of clinicians billing the program outpaced beneficiary growth from 2013 to 2018, but the mix of clinicians changed. The number of primary care physicians decreased slightly while the number of APRNs and PAs grew rapidly. The share of clinicians who bill Medicare as a participating provider remains very high. The number of clinician

encounters per beneficiary increased modestly over time, with faster growth from 2017 to 2018 (1.5 percent) compared with the average annual growth rate from 2013 to 2017 (0.9 percent). The number of encounters with primary care physicians declined while encounters with APRNs and PAs grew dramatically.

In terms of quality, patient experience scores in FFS Medicare remain stable, and geographic variation in ACS hospitalizations and ED visits signals opportunities to improve the quality of FFS ambulatory care.

Medicare FFS allowed charges for clinician services grew faster from 2017 to 2018 than in prior years. From 2017 to 2018, across all services, allowed charges per beneficiary grew by 2.3 percent. Among broad service categories, growth rates were 1.9 percent for E&M services, 2.4 percent for imaging services, 2.7 percent for major procedures, 3.5 percent for other procedures, 2.4 percent for tests, and 1.3 percent for anesthesia services. In 2018, commercial payment rates for PPOs were 135 percent of Medicare's FFS payment rates for clinician services, compared with 134 percent in 2017. Median physician compensation from all payers grew rapidly from 2014 to 2018, although compensation was much lower for primary care physicians than for physicians in certain other specialties in 2018. As of the third quarter of 2019, input prices for clinicians were projected to increase by 2.6 percent in 2021.

MACRA established a set of statutory updates for clinicians, including no statutory update for calendar year 2021. In recommending an update for physicians and other health professionals, the Commission balanced the following objectives:

- maintaining beneficiary access to physician and other health professional services;
- minimizing the burden on taxpayers and beneficiaries, who finance the Medicare program; and
- ensuring adequate payments for the efficient provision of services.

In balancing these objectives with the overall findings that payments appear adequate, the Commission recommends no update for 2021, consistent with current law.

RECOMMENDATION 4

For calendar year 2021, the Congress should update the calendar year 2020 Medicare payment rates for physician and other health professional services by the amount determined under current law.

RATIONALE 4

Overall, access to clinician services for Medicare beneficiaries appears stable and comparable with that for privately insured individuals. Other measures of payment adequacy are stable and consistent with prior years. Therefore, the Commission does not see a reason to diverge from the current-law policy of no update for 2021.

IMPLICATIONS 4

Spending

- No change as compared with current law.

Beneficiary and provider

- The Commission's recommendation of the current-law update should not affect beneficiaries' access to care or providers' willingness and ability to furnish care. ■

Endnotes

1 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_physician_final_sec.pdf?sfvrsn=0.

2 In 2017, the MCBS began asking a larger subset of respondents about more types of doctor's appointments than in prior years. As a result, these 2017 results are not comparable with prior years.

3 In this section, the category *White* refers to White persons not of Hispanic origin. See the U.S. Census Bureau's "Explanation of Race and Hispanic Origin Categories" at https://www.census.gov/population/estimates/rho.txt.

4 A substantial number of clinicians billed for 15 or fewer beneficiaries in a given year, but they accounted for a small share of services and allowed charges. For example, in 2018, about 17 percent of clinicians who billed the fee schedule billed for 15 or fewer beneficiaries, but these clinicians billed for less than 1 percent of total allowed charges.

5 We used the number of total Part B beneficiaries, including those in FFS Medicare and Medicare Advantage, to calculate the ratio of physicians and other health professionals per 1,000 beneficiaries because we assume that clinicians generally furnish services to beneficiaries covered under both programs.

6 Nearly all the physicians the Commission considers to be primary care physicians have specialties of family medicine or internal medicine, which are the same two specialties under which nearly all hospitalists previously billed. The Commission's definition of primary care physicians also includes pediatricians and geriatricians. We allowed physicians with these specialties to be considered hospitalists under our methodology because, while small in number, we observed in the claims data that some of these clinicians appeared to be practicing as hospitalists. Further, including them in our definition did not pose an undue risk of falsely classifying nonhospitalists as hospitalists, as is the case for many hospital-based specialist physicians.

7 While excluding hospitalists from our historical counts of primary care physicians reveals slower growth (or slight declines) in the number of primary care physicians billing under the fee schedule, the remaining primary care physicians could have become more efficient over time (e.g., by focusing exclusively on their outpatient practice instead of splitting time between their outpatient practice and a hospital). One study found that primary care physicians who relied on hospitalists for more than three-quarters of their hospitalized patients performed an extra 8.8 office visits per week on average, which was equivalent to a 10 percent increase in productivity (Park and Jones 2015). Despite possible efficiency gains, the decline in encounters with primary care physicians documented in this chapter suggests the efficiency gains were modest (e.g., because most primary care physicians already exclusively focused on their outpatient practice during our study period) or other trends outweighed any efficiency gains.

8 In such scenarios, the beneficiary is billed 20 percent cost sharing for 95 percent of the fee schedule amount, plus the difference between 95 percent of the fee schedule amount and the total amount billed by the provider (which can reach up to 109.25 percent of the fee schedule amount).

9 The behavioral health clinicians referenced here are psychiatrists, clinical psychologists, and clinical social workers.

10 The oral health professionals referenced here are dentists, oral surgeons, and maxillofacial surgeons.

11 The primary care specialties referenced here are family medicine, internal medicine, and pediatric medicine. If additional specialties are included (i.e., obstetrics and gynecology, general medicine, general practice, and preventative medicine), the share of opt-out clinicians who practice primary care is 16 percent.

12 Specifically, we define *encounters* as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers (NPIs) of the clinicians who billed for the services. We tested alternative definitions of encounters (e.g., unique combinations of date of service, beneficiary, and performing NPI) to determine the extent to which our definition was sensitive to different specifications. Our results for alternative definitions of encounters were substantially similar to the results presented in this chapter.

13 Primary care physicians billed for very few services classified as "major procedures" or "anesthesia."

14 In 2018, about 26 percent of PAs worked in primary care (National Commission on Certification of Physician Assistants 2019). While estimates of the share of NPs (the largest subgroup of APRNs) who work in primary care vary, one national survey and another study that relied on the specialties of the professionals with whom nurse practitioners worked found that roughly half practiced in primary care

(Agency for Healthcare Research and Quality 2011, Health Resources & Services Administration 2014). In 2019, the Commission recommended that the Secretary collect better information on the specialties in which APRNs and PAs practice (Medicare Payment Advisory Commission 2019).

15 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

16 There are about 3,400 Dartmouth-defined HSAs—a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area.

17 In 2016, CMS also established a billing code for monthly enhanced oncology services for the Oncology Care Model (OCM). From 2017 to 2018, allowed charges for OCM grew by 1.2 percent.

18 When this type of visit is provided in an HOPD, it is billed as Healthcare Common Procedure Coding System code G0463. We used the hospital outpatient prospective payment system rate for the HOPD payment.

19 Section 603 of the Bipartisan Budget Act of 2015 prohibits HOPDs that began billing under the OPPS on or after November 2, 2015, and are located off a hospital campus from billing under the OPPS after January 1, 2017. In 2018, the facility payment rate for services provided at these off-campus HOPDs was equal to 40 percent of the rate under the OPPS. On-campus HOPDs, off-campus HOPDs that began billing before November 2, 2015, and dedicated emergency departments are permitted to continue billing under the OPPS. However, as of 2019, Medicare pays all off-campus HOPDs (regardless of when they began billing under the OPPS) an amount equal to 40 percent of the OPPS rate for office/outpatient E&M visits. This change is the subject of ongoing litigation and, for 2019, CMS is retrospectively reprocessing claims for certain off-campus facilities at the higher OPPS rate.

20 For the OPPS, CMS classifies services into APC groups on the basis of clinical and cost similarity; all services within an APC group have the same payment rate.

21 Our analysis excludes anesthesia services.

22 We compared responses by MA enrollees and Medicare FFS beneficiaries to a number of MCBS questions related to access to care (e.g., whether beneficiaries had a usual source of care, whether they thought their provider spent enough time with them, how satisfied they were with the overall quality of their health care). There was little to no difference in their responses to these questions.

23 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.

24 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.

25 To account for differences among specialties in hours worked per week, an earlier analysis based on MGMA data from 2007 included comparisons of hourly compensation. Hourly compensation for nonsurgical, procedural specialties and radiology was more than double the hourly compensation rate for primary care.

26 To control for annual changes in survey respondents, we based the percent changes on a cohort analysis in which the sample was restricted to physicians who were present in both the 2014 and 2018 data.

27 Ambulatory E&M services include office visits, hospital outpatient department visits, visits to patients in certain other settings such as nursing facilities, and home visits.

28 We estimate, based on claims data from 2015, that primary care clinicians would receive per beneficiary payments for 127 beneficiaries, on average.

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