CHAPTER 4

Physician and other health professional services

RECOMMENDATIONS

(For previous recommendations on updating Medicare's payments to physicians and other health professionals, see Appendix B, pp. 377–400.)

CHAPTER 4

Physician and other health professional services

Chapter summary

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In 2010, fee-for-service (FFS) Medicare spent about $62 billion under the physician fee schedule on physician and other health professional services, accounting for 12 percent of total Medicare spending and 18 percent of Medicare's FFS spending. Approximately 900,000 health professionals billed Medicare for fee schedule services in 2010. Among them were 588,000 physicians and 335,000 other clinicians, such as podiatrists, chiropractors, nurse practitioners, physician assistants, and physical therapists. Almost all FFS Medicare beneficiaries (97 percent) received at least one fee schedule service in 2010. Under current law, fee schedule rates are supposed to be updated annually based on a statutory formula called the sustainable growth rate (SGR) system. However, since 2003, the Congress has implemented multiple temporary overrides of the SGR formula to prevent fee cuts—including two overrides in 2012 to avert a 27 percent cut.

In this chapter

Moving forward from the sustainable growth rate system

Medicare faces increased urgency to resolve the growing problems created by the SGR system and its destabilizing short-term "fixes." In a recent letter to the Congress, the Commission recommended repealing the SGR and replacing it with specified updates that would no longer be based on an expenditure-

control formula. In the initial years, these updates would favor primary care, given our assessment that access risks are concentrated in primary care.

It is critical for the Congress to act now to resolve the SGR for a number of reasons. First, the total cost of repealing the SGR grows inexorably with each passing year, as does the cost of temporary "fixes." Second, growth in the size of the deficit has increased pressure to fully offset the cost of repealing the SGR. And third, opportunities to offset the costs of repealing the SGR within Medicare are becoming more difficult to identify and are being used for other purposes (such as to help finance coverage for the uninsured or for deficit reduction).

In determining our recommendation, the Commission concluded that the SGR's formulaic update mechanism has failed to restrain volume growth and, in fact, may have exacerbated it. Although the pressure of the SGR likely minimized fee increases in the past decade, this effect has disproportionately burdened physicians and health professionals in specialties with less ability to increase volume. Additionally, temporary stop-gap "fixes" to override the SGR undermine the credibility of Medicare by engendering uncertainty and frustration among providers, which may cause anxiety about Medicare among beneficiaries. The Commission concluded that the risks of retaining the SGR outweigh the benefits.

With this assessment, the Commission recommended repeal of the SGR system and proposed a series of legislated updates that would no longer be based on an expenditure-control or volume-control formula. Specifically, these updates would include a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years followed by a freeze. Even with these cuts, this recommendation carries a high budgetary score—costing roughly $200 billion over 10 years. Understanding the need for fiscal responsibility, the Commission offered the Congress a list of potential offsets within the Medicare program—purposefully limiting ourselves to options within Medicare, given our legislative mission. The Congress may seek offsets for repealing the SGR inside or outside of the Medicare program, and the Commission is not necessarily recommending that the cost of repealing the SGR be offset entirely within Medicare. We emphasize (as we did in our letter to the Congress) that our update recommendations and potential offsets were outlined specifically in the context of repealing the SGR system, recognizing that the high cost of repealing the SGR compels difficult choices that, in other contexts, the Commission might not support.

When repealing the SGR, it is important to realize that legislating a new schedule of updates (the schedule we propose or another) is not an irrevocable step. The Congress may determine in later years that a different course is appropriate to ensure sufficient access to fee schedule services. To assist the Congress, the Commission will continue annual reviews of whether payments to physicians and

other health professionals are adequate. Although we currently recommend fee reductions for three consecutive years for nonprimary care services, if, on the basis of access concerns, the Congress decides to discontinue the cuts after one or two years, then the full cost of repealing the SGR would still be lower than if fee cuts were never implemented.

In addition to our recommendation on the SGR, the Commission also proposed refinements to the accuracy of Medicare's fee schedule through targeted data collection and reducing payments for overpriced services. Even with such improvements to the fee schedule's pricing, the Commission stressed that Medicare must ultimately implement payment policies that shift providers away from FFS and toward payment approaches that better support delivery models that reward improvements in quality, efficiency, and care coordination—particularly for chronic conditions. Accordingly, the Commission recommended incentives in Medicare's accountable care organization program to accelerate this shift because new payment models—distinct from FFS and the SGR—may have greater potential to slow volume growth while also improving care quality. Similarly, incentives for physicians and health professionals to participate in the newly established Medicare bundling pilot projects could also improve efficiency across sectors of care.

Assessment of payment adequacy

Our analysis of payment adequacy for Medicare fee schedule services finds that most indicators are positive, suggesting that most beneficiaries can obtain care from physicians and other health professionals when needed. The Commission underscores, however, the increasing urgency to resolve the problems created by the SGR system, as described above.

***Beneficiaries' access to care*—**Overall, beneficiary access to fee schedule services is good and generally similar to access reported by privately insured patients age 50 to 64. In our survey conducted in the fall of 2011, among beneficiaries who needed a routine care appointment in the past year, 74 percent reported that they never had to wait longer than they wanted to get an appointment; percentages were even better for illness or injury appointments. Among the small share of beneficiaries looking for a new physician, most could find one without major problems; however, finding a new primary care physician continues to be more difficult than finding a new specialist. In our survey, this discrepancy in access between specialty and primary care has grown, with more frequent reports of big problems finding a new primary care physician in 2011 compared with 2010. Because the share of people looking for a new primary care physician is very small, survey results are expected to fluctuate from year to year. Nonetheless, the Commission remains concerned about beneficiary access to primary care. In addition to our previous recommendations for payment rate increases for primary care, we eagerly await results from CMS and private insurer efforts to

examine payment approaches that move away from FFS, such as medical home initiatives and care coordination payments for primary care providers.

As in past surveys, racial and ethnic minorities in both the Medicare and the privately insured populations were more likely to experience access problems, particularly in finding a new specialist. In future work, the Commission will conduct research to ask questions and learn more about the specific difficulties minority beneficiaries face when trying to find new specialists. Responses could help inform the Commission's consideration of policy options for addressing this important issue.

Other indicators of access include the supply of providers serving Medicare beneficiaries and changes over time in the volume of services provided.

- ***Supply of providers*—**The number of physicians and other health professionals billing Medicare grew by almost 4 percent in 2010. Additionally, the 2009 National Ambulatory Medical Care Survey found that among physicians with at least 10 percent of their practice revenue coming from Medicare, 90 percent accepted new Medicare patients. By specialty, 82 percent of primary care physicians and 96 percent of physicians in other specialties accepted new Medicare patients according to this survey.
- ***Volume of services*—**The number of services per FFS beneficiary decreased slightly (0.2 percent) in 2010 consistent with recent trends among the privately insured. Growth rates varied among broad categories of services, ranging from −1.5 percent for imaging to 1.1 percent for major procedures.

***Quality of care*—**Most claims-based indicators for ambulatory care quality that we examined for the elderly improved slightly or did not change significantly from 2008 to 2010.

***Medicare payments and providers' costs*—**In the absence of cost reports from physicians and other health professionals, we use certain indirect measures of this sector's financial status, including a comparison of Medicare's payments with private insurers' payments and an analysis of physician compensation.

- Medicare's payment for physician fee schedule services in 2010 averaged 81 percent of private insurer payments for preferred provider organizations. This rate is very similar to the rate calculated for the previous year—80 percent.
- In 2010, compensation was lower for primary care physicians than for most specialists, and the disparity between them was large enough to raise significant concerns about fee schedule pricing.

Although fee schedule payments may be adequate at the moment, the major policy issue concerning Medicare payment for physicians and other health professionals is the SGR system and the urgent need to move beyond it. ■

Background

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities, other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Approximately 900,000 health professionals billed Medicare for fee schedule services in 2010. Among them were 588,000 physicians and 335,000 other clinicians, such as podiatrists, chiropractors, nurse practitioners, physician assistants, and physical therapists.

Under the physician fee schedule in Medicare Part B, fee-for-service (FFS) payments for physician and other health professional services totaled $62 billion in 2010, accounting for about 12 percent of Medicare's overall spending and 18 percent of Medicare's FFS spending (Boards of Trustees 2010). From 2000 to 2010, Medicare spending per beneficiary on physician fee schedule services grew by 64 percent. Almost all FFS Medicare beneficiaries (97 percent) received at least one physician service in 2010.

In the FFS program, Medicare pays for physician and other health professional services according to a fee schedule that lists services and their associated payment rates. The fee schedule assigns each service a set of three relative weights (physician work, practice expense, and professional liability insurance) intended to reflect the typical resources needed to provide the service. These weights are adjusted for geographic differences in practice costs and multiplied by a dollar amount—the conversion factor—to determine payment amounts. In general, Medicare updates payments for physician services by increasing or decreasing the conversion factor. For further information, see the Commission's *Payment basics: Physician services payment system.*[1]

By law, the update of the physician fee schedule conversion factor is determined by a formula—the sustainable growth rate (SGR)—set forth in the Balanced Budget Act of 1997. It ties payment updates to four factors: changes in input costs, changes in Medicare FFS enrollment, changes in the volume of physician services relative to growth in the national economy, and changes in law and regulation. Although the SGR formula has yielded negative updates for the past several years, the Congress has overridden the formula multiple times since 2003 to prevent payment reductions—including two overrides in 2012 to avert a 27 percent cut.

Moving forward from the sustainable growth rate system

Responding to the increasing urgency of the problems created by the SGR system, the Commission submitted a letter to the Congress with several policy recommendations, including one to repeal the SGR and replace it with specified updates that would no longer be based on an expenditure-control formula. In the initial years, these updates would favor primary care. We include a copy of this October 2011 letter in Appendix B of this report.

In summary, the Commission determined that the SGR system is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. This system, which links annual updates to cumulative expenditures since 1996, has failed to restrain volume growth and, in fact, may have exacerbated it. Although the pressure of the SGR likely minimized fee increases in the past decade, this effect has disproportionately burdened physicians and health professionals in specialties with less ability to increase volume. Additionally, temporary, stop-gap "fixes" to override the SGR undermine the credibility of Medicare because they engender uncertainty and frustration among physicians and other health professionals, which may cause anxiety about Medicare among beneficiaries. The Commission concluded that the risks of retaining the SGR outweigh the benefits.

It is critical for the Congress to act now to resolve the SGR for a number of reasons. First, the total cost of repealing the SGR grows inexorably with each passing year, as does the cost of temporary "fixes." Second, as the deficit grows, there is greater need to offset the full cost of repealing the SGR. And third, opportunities to offset the costs of repealing the SGR within Medicare are becoming more difficult to identify and are being used for other purposes (such as to help finance coverage for the uninsured or for deficit reduction).

With this assessment, the Commission recommended that the Congress repeal the SGR system and replace it with specified updates for the physician fee schedule. The Commission drew on three governing principles to form its proposal. First, the link between cumulative fee schedule expenditures and annual updates is unworkable

and should be eliminated. Second, beneficiary access to care must be protected. Third, proposals to replace the SGR must be fiscally responsible.

From these principles, the Commission recommended repeal of the SGR system and proposed a series of updates that would no longer be based on an expenditure-control or volume-control formula. Specifically, these updates would include a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. Given expected volume growth over the next decade, these legislated updates are expected to increase Medicare expenditures for fee schedule services annually—roughly doubling over the next 10 years. Approximately two-thirds of this increase would be attributable to growth in beneficiary enrollment and one-third would be attributable to growth in per beneficiary service use. Although our proposed updates reduce fees for most services, current law (under the SGR) calls for far greater fee reductions and could lead to potential access problems. The Commission finds it crucial to protect primary care from fee reductions, considering that the most recent data show that access risks are concentrated in primary care.

When repealing the SGR, it is important to realize that legislating a new schedule of updates (the schedule we propose or another) is not an irrevocable step. The Congress may determine in later years that a different course is appropriate to ensure sufficient access to fee schedule services. To assist the Congress, the Commission will continue to conduct our annual review of whether payments to physicians and other health professionals are adequate, as we do in this report. To this end, we will maintain our beneficiary survey, conduct physician focus groups, track physician and practitioner participation in Medicare, and examine changes in the volume and quality of ambulatory care. If, through these analyses, we determine that a future increase in fee schedule rates is needed to ensure beneficiary access to care, then the Commission will submit such a recommendation to the Congress.

Enacting our initial recommendation would eliminate the SGR and would alter the trajectory of fee schedule spending in Medicare's baseline. Therefore, future fee increases relative to this new baseline would require new legislation and would carry a budgetary cost. Nevertheless, if, on the basis of access concerns, the Congress decides to discontinue the cuts after one or two years, then the full cost of repealing the SGR would still be lower than if fee cuts were never implemented.

The Commission's recommendation for repealing the SGR carries a high budgetary score—roughly $200 billion over 10 years. Understanding the need for further fiscal responsibility, the Commission offered the Congress a list of potential offsets within the Medicare program—limiting ourselves only to Medicare, given our legislated purview. The Congress may seek offsets for repealing the SGR inside or outside of the Medicare program, and the Commission is not necessarily recommending that the cost of repealing the SGR be offset entirely within Medicare. The Commission emphasizes (as we did in our letter to the Congress) that these update recommendations and potential offsets were outlined specifically in the context of repealing the SGR system, recognizing that the high cost of repealing the SGR compels difficult choices that, in other contexts, the Commission might not support.

The Commission also proposed refinements to the accuracy of Medicare's physician fee schedule through targeted data collection and reducing payments for overpriced services. Even with such improvements to the fee schedule's pricing, Medicare must ultimately implement payment policies that shift providers away from FFS and toward payment approaches that better support delivery models that reward improvements in quality, efficiency, and care coordination, particularly for chronic conditions. Accordingly, the Commission recommended incentives in Medicare's accountable care organization program to accelerate this shift because new payment models—distinct from FFS and the SGR—may have greater potential to slow volume growth while also improving care quality. Similarly, incentives for physicians and health professionals to participate in the newly established Medicare bundling pilot projects could also improve efficiency across sectors of care.

Are Medicare's fee schedule payments adequate?

Our annual analysis of payments for Medicare fee schedule services finds that current payments are generally adequate. However, the Commission recently recommended that the Congress realign Medicare's fee schedule to bring primary care fees closer to those for specialty services and identify overpriced services and correct fees accordingly (Appendix B). Our annual assessment of payment adequacy examines several indicators: beneficiary access to care provided by

physicians and other health professionals, including rates of physicians participating with Medicare and taking assignment, and changes in the volume of services provided, quality of care, and Medicare reimbursement levels compared with those in the private sector. In the most recent years for which we have data, most payment adequacy indicators were positive. Unlike our assessments of other providers in this report, we cannot examine the financial performance of physicians and other health professionals directly because they are not required to report their costs to Medicare.

Beneficiaries' access to care: Generally good with relatively few problems reported

Physicians and other health professionals are often the most important link between Medicare beneficiaries and the health care delivery system. Our analysis of the 2009 Medicare Current Beneficiary Survey shows that about 85 percent of noninstitutionalized FFS beneficiaries report that a doctor's office or clinic is their usual source of care. Beneficiary access to physicians, therefore, is an important indicator to monitor when assessing Medicare's payment adequacy. Our analysis of access to physician services focused on indicators from several sources, including patient surveys, physician surveys, beneficiary focus groups, physician focus groups, and claims data.

2011 patient survey shows that, overall, access is good, but primary care continues to be a concern

To obtain the most current access measures possible, the Commission sponsors a telephone survey each year of a nationally representative, random sample of two groups of people: Medicare beneficiaries age 65 years or older and privately insured individuals age 50 to 64. The sample size is about 4,000 in each group (totaling 8,000 completed interviews, including an oversample of minority respondents).[2] By surveying both groups of people—privately insured individuals and Medicare beneficiaries—we can assess the extent to which access problems, such as delays in scheduling an appointment and difficulty finding a new physician, are unique to the Medicare population.[3]

Results from our 2011 survey indicate that most beneficiaries have reliable access to physician services. Most beneficiaries are able to schedule timely medical appointments and find a new physician when needed, but some beneficiaries experience problems, particularly when they are looking for a primary care physician. For both Medicare beneficiaries and privately insured individuals age 50 to 64, access to specialists is better than access to primary care when looking for a new physician.

On a national level, this survey does not find widespread problems with physician access, but certain market areas may experience more access problems than others due to factors unrelated to Medicare—or even private—payment rates, such as relatively rapid population growth. Moreover, although the share of beneficiaries reporting a major problem finding a primary care physician is small (representing about 1.3 percent of the entire Medicare population), this issue is a serious concern not only to the beneficiaries who are personally affected but also—on a larger scale—for the functioning of our health care delivery system. Our concern is amplified by the most recent survey results, which show that, among the small subset of beneficiaries who looked for a primary care physician in the past year, the share that reported "a big problem" finding one is larger this year than it was in the two preceding years. As described earlier, the Commission sought to protect primary care from payment reductions in its recommendation to repeal the SGR system because beneficiary access risks are concentrated in primary care. Before this recommendation, the Commission recommended budget-neutral increases for primary care services in reports that we released in 2008 and 2009. The Patient Protection and Affordable Care Act, enacted in 2010, contains several provisions to enhance access to primary care, including increasing Medicare payments for primary care services.

Most beneficiaries report timely appointments

Because most Medicare beneficiaries have multiple doctor appointments in a given year, an important access indicator we examine is their ability to schedule timely appointments. As in previous years, most beneficiaries continue to have good access to timely appointments. For 2011 specifically, among those seeking an appointment, most beneficiaries (74 percent) and most privately insured individuals (71 percent) reported "never" having to wait longer than they wanted for an appointment for routine care (Table 4-1, p. 92). Another 18 percent of Medicare beneficiaries and 21 percent of privately insured individuals reported that they "sometimes" had to wait longer than they wanted for a routine appointment. Though relatively small, the differences between the Medicare and the privately insured populations on this measure were statistically significant, suggesting that Medicare beneficiaries were more satisfied with the timeliness of their routine care appointments.

TABLE 4–1

Most Medicare beneficiaries and older privately insured individuals have good access to physician care, 2008–2011

Survey question	Medicare (age 65 or older) 2008	2009	2010	2011	Private insurance (age 50–64) 2008	2009	2010	2011
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	76%[a]	77%[a]	75%[a]	74%[a]	69%[a]	71%[a]	72%[a]	71%[a]
Sometimes	17[a]	17[a]	17[a]	18[a]	24[a]	22[a]	21[a]	21[a]
Usually	3[a]	2[ab]	3[a]	3	5[a]	3[a]	4[a]	4
Always	2	2	2	2[a]	2	3	3	3[a]
For illness or injury								
Never	84[a]	85[ab]	83[a]	82	79[a]	79[a]	80[a]	79
Sometimes	12[a]	11[ab]	13[a]	14[a]	16[a]	17[a]	15[a]	17[a]
Usually	1	2	2	2	2	2	2	2
Always	1[a]	1	1[a]	1	2[a]	2	2[a]	1
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")								
Primary care doctor	6	6	7	6	7	8	7	7
Specialist	14[a]	14[a]	13[a]	14[a]	19[a]	19[a]	15[a]	16[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	71	78[b]	79[ab]	65	72	71	69[a]	68
Percent of total insurance group	*4.6*	*5.0*	*5.2*	*3.6*	*4.8*	*5.4*	*4.8*	*4.5*
Small problem	10	10	8	12	13	8[b]	12	16
Percent of total insurance group	*0.6*	*0.6*	*0.5*	*0.7*	*0.9*	*0.6*	*0.8*	*1.1*
Big problem	18	12[ab]	12[b]	23[a]	13	21[a]	19	14[a]
Percent of total insurance group	*1.1*	*0.8*	*0.8*	*1.3*	*0.9*	*1.6*	*1.3*	*0.9*
Specialist								
No problem	88	88	87[a]	84	83	84	82[a]	86
Percent of total insurance group	*12.8*	*12.5*	*11.0*	*12.1*	*15.5*	*16.1*	*12.6*	*13.9*
Small problem	7	7	6[a]	8	9	9	11[a]	8
Percent of total insurance group	*1.0*	*1.0*	*0.8*	*1.1*	*1.7*	*1.7*	*1.8*	*1.3*
Big problem	4	5	5	7	7	7	6	6
Percent of total insurance group	*0.6*	*0.7*	*0.7*	*1.0*	*1.4*	*1.3*	*1.0*	*1.0*
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?"								
Percent answering "Yes"	8[a]	7[ab]	8[a]	8[a]	12[a]	11[a]	12[a]	11[a]

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Sample sizes for each group (Medicare and privately insured) were 3,000 in 2008 and 4,000 in 2009, 2010 and 2011. Overall sample sizes for individual questions varied.

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

[b] Statistically significantly different from 2011 within the same insurance coverage category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2008, 2009, 2010, and 2011.

As expected, patients have an easier time scheduling illness-related and injury-related appointments than routine care appointments. Among those needing appointments for injury or illness, 82 percent of Medicare beneficiaries and 79 percent of privately insured individuals reported "never" having scheduling problems; 14 percent of Medicare beneficiaries and 17 percent of privately insured individuals reported "sometimes" having to wait longer than they wanted.

Beneficiaries' access to appointments in 2011 varied by race, with minorities reporting access problems more frequently than whites (Table 4-2, p. 94). This racial disparity existed for both the Medicare and the privately insured populations. Although a wider racial disparity in access is seen among privately insured patients, for routine care appointments, minority Medicare beneficiaries were more likely to report problems finding a specialist, as discussed later in this section. Disparities in access between whites and minorities have been documented by a large body of research, notably summarized in the Agency for Healthcare Research and Quality's 2010 National Healthcare Disparities Report. These reports show that disparities related to race, ethnicity, and socioeconomic status remain a factor in patient access to care (Agency for Healthcare Research and Quality 2011, Institute of Medicine 2002, Reschovsky and O'Malley 2008, Williams et al. 2004).

When respondents were asked about what they did when faced with not being able to schedule a timely appointment for either routine or illness care, most reported that they took a later appointment date; that was the case for 64 percent of the Medicare sample and 76 percent of the privately insured sample.

Among respondents who said they went to the emergency room during the year (25 percent of Medicare beneficiaries and 18 percent of privately insured individuals), 16 percent of Medicare beneficiaries and 11 percent of privately insured individuals reported that their doctor met them there. For both the Medicare sample and the privately insured sample, minorities were more likely than whites to report that their doctor met them at the emergency room.

Most beneficiaries can find a new physician but more difficulties reported for primary care

In addition to the ease of scheduling appointments, our survey also asks about respondents' ability to find a new physician if they are seeking one. As in previous years, relatively few survey respondents reported that they tried to find a new primary care physician or specialist in the past year. This finding suggests that most respondents were either satisfied with their current physician or did not have a health event or other reason that made them search for a new one. Specifically, in 2011 6 percent of Medicare beneficiaries and 7 percent of privately insured individuals reported that they looked for a new primary care physician in the preceding year; larger percentages (14 percent of Medicare beneficiaries and 16 percent of privately insured individuals) reported seeking a new specialist.

In our 2011 survey, we asked respondents who looked for a primary care physician about the main factors that caused them to seek a new primary care physician. The most commonly reported reason for both Medicare and privately insured respondents was that they wanted to change doctors. The next most common reason was that their doctor retired or stopped practicing. Also, some respondents said that they did not have a primary care doctor in their area (e.g., because they recently moved). Compared with these reasons, relatively few respondents stated that they were looking because their doctor was no longer accepting Medicare (in the case of respondents age 65 or older) or their private insurance (in the case of people age 50–64).

Among the small share of people (6 percent in Medicare and 7 percent in private insurance) who looked for a new primary care physician in the past year, similar percentages of Medicare and privately insured patients reported "no problem" (65 percent with Medicare and 68 percent with private insurance). When these findings are translated to the population at large, 3.6 percent of Medicare beneficiaries and 4.5 percent of privately insured individuals looked for a new primary care physician and reported "no problem" finding one.

Of the patients reporting a problem, Medicare beneficiaries were more likely to characterize their problem as "big." Specifically, 1.3 percent of Medicare beneficiaries and 0.9 percent of privately insured individuals said that they looked for a new primary care physician and experienced a "big problem" finding one in the past year. When confining results to those respondents who said they searched for a new primary care physician in the past year, 23 percent of Medicare beneficiaries and 14 percent of privately insured individuals said they experienced a "big problem."

Given that a small share of people seek a primary care physician in the year, annual fluctuations in these results

TABLE 4–2

Medicare beneficiaries have better or similar access to physicians compared with privately insured individuals, but minorities in both groups report problems more frequently, 2011

	Medicare (age 65 or older)			Private insurance (age 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	74%[a]	75%	72%[a]	71%[a]	72%[b]	64%[ab]
Sometimes	18[a]	19	18[a]	21[a]	21[b]	25[ab]
Usually	3	4	3	4	4	4
Always	2[a]	2[ab]	3[ab]	3[a]	3[ab]	6[ab]
For illness or injury						
Never	82	83[b]	75[b]	79	81[b]	75[b]
Sometimes	14[a]	13[ab]	17[b]	17[a]	16[a]	19
Usually	2	2	2	2	2	3
Always	1	1[b]	2[b]	1	1[b]	2[b]
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")						
Primary care physician	6	6	6	7	6	6
Specialist	14[a]	16[b]	9[ab]	16[a]	17[b]	13[ab]
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	65	67	57	68	72	58
Percent of total insurance group, by race	*3.6*	*3.7*	*3.4*	*4.5*	*4.7*	*3.6*
Small problem	12	10	19	16	15	19
Percent of total insurance group, by race	*0.7*	*0.6*	*1.1*	*1.1*	*1.0*	*1.2*
Big problem	23[a]	23[a]	23	14[a]	12[a]	18
Percent of total insurance group, by race	*1.3*	*1.3*	*1.4*	*0.9*	*0.8*	*1.1*
Specialist						
No problem	84	86[b]	65[ab]	86	88[b]	78[ab]
Percent of total insurance group, by race	*12.1*	*13.5*	*5.7*	*13.9*	*15.0*	*10.1*
Small problem	8	7	11	8	8	10
Percent of total insurance group, by race	*1.1*	*1.2*	*0.9*	*1.3*	*1.3*	*1.3*
Big problem	7	6[b]	19[b]	6	5[b]	11[b]
Percent of total insurance group, by race	*1.0*	*0.9*	*1.6*	*1.0*	*0.8*	*1.5*
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?"						
Percent answering "Yes"	8[a]	8[ab]	10[b]	11[a]	11[a]	12

Note: Respondents who did not report race or ethnicity were not included in "White" or "Minority" results but were included in "All" results. Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 4,000. Sample sizes for individual questions varied.

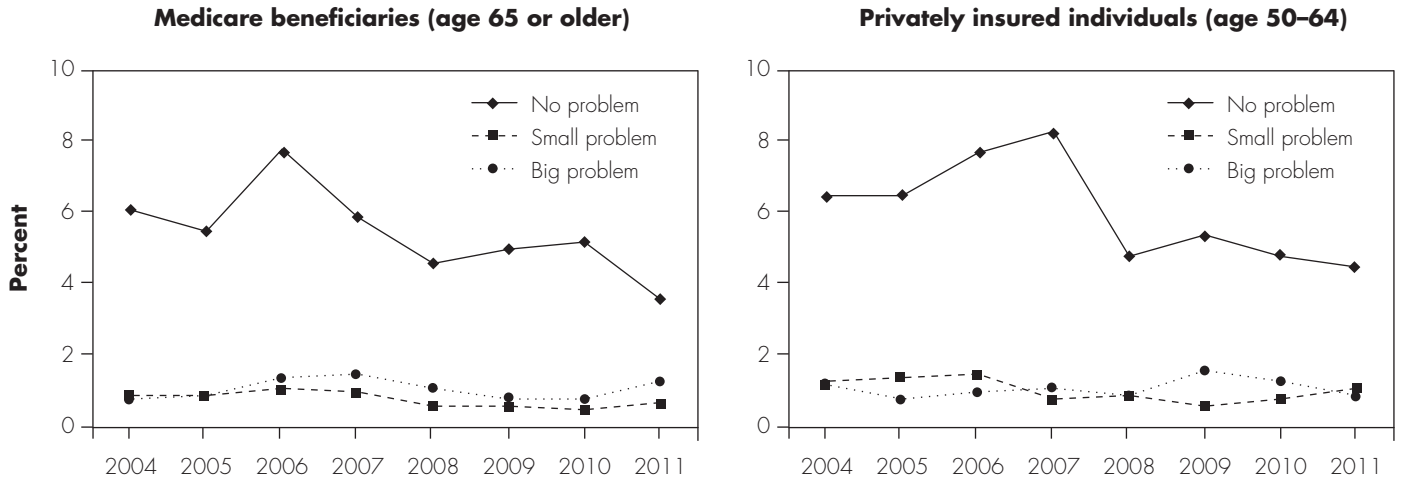
[a] Statistically significant difference between the Medicare and privately insured populations in the given race category (at a 95 percent confidence level).

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

Source: MedPAC-sponsored telephone surveys, conducted in 2011.

FIGURE 4–1

Ability to find a new primary care physician, Medicare beneficiaries and privately insured individuals, 2004–2011



Note: The remaining percent of respondents in the survey (e.g., 94 percent with Medicare, 93 percent with private insurance in 2011) did not seek a new primary care physician in the past year. This figure is corrected from the hard copy version of this report in which the lines for "small problem" and "big problem" were transposed for several of the years in both charts.

Source: MedPAC-sponsored telephone surveys, conducted 2004–2011.

are expected. In fact, the graphs in Figure 4-1 show considerable year-to-year variation. For the Medicare population, fluctuations are more apparent among those reporting "no problem"; for the privately insured group, we see more annual variation in those reporting a "big problem." Table 4-1 (p. 92) also shows that the share of beneficiaries reporting a "big problem" finding a primary care physician in 2011 was statistically different from 2009 and 2010 but not from 2008. For both the Medicare and privately insured groups, the rate of people reporting "no problem" finding a primary care physician has declined.

Because several recent media reports and association publications have misstated the numbers that we present in this annual chapter, we want to emphasize, at the risk of being redundant, that the percentage of beneficiaries and privately insured people reporting problems comes from a subset of those who indicate that they were, in fact, looking for a new physician or tried to schedule an appointment in the past year. Survey respondents who did not look for a new physician or did not try to make a physician appointment were not asked about related problems. Thus, the rates of patients reporting problems refer only to those people to whom the question applies and not to the Medicare or privately insured population at large. Accordingly, among the 6 percent of Medicare beneficiaries reporting that they looked for a new primary care physician in the preceding year, those reporting that they experienced a "big problem" correspond to about 1.3 percent of the aged Medicare population. Although this percentage may seem small, the problems these beneficiaries (roughly half a million as calculated from our survey)—and their younger counterparts—face can be personally distressing and are often featured in local and national media reports.

One response to these findings is to examine the accuracy of fee schedule payments and make improvements where needed. In the Commission's letter to the Congress (Appendix B), we recommended stronger efforts by CMS to refine the accuracy of Medicare's physician fee schedule through targeted data collection and reducing payment for overpriced services. Such action could lead to reductions in relatively overpriced procedures and tests. The accuracy of payments for primary care depends also on how services such as office visits are defined. In the fee schedule final rule for 2012, CMS draws attention to a technical expert panel (TEP) convened by the Department of Health and Human Services Assistant Secretary for Planning and Evaluation (Centers for Medicare & Medicaid Services 2011). A major task of the TEP is to develop approaches to defining visits and paying for

TABLE 4–3 **Use of physician assistants and nurse practitioners for primary care, 2011**

	Medicare (age 65 or older)			Private insurance (age 50–64)		
Survey question	**All**	**Urban**	**Rural**	**All**	**Urban**	**Rural**
"For your primary care, do you see a nurse practitioner or physician assistant for…?"						
All or most	11%	10%[b]	14%[b]	10%	9%[b]	13%[b]
Some	22[a]	21[a]	24[a]	26[a]	25[ab]	29[ab]
None	63	64[b]	58[b]	62	63[b]	55[b]

Note: Numbers may not sum to 100 percent because missing responses ("Not applicable," "Don't Know," or "Refused") are not presented.
[a] Statistically significant difference between the Medicare and privately insured populations (at a 95 percent confidence level).
[b] Statistically significant difference between urban and rural within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey, conducted in 2011.

primary care services.[4] Additionally, CMS stated in the final rule mentioned earlier that the Relative Value Scale Update Committee and several organizations have called on CMS to explore Medicare payment and coverage options for many care coordination services that primary care physicians typically perform.

As stated in our letter to the Congress, even with improvements in the fee schedule, Medicare must implement payment policies that shift providers away from FFS and toward delivery models that reward improvements in quality, efficiency, and care coordination, particularly for chronic conditions. Payment approaches that recognize the benefits of non–face-to-face care coordination between visits and among providers may be more appropriate for primary care, particularly for patients with chronic conditions. In addition to examining the feasibility of specific care coordination payments, CMS is embarking on several projects to examine the results (patient health and total spending outcomes) of monthly per patient payments to primary care providers for their care coordination activities. They include the Comprehensive Primary Care initiative, the Multi-payer Advanced Primary Care Initiative, and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration.

Recognizing that physicians are not the only health professionals who provide primary care, our 2011 survey also asked respondents whether they saw a nurse practitioner or physician assistant for primary care in the past year. In general, the responses among the Medicare sample and the privately insured sample were very similar, with about one-third of the respondents in each group reporting that they saw a nurse practitioner or physician assistant for at least some of their primary care (Table 4-3). More specifically, 11 percent of beneficiaries reported that they saw a nurse practitioner or physician assistant for "all or most" of their primary care and an additional 22 percent reported that they saw a nurse practitioner or physician assistant for "some" of their primary care. For the privately insured population, the shares were 10 percent and 26 percent, respectively. Rural respondents in both groups were more likely than urban respondents to see a nurse practitioner or physician assistant for their primary care. Other researchers have also found higher use of nurse practitioners and physician assistants for primary care in rural areas (Everett et al. 2009, Hooker and McCaig 2001).

As in previous years, we continue to find that patients seeking a new specialist were less likely to report problems than those seeking a new primary care physician. In 2011, among those looking for a new specialist, 84 percent of Medicare beneficiaries and 86 percent of privately insured individuals reported "no problem" finding one in the past year. Although our survey results indicate that Medicare patients have an easier time finding a new specialist than a new primary care physician, the Commission is aware that access may be more difficult for some specialties than for others. For example, in previous physician focus groups, psychiatry was the most frequently identified specialty for which physicians reported having difficulty finding referrals for their Medicare patients (Medicare Payment Advisory

Commission 2010). In future work, we will explore ways to examine access by more specific specialty types.

Our patient survey reveals that although minorities were less likely than whites to report looking for a new specialist, when minorities were trying to find one they were more likely to report problems (Table 4-2, p. 94). Specifically, among Medicare beneficiaries seeking a new specialist, 30 percent of minorities reported either a "small problem" or a "big problem" compared with 13 percent of whites. In the privately insured population, a smaller disparity existed: 21 percent of minorities and 13 percent of whites reported problems finding a specialist.

Racial and ethnic differences in Medicare beneficiaries' access to specialists are problematic and compel deeper investigation into possible causes and potential policy options. In future work, the Commission will conduct research to ask questions and learn more about the specific difficulties minority beneficiaries face when trying to find specialists. For example, are fewer specialists practicing in communities with larger shares of minority beneficiaries; are physicians more reluctant to accept Medicare patients who have Medicaid or no supplemental coverage; are there issues related to physician referral networks in minority communities; how do access issues vary by specific race and ethnicity (e.g., Asian American, African American, Hispanic, Native American)? Policy options that this research could inform may highlight potential focus areas, such as workforce goals, quality initiatives targeted for minority populations, and developing ways to ensure that accountable care organizations provide access to specialists comparable to that in surrounding areas.

Several other studies have found racial and ethnic disparities in access to specialists. One study, for example, found that primary care physicians with relatively large proportions of African American patients in their Medicare caseloads reported facing greater difficulty obtaining high-quality referrals to subspecialists (Bach et al. 2004). Though not limited to Medicare patients, a more recent study similarly found that physicians with a larger share of minorities in their practice were more likely to report difficulties obtaining referrals to specialists for their patients (Reschovsky and O'Malley 2008). In this study, physicians attributed such problems to the fact that many of their patients were uninsured or had insurance coverage that posed access barriers rather than to an inadequate supply of qualified specialists in the area. Recent work in the Department of Health and Human Services has focused on developing an action plan to reduce racial and ethnic disparities (Koh et al. 2011).

Reports of not getting needed physician care were more frequent for privately insured individuals

Our survey also examines rates of patients reporting that they did not see a physician when they thought they should have. As in previous years, Medicare beneficiaries (8 percent) were less likely than their privately insured counterparts (11 percent) to say that they should have seen a doctor for a medical problem in the past year but did not (Table 4-1, p. 92). This difference was also reported in a 2007 survey conducted by the Center for Studying Health System Change (Cunningham 2008).

The two most frequently reported reasons for forgoing care among the Medicare respondents were that they "just put it off" and "didn't think the problem was serious." Among the 8 percent of beneficiaries who reported forgoing care, 11 percent (corresponding to 0.9 percent of the entire beneficiary population) listed physician availability issues (e.g., scheduling an appointment time or finding a doctor) as the problem. As in previous years, privately insured individuals were more likely than Medicare beneficiaries to attribute cost as a factor in forgoing care. Specifically, among the 8 percent of beneficiaries who reported forgoing care, 11 percent (corresponding to 0.9 percent of the entire beneficiary population) attributed it to thinking that it "would cost too much." In comparison, among the privately insured individuals who reported forgoing care, more than a quarter attributed it to cost. Although in previous years, for both Medicare and privately insured people, those with lower incomes were more likely to report forgoing physician care, this pattern was less conclusive in 2011.

Rural, urban, and other market area analyses

Despite having 8,000 respondents, our survey is not large enough to evaluate access by specific market areas, but we are able to examine results by rural and urban designation. Rates for getting appointments were more similar between rural and urban patients than rates for finding new physicians. For example, 76 percent of rural beneficiaries and 74 percent of urban beneficiaries reported that they "never" had a problem getting appointments for routine care. Among the privately insured, comparable rates for getting timely appointments were 71 percent for both rural and urban respondents. Among the 6 percent of Medicare beneficiaries looking for a new primary care physician, 75 percent of rural beneficiaries and 63 percent of urban beneficiaries reported "no problem." (For more details, see online Appendix A to this chapter, available at http://www.medpac.gov.)

In 2011, the Commission contracted with NORC (formerly the National Opinion Research Center) to conduct focus groups in Boston, Dallas, and the Washington, DC, area to gain further insight into selected issues in different market areas. Participants in these focus groups included Medicare beneficiaries, future beneficiaries (people aged 55–64), and physicians. In many instances, the focus group results comport with findings from our patient survey.

Specifically, nearly all current and future beneficiaries in the focus groups affirmed that they had a primary care physician. For nonurgent care, most participants said they could be seen on the same day or the next day, while a few said they typically had to wait longer. Several participants, whose primary care physician worked in a larger group practice, said that if their physician was not available, they could see other internists or physician assistants.

A small number of participants reported difficulty finding a new physician for themselves or for a parent because of nonacceptance of Medicare or other provider network restrictions, including Medicare Advantage plans. Participants often stated that they were not aware of many access problems in their own geographic area but that they heard of difficulties in other communities.

In several instances, consumers who changed providers because they had recently moved to the area reported challenges finding a new physician for themselves or a family member and believed that problems were exacerbated by their "newness to the neighborhood" (i.e., limited social connections for recommendations and other physician referrals). For people who did not move but had to change providers (e.g., because of insurance changes, such as enrollment in a Medicare Advantage plan, switching into or out of a closed provider network, or an employer changing insurance carriers), participants reported relatively less difficulty because they had resources and referrals from their previous doctors for their search.

When asked about their ability to find specialists, a few patients in each focus group reported long waits for initial visits with specialists. Patients who were already seeing a specialist regularly, such as a cardiologist or oncologist, did not report problems scheduling appointments.

In our physician focus groups, the vast majority reported that they accepted Medicare patients and "took assignment" (i.e., accepted Medicare fee schedule rates as payment in full for Medicare services and therefore did not balance bill their Medicare patients). Principal reasons physicians gave for not accepting certain types of insurance—including Medicare—were reimbursement rates and paperwork burdens. Among those who reported that they did not accept new Medicare patients, most said that they make exceptions, such as keeping existing patients when they age into Medicare or taking certain referrals. Primary care physicians reported some difficulty referring patients to certain specialists. Some said that their offices had to call the specialists themselves and use their "clout" to ensure that their patients could get appointments. The most frequently cited specialties for access problems were dermatology and psychiatry.

Other national patient surveys show comparable results for access to care

Results from other patient surveys are analogous to the Commission's survey results on access to physician services. We summarize findings from these studies below.

- The Consumer Assessment of Healthcare Providers and Systems for Medicare FFS—a large CMS-sponsored survey of FFS beneficiaries—found that for 2011, 88 percent of Medicare beneficiaries reported "always" or "usually" being able to schedule timely appointments for routine care. Also, 92 percent of beneficiaries reported that they "always" or "usually" were able to schedule an appointment with a specialist as soon as they wanted. The share of beneficiaries reporting major problems accessing physicians (i.e., "never" getting timely appointments) was below 3 percent for both routine care and specialty care.

- Results from the 2009 Medicare Current Beneficiary Survey—another large CMS survey of beneficiaries—found that 94 percent of noninstitutional FFS beneficiaries had a usual place for seeking medical care. For the vast majority of them, it was a doctor's office (73 percent) or a doctor's clinic (11 percent). Other care sites reported included HMOs and Department of Veterans Affairs facilities. About 5 percent of FFS beneficiaries said that they had trouble getting care, and 8 percent reported that they had a health problem in the past year for which they thought they should have seen a doctor but did not.

- Using a variety of methods, the Government Accountability Office also concluded that Medicare beneficiaries had stable access to physician services

TABLE 4–4 **Most physicians accept new Medicare patients**

Patient insurance type	2008 All physicians	2008 Primary care	2008 All other specialties	2009 All physicians	2009 Primary care	2009 All other specialties
Any new patients	94%	90%	98%	94%	87%	98%
Medicare	90	83	95	90	82	96
Medicaid	63	55	69	65	56	70
Capitated private insurance	50	58	44	43	47	42
Noncapitated private insurance	79	76	81	76	73	79
Worker's compensation	58	53	61	58	55	59
Self-pay	91	86	95	88	81	92
No charge	47	40	52	40	34	44

Note: Results include office-based physicians with at least 10 percent of practice revenue coming from Medicare.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey.

(Government Accountability Office 2009). This study found that Medicare beneficiaries experienced few problems accessing physician services during a 2007–2008 study period. Furthermore, the proportion of beneficiaries who received physician services and the number of services per beneficiary served increased nationwide from 2000 to 2008.

The supply of physicians and other health professionals billing Medicare grew and surveys show high acceptance of Medicare patients

Our analysis of Medicare claims data shows that the number of physicians and other health professionals billing Medicare grew almost 4 percent in 2010. More specifically, the number of physicians billing Medicare grew from 571,000 in 2009 to 588,000 in 2010. The number of other health professionals—such as podiatrists, chiropractors, nurse practitioners, physician assistants, and physical therapists—grew from 317,000 in 2009 to 335,000 in 2010.

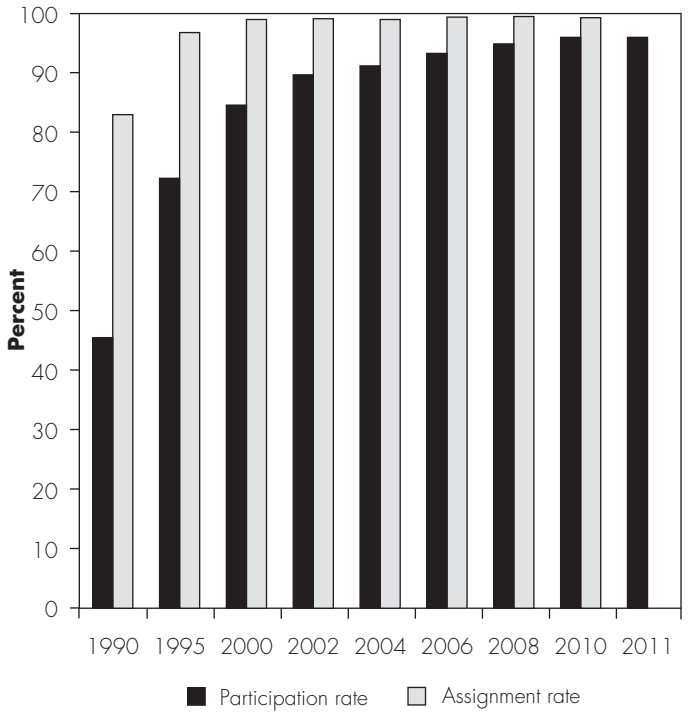
We also measure physician supply and beneficiary access to physicians through information obtained in physician surveys conducted by various organizations and the National Center for Health Statistics. For the most part, these surveys explore physicians' willingness to accept new patients by various insurance types and find that most physicians are willing to accept some or all Medicare patients.

The National Ambulatory Medical Care Survey—a national survey of office-based physicians—shows that over the past several years most physicians continued to accept new Medicare patients (Table 4-4). (This survey does not distinguish physicians who accept all new Medicare patients from those who accept only some new Medicare patients.) For 2009, among physicians with at least 10 percent of their practice revenue coming from Medicare, 90 percent accepted new Medicare patients (Cherry 2011).[5] By specialty, 82 percent of primary care physicians and about 96 percent of physicians in all other specialties accepted new Medicare patients. The rate of primary care physicians accepting new Medicare patients fell slightly, while the rate of specialist physicians accepting new Medicare patients increased slightly.

In the Center for Studying Health System Change 2008 physician survey, 86 percent of physicians reported that they accept at least some new Medicare patients (Boukus et al. 2009). Specifically, 74 percent reported that their practices accepted all or most new Medicare patients and about 12 percent reported accepting some new Medicare patients.[6] For privately insured patients, 96 percent of physicians reported accepting at least some new privately insured patients. Specifically, 87 percent said they accepted all or most and 9 percent said they accepted some new privately insured patients. Physicians' acceptance of new Medicaid patients was lower than for Medicare and privately insured patients.

FIGURE 4–2

Medicare participation and assignment rates have grown to high levels, 1990–2011



Note: "Participation rate" is the percentage of physicians and other health professionals with signed Medicare participation agreements among those in Medicare's registry. Participation agreements require the provider to accept assignment (i.e., accept Medicare's fee schedule rate as payment in full) for all services provided to Medicare beneficiaries. Participation agreements do not require physicians to accept new Medicare patients. "Assignment rate" is the percentage of allowed charges paid on assignment. Data for calculating the assignment rate are not available for 2011.

Source: Ways and Means Greenbook (2004), unpublished CMS data, and MedPAC analysis of Medicare claims for a 5 percent random sample of Medicare beneficiaries.

Physicians who classified themselves in surgical or medical specialties were more likely than primary care physicians to accept all new Medicare and privately insured patients. Physicians in rural areas were more likely than those in urban areas to accept new patients of all insurance types. Newer physicians were more likely than physicians who had been in practice longer to accept new Medicare patients. Additionally, employee physicians and physicians who are part of a group practice were more likely to accept all new Medicare patients. This last finding is consistent with a recent report released by the Medical Group Management Association (MGMA). It stated that 92 percent of surveyed group medical practices currently accept new Medicare patients; another 6.5 percent limit their Medicare patients to those who are established patients aging into Medicare; and 1 percent of practices do not accept any Medicare patients.

In a smaller 2009 survey funded by the Robert Wood Johnson Foundation, physicians were more likely to say that private insurance had better payments than FFS Medicare, but more than half reported that Medicare was the same or better on three measures: paperwork, ease of obtaining services for patients, and autonomy in decision making (Keyhani and Federman 2009).

A different type of study—restricted to claims-processing analysis—also compares Medicare with private insurers. Conducted by the American Medical Association (AMA), the 2011 National Health Insurer Report Card shows that Medicare performed similar to or better than private insurers on several claims-processing measures, such as indicators for payment timeliness, transparency, and accuracy of claims processing (American Medical Association 2011).

Rates of physician participation and services paid on assignment remain high

To supplement our data on the supply of physicians treating Medicare patients and beneficiaries' reported access to physician care, we examine assignment rates (the share of Medicare-allowed charges for which physicians accept assigned fee schedule amounts as payment in full) and provider participation rates (the share of physicians and other health professionals who agree to always accept fee schedule amounts as payment in full). Our analysis of Medicare claims data shows that 99.4 percent of allowed charges for physician services were assigned in 2010 (Figure 4-2); that is, for almost all allowed services that year, physicians agreed to accept the Medicare fee schedule amount as payment in full for the service.[7] The assignment rate has held steady at more than 99 percent since 2000.

The high rate of assigned charges reflects the fact that most physicians and other health professionals who bill Medicare are "participating" physicians and other health professionals. That is, for 2011, 96 percent of physicians, limited license practitioners, and other practitioners who billed Medicare had participation agreements with Medicare. Participating providers agree to accept assignment on all allowed Medicare claims in exchange for a 5 percent higher payment on allowed charges. Participating providers also receive nonmonetary benefits, such as being able to receive payments directly

from Medicare (less the beneficiary cost-sharing portion) rather than having to collect the total amount from the beneficiary. This arrangement is a major convenience for many physicians and other health professionals. Participating providers also have their name and contact information listed on Medicare's website and they have the ability to electronically verify a patient's Medicare eligibility and supplemental insurance status.[8] In contrast, physicians and other health professionals who elect to be "nonparticipating" receive a 5 percent lower payment from Medicare for each service they provide but may charge their Medicare patients rates that are up to 9.25 percent higher. This practice of "balance billing" results in higher cost-sharing liabilities for patients. Balance billing is generally rare but varies by geographic area and specialty.

Changes in service use consistent with reports of decreases outside of Medicare

We analyze annual changes in use of services as an indicator of beneficiary access but caution that interpreting such data is complex because of factors unrelated to Medicare's pricing of services. Decreases in volume could signify price inadequacy if physicians were reluctant to offer such services based on their Medicare payment. However, our evidence indicates that volume decreases are more likely to be due to other factors, such as general practice pattern changes or—in the case of some imaging services—concerns about radiation exposure. For example, the volume of coronary artery bypass grafting has been declining as other interventions substitute for the procedure. Increases in volume may signal overpricing if physicians favor certain services because they are exceedingly profitable; similarly, other factors—including population changes, disease prevalence, changes in Medicare benefits, shifts in the site of care, technology, and beneficiaries' preferences—can also explain volume increases. As an example, procedures for injecting pharmacologic agents into the eye have increased in volume in recent years as therapies have emerged for treating macular degeneration. Another confounding factor is that the volume of services sometimes increases when payment rates decline (Codespote et al. 1998). The possibility of such a response—known as a behavioral or volume offset—makes it particularly difficult to interpret volume increases by themselves as an indicator of payment adequacy.

For this report, we used claims data for 2005, 2009, and 2010; identified the services furnished by physicians and other professionals billing under Medicare's physician fee schedule; and calculated two measures of changes in service use. First, we calculated growth in the units of service per beneficiary. Second, we calculated growth in the volume of services per beneficiary. Volume is units of service weighted by each service's relative value units (RVUs) from the physician fee schedule. The RVUs were those for 2010, which puts service volume for all years on a common scale. The result is that volume growth accounts for changes in both the number of services and the complexity, or intensity, of those services. For example, growth in the volume of imaging services would account not just for any change in the number of such services but also for any change in intensity from X-rays to higher complexity computed tomography (CT) scans.

Our volume analysis also accounts for the policy changes that have occurred in payments for office and inpatient consultations. As of 2010, CMS stopped recognizing the billing codes for consultations.[9] Physicians and other health professionals now use office visit codes and codes for hospital and nursing facility visits. If we ignored this change in policy, the volume analysis would show a change in intensity of services—use of lower payment rate visits in place of higher payment rate consultations—when in fact the change was in payment rates. To avoid this situation, we focus the discussion below on the change in units of service and limit discussion of changes in volume growth to those services not affected by the change in payments for consultations. We will resume discussion of growth in volume of office and inpatient visits in later reports.

Across all services, units of service per FFS beneficiary decreased slightly in 2010, by 0.2 percent (Table 4-5, p. 102). Among broad categories of service, growth rates were negative at –0.1 percent for evaluation and management (E&M), –1.5 percent for imaging, and –0.6 percent for tests. Services with positive growth rates were major procedures, at 1.1 percent, and other procedures, at 0.2 percent.

Small imaging decrease after decade of rapid growth

Despite the decrease in 2010, use of imaging services remained much higher than it was a decade ago. Units of service per 1,000 beneficiaries for the type of CT scan that accounts for the largest share of imaging spending—CT of parts of the body other than the head—grew rapidly from 2000 to 2009: The rate went from 258 to 551. With the 0.7 percent decrease in units of service per beneficiary in 2010, use of this CT service remained at 548 per 1,000 beneficiaries, more than double the rate in 2000. The most

TABLE 4–5

Use of services furnished by physicians and other health professionals, per fee-for-service beneficiary

Type of service	Change in units of service per beneficiary		Change in volume per beneficiary		Percent of 2010 allowed charges
	Average annual 2005–2009	2009–2010	Average annual 2005–2009	2009–2010	
All services	**2.0%**	**–0.2%**	**N/A%**	**N/A%**	**100.0%**
Evaluation and management	**1.2**	**–0.1**	**N/A**	**N/A**	**44.3**
Office visit—new and established	1.5	–0.4	N/A	N/A	24.0
Inpatient visit—hospital and nursing facility	0.5	–0.3	N/A	N/A	15.5
Emergency room visit	1.0	2.7	3.0	4.2	3.1
Hospital visit—critical care	6.1	8.5	8.0	8.7	1.4
Home visit	4.3	5.4	6.1	6.2	0.4
Imaging	**2.2**	**–1.5**	**3.9**	**–2.5**	**13.5**
Advanced—CT: other	6.4	–0.7	6.4	–2.3	2.2
Standard—nuclear medicine	–0.2	–7.8	4.2	–5.4	1.7
Echography—heart	2.6	–0.8	3.7	–1.8	1.5
Advanced imaging—MRI: other	3.0	–2.4	2.5	–4.4	1.4
Standard—musculoskeletal	1.2	–0.5	1.2	–1.4	1.0
Echography—other	6.7	3.5	8.3	4.4	0.9
Imaging/procedure—other	7.0	–5.9	11.9	–1.1	0.7
Standard—breast	5.3	–2.1	4.4	–2.4	0.7
Advanced—MRI: brain	1.5	–4.6	–0.9	–7.5	0.6
Advanced—CT: head	5.0	–0.9	5.3	–3.1	0.5
Standard—chest	–0.3	–2.1	–0.8	–3.0	0.5
Echography—carotid arteries	1.9	–2.6	4.1	–2.4	0.5
Major procedures	**1.6**	**1.1**	**2.8**	**1.4**	**7.7**
Cardiovascular—other	0.0	0.3	4.3	2.1	1.9
Orthopedic—other	6.0	4.6	7.2	5.1	1.0
Knee replacement	2.2	2.6	3.0	3.1	0.5
Coronary angioplasty	–2.6	0.6	–2.9	0.1	0.4
Explore, decompress, or excise disc	4.3	1.6	6.1	2.8	0.3
Coronary artery bypass graft	–7.2	–6.7	–7.3	–6.9	0.3
Hip replacement	2.1	2.3	3.0	2.9	0.3
Pacemaker insertion	2.5	–1.9	0.6	–2.7	0.3
Hip fracture repair	–0.8	–2.9	–0.4	–2.8	0.3
Other procedures	**3.7**	**0.2**	**4.0**	**0.0**	**22.3**
Skin—minor and ambulatory	2.9	0.8	N/A	1.3	4.4
Outpatient rehabilitation	4.7	1.1	5.5	1.8	3.3
Radiation therapy	2.0	–7.4	5.3	–1.9	2.3
Minor—other	3.6	–0.5	3.4	–2.2	2.1
Cataract removal/lens insertion	–0.6	–2.6	–0.1	–2.3	1.5
Minor—musculoskeletal	4.9	–1.2	6.6	–2.3	1.4
Eye—other	12.7	9.7	7.0	6.0	1.1
Colonoscopy	–1.4	–2.2	–1.3	–2.0	0.9
Upper gastrointestinal endoscopy	1.9	0.2	2.6	0.6	0.5
Cystoscopy	0.7	–1.3	1.4	–1.5	0.5
Tests	**0.7**	**–0.6**	**4.6**	**1.6**	**5.2**
Other tests	–1.1	–4.8	4.3	–1.4	2.0
Electrocardiograms	0.5	0.1	1.5	0.3	0.5
Cardiovascular stress tests	–2.6	–4.6	–1.2	–6.2	0.4

Note: N/A (not available), CT (computed tomography). Volume is measured as units of service multiplied by each service's relative value unit (RVU) from the physician fee schedule. To put service use in each year on a common scale, we used the RVUs for 2010. For billing codes not used in 2010, we imputed RVUs based on the average change in RVUs for each type of service. Some low-volume categories are not shown but are included in the summary calculations. Evaluation and management volume is not reported for some types of service because a change in payment policy for consultations prevented assignment of RVUs to those services. For 2005 and 2009, office visits and inpatient visits include, respectively, office and inpatient consultations. Skin procedures volume is not reported for 2005 to 2009 due to a change in coding of Mohs procedures that prevented assignment of RVUs for these services in 2005.

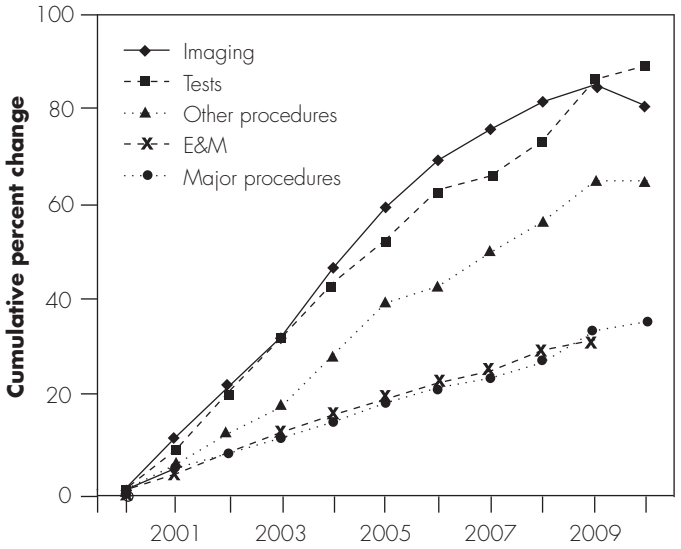
Source: MedPAC analysis of claims data for 100 percent of Medicare fee-for-service beneficiaries.

frequently used MRI service—MRI of parts of the body other than the brain—is another example of an imaging service that experienced rapid growth in use in recent years and then a small decline in 2010. In 2000, beneficiaries received this service at a rate of 64 services per 1,000 beneficiaries. By 2009, the rate had gone up to 144 per 1,000. While there was a 2.4 percent decrease in units of service per beneficiary in 2010, the use rate remained well above double the 2000 rate, at 141 per 1,000.

This pattern—a large increase in service use from 2000 to 2009 followed by a comparatively small decrease in 2010—is characteristic of imaging services overall (Figure 4-3). Cumulative growth in the volume of imaging from 2000 to 2009 totaled 85 percent. By contrast, the 2.5 percent decrease in imaging volume in 2010 was 1/30th of the cumulative increase that occurred the previous decade. The growth in imaging volume from 2000 to 2009 was exceeded only by the growth in use of tests—such as electrocardiograms and cardiovascular stress tests—during those years. Such growth was more than double the cumulative growth rates for E&M and major procedures from 2000 to 2009, which were 32 percent and 34 percent, respectively.

FIGURE 4–3

Growth in the volume of practitioner services, 2000–2010



Note: E&M (evaluation and management). Volume growth for E&M is through 2009 only due to change in payment policy for consultations.

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

Decrease in use of imaging occurred amid concerns about appropriateness

Concerns about use of imaging are widespread.

- Physicians have voiced concerns about diagnostic tests that are ordered without an understanding of how the results could change patient treatment (Redberg et al. 2011). One test can start a cascade of other more invasive tests or treatments.
- In a study for the Commission documenting trends in the services furnished to Medicare beneficiaries by cardiologists from 1999 to 2008, physician researchers found that the bulk of the growth occurred in two established technologies: echocardiograms and stress tests with nuclear imaging (Andrus and Welch 2012). They conclude that it is unlikely that these services were underutilized in 1999 and express doubt that there was a clinical justification for a threefold increase in nuclear stress testing and a twofold increase in echocardiography. They note further that excessive use of such services poses a number of potential harms, including cancer risk due to radiation exposure, anxiety related to false-positive results, and complications of invasive procedures pursued in response to those false-positive results.
- Another study for the Commission—in progress—is considering the extent to which certain diagnostic services are repeated. The list of services includes three imaging services: echocardiography, imaging stress tests, and chest CT. Given the lack of research on this topic, the first aim of the project is to document the extent to which services are repeated at given intervals, such as within one year after an index service. But the study is also showing that some clinicians routinely repeat services, even though standards for doing so are lacking. In addition, a finding of wide geographic variation in the amount and frequency of repeat testing suggests that—in the absence of external standards—local practice style is determining testing thresholds. One reason to study repeat testing is that it is a risk factor for overdiagnosis (Welch et al. 2011). In addition, a tendency to repeat services routinely can reduce the capacity of physicians and other health professionals to serve new patients, raise practice costs as more equipment and personnel are used to serve a given population, and raise spending.
- The popular press has included a number of stories in recent years focused on overuse of services, including

imaging (Elton 2009, Holohan 2011, Johnson 2008, Kolata 2011, Palfrey 2011). For example, in an essay for the *New York Times*, a physician wrote that "Overconsultation and overtesting have now become facts of the medical profession. The culture in practice is to grab patients and generate volume. 'Medicine has become like everything else,' a doctor told me recently. 'Everything moves because of money.'" (Juahar 2008). In a commentary for the *New England Journal of Medicine*, a physician and another author wrote that "The goal should be to redirect nascent physicians from a shotgun approach toward the critical use of imaging in thoughtful and elegant diagnosis.'" (Hillman and Goldsmith 2010).

As discussed in the Commission's June 2011 report, there is evidence that some diagnostic imaging services ordered by physicians are not clinically appropriate and that inappropriate use occurs in both physicians' offices and hospitals. For example, the American College of Cardiology Foundation (ACCF) and UnitedHealthcare sponsored research to assess the appropriateness of nuclear cardiology procedures performed by six nonhospital practices using criteria developed by the ACCF and the American Society of Nuclear Cardiology (Hendel et al. 2010). The researchers found that 14 percent of the studies performed at these sites were inappropriate and 15 percent were of uncertain appropriateness.

Decreases in service use not limited to Medicare

National Health Expenditures data show that spending for the services furnished by physicians and other health professionals grew at a historically low rate in 2010: 2.4 percent (Keehan et al. 2011). For 2009 and 2008, the growth rates were 4.0 percent and 6.7 percent, respectively. Reasons given for the low growth are elevated unemployment, higher cost sharing in employer-based health plans, and a less severe flu season in 2010 compared with 2009.

Decreases in use of imaging may have contributed to the low growth in spending. One report cites decreases in 2010 of 2 percent for outpatient CT and 6 percent for nuclear medicine (The Advisory Board Company 2010). In one market, fears of radiation exposure and physician incentive programs introduced by some insurers have contributed to less use of imaging (Mahar 2011).

There is evidence also of decreases in office visits by nonelderly patients with private insurance. According to a study for the Kaiser Family Foundation based on data for 2009 to 2011, the number of such visits fell by 17 percent (Claxton and Leavitt 2011). It was not the result of a decrease in the number of private insurance enrollees: The enrollment decline from 2009 to 2010 was 2 percent and enrollment is believed to have increased in 2011. The authors cited instead the economic downturn coupled with higher deductibles, copays, and coinsurance.

Quality of care: Most ambulatory care quality measures improved or did not change significantly

Our most recent analysis of a nationally representative sample of Medicare claims data shows that most indicators of ambulatory care quality improved or did not change significantly for the period reviewed. Each year, we compare changes in 38 ambulatory care quality indicators between two time periods—in this case, 2007–2008 and 2009–2010—to determine whether the rates at which beneficiaries with certain diagnoses received clinically indicated care for their conditions improved, worsened, or remained stable. The 38 quality indicators, called the Medicare Ambulatory Care Indicators for the Elderly (MACIEs), were developed by the Commission with input from an expert panel of clinicians. They are designed to measure changes in the rates of clinically indicated treatment and follow-up care from physicians, clinics, and other ambulatory care providers to FFS Medicare beneficiaries who were diagnosed with specific acute or chronic diseases that are prevalent in the Medicare population age 65 or older, such as heart disease, diabetes, cancer, and stroke. The MACIEs include six measures of potentially avoidable hospitalizations for five chronic conditions. A complete description of the development of the MACIEs and a list of the 38 measures is available on the Commission's website at http://www.medpac.gov/chapters/Mar11_Ch04_APPENDIX.pdf.

Our claims analysis found that from 2008 to 2010, 14 MACIE measures improved and 16 showed no statistically significant change. Overall, this finding indicates that in most cases Medicare beneficiaries diagnosed with selected conditions received clinically necessary ambulatory services and averted potentially avoidable hospitalizations at similar or better rates in 2010 compared with 2008. However, we found small but statistically significant declines in rates for eight MACIE measures, including six for care related to cancer and two for potentially avoidable hospital care for beneficiaries with unstable angina and hypertension. For example, there were two very small decreases (less than 1 percentage point) in the rate of

breast cancer screening for all female beneficiaries ages 65 to 74 and in the rate of follow-up mammography for beneficiaries diagnosed with breast cancer. There also were small decreases (2 to 3 percentage points) in the rates of chest X-ray and other diagnostic imaging services for beneficiaries diagnosed with breast cancer.

To examine these declines further, we researched quality reported in the private insurance market, using the Healthcare Effectiveness Data and Information Set—a widely used set of health care performance measures, focusing on results for commercial insurers. For 2010, these measures also showed small declines in rates of imaging for breast cancer for both the HMO and preferred provider organization (PPO) markets (National Committee for Quality Assurance 2011). Reasons for small declines in breast cancer screening across Medicare and private insurers could be related to the current debate on guidelines for how often—and whether—women should be screened for breast cancer. This issue suggests that a review of the MACIE measures could be useful to keep up-to-date with current medical guidelines, particularly for process measures that focus on services that patients receive rather than health outcomes (such as potentially avoidable hospitalizations).

Six of the MACIE indicators measure rates of potentially avoidable hospitalizations and emergency department visits for beneficiaries diagnosed with five chronic conditions: coronary artery disease, congestive heart failure, diabetes, hypertension, and chronic obstructive pulmonary disease (COPD). In this year's analysis, one of these measures improved (hospitalization rates for beneficiaries with COPD), two worsened (rates for emergency department visits for unstable angina and hospitalization for a primary diagnosis of hypertension), and the other three rates did not change significantly. The latter three rates (e.g., hospitalization rates for treatment of both short-term and long-term complications of diabetes) coincided with improvements in the rates of other applicable ambulatory care measures (e.g., diabetic eye examinations, lipid and blood glucose level testing, and periodic follow-up visits for diabetic beneficiaries).

Medicare payments and providers' costs

In the absence of cost reports for physician and other health professional services, we use certain indirect measures of this sector's financial status. One such measure is the ratio of Medicare's payments to private insurer payments for fee schedule services. As has been the case for more than a decade, the rate for 2010 continues to be about 80 percent. Physician compensation is another indicator. In 2010, compensation was lower for primary care physicians than for most specialists, and the disparity between them was large enough to raise significant concerns about fee schedule pricing and equity. We also consider forecasts of medical inflation, as measured by the Medicare Economic Index (MEI). Revised quarterly, the most recent MEI forecast for 2013 is 1.4 percent. The MEI is adjusted for expected gains in productivity.

Ratio of Medicare to private insurer fees has remained stable

One measure of Medicare payment adequacy examines the trend in Medicare's allowed physician and other health professional fees (including patient cost sharing) relative to private insurer allowed fees.[10] In the early to mid-1990s, Medicare payment rates averaged about two-thirds of commercial payment rates for physician and other health professional services, but since 1999 Medicare rates consistently have been near 80 percent of commercial rates.

For 2010, we find little change from the results reported for 2009. In 2010, Medicare's payments for physician and other health professional services were at 81 percent of commercial rates for PPOs when averaged across all physician services and geographic areas compared with 80 percent in the preceding year. We base this analysis on a data set of paid claims for PPO members of a large national private insurer. More than 70 percent of commercially insured individuals are in PPO arrangements (Kaiser Family Foundation and Health Research & Educational Trust 2011).[11] We are unable to include additional private insurer payments (or penalties) to providers, such as quality incentives and other bonuses, because data on these payments for private insurers are unavailable. In contrast, the Medicare fees in our analysis do include bonuses that Medicare pays as part of the claims, such as the health professional shortage area bonus—in effect since 1991.

Findings on access to care for Medicare beneficiaries relative to the commercially insured population suggest that Medicare's lower average payment rates may have less effect on access than local market factors. Research by the Center for Studying Health System Change cited earlier found that beneficiaries in markets with the widest gaps between Medicare and commercial payment rates reported access problems in proportions similar to those in markets with narrow payment rate differences (Trude and Ginsburg 2005). Moreover, in markets with higher

commercial payment rates relative to Medicare, the commercially insured population did not appear to gain better access than Medicare beneficiaries. These findings suggest that developments in local health systems and markets may strongly influence access for both Medicare beneficiaries and the privately insured.

Compensation is lower for primary care physicians than for specialists

Physician compensation provides another perspective on the relationship between Medicare's fees for the services of physicians and other health professionals and the fees of other payers. Private payers often use a conversion factor—or multiple conversion factors, depending on the type of service—that differs from Medicare's.

For an analysis of the compensation received by physicians—the largest subset of practitioners—the Commission contracted with the Urban Institute, working in collaboration with the MGMA (Berenson et al. 2010). The contractor developed a method for analysis of two measures of compensation: "actual compensation," or actual revenues received by a physician from all payers, and "simulated compensation," or payments a physician would receive if all the services the physician furnished were paid under Medicare's physician fee schedule.[12]

For this report, the contractor used data from MGMA's Physician Compensation and Production Survey to analyze physician compensation in 2010.[13] The analysis showed that—averaged across all specialties—actual physician compensation was about $305,000 per year. Simulated annual compensation for all specialties was about $254,000—17 percent lower.[14]

Within these averages, compensation is much higher for some specialties than others. The specialty groups with the highest compensation were the nonsurgical, procedural group and radiology (Figure 4-4).[15] Their actual levels of compensation were about $445,000 and $460,000, respectively. Compensation at these levels was more than double that of the $207,000 average for primary care specialties.[16,17]

Use of simulated annual compensation instead of actual annual compensation resulted in minimal narrowing of the disparities between primary care physicians and specialists. Simulated, radiologists' average annual compensation was about $408,000, or 2.4 times the $170,000 compensation for primary care physicians. For nonsurgical, procedural physicians, the average simulated compensation was about $398,000, or 2.3 times the $170,000 compensation for primary care physicians.

The Commission is not alone in drawing attention to such disparities in physician compensation. An international comparison of physician fees and earnings has shown that the earnings of U.S. orthopedic surgeons in 2008 were 2.4 times the earnings of their colleagues in primary care (Laugesen and Glied 2011). Comparable multiples for the five other comparison countries in the study—Australia, Canada, France, Germany, and the United Kingdom—were smaller, with a range from 2.0 to 1.5.

The data on physician compensation raise concerns about the equity of some of the compensation levels, especially the compensation some specialists receive. The level of payments to physicians is a function of price and quantity—the fees paid for services and the number of services furnished. Under Medicare's physician fee schedule, fees are tightly controlled. Such a payment system can lead to compensation levels that are skewed in favor of some physicians at the expense of others. These payment inequities stem from two inherent risks.

One risk is mispricing. In our recent recommendations on the SGR, the Commission made recommendations aimed at improving the accuracy of the fee schedule's RVUs (see Appendix B at the end of this report). The concern is that mispricing has contributed to inequities in physician compensation.

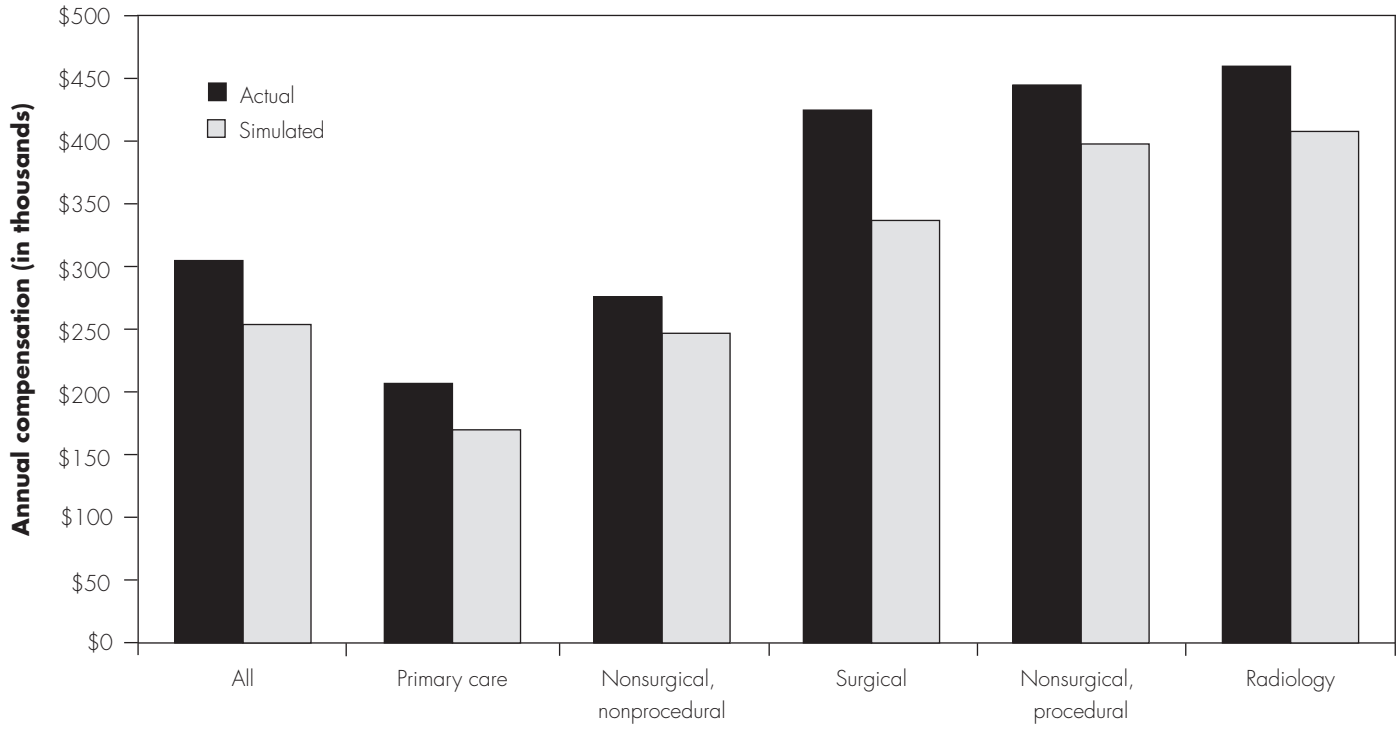
Another risk to the equitable distribution of payments is the ability—or inability—of some practitioners to generate volume. For instance, primary care practitioners who focus on E&M services have limited opportunity to increase the number of services they furnish. The main component of E&M services is face-to-face time spent with patients, making it difficult to fit more visits into a day's schedule. By contrast, imaging, tests, and procedures other than major surgical procedures have all grown at much faster rates than other services. The specialists who furnish these high-growth services are generally the ones at the high end of the compensation scale. This finding is not surprising under a FFS payment system that rewards practitioners for generating volume, regardless of clinical value.

Certain physicians and other health professionals are eligible for Medicare payment bonuses (and penalties)

Across most sectors, we consider provider payments in our analysis of payment adequacy. Apart from the payment reductions scheduled for 2013 under the SGR, the Patient

FIGURE 4–4

Disparities in physician compensation are widest when primary care is compared with nonsurgical proceduralists and radiologists, 2010



Note: Simulated compensation is compensation as if all services were paid under the Medicare physician fee schedule.

Source: Urban Institute and Medical Group Management Association (MGMA) analysis of 2010 data from the MGMA's Physician Compensation and Production Survey.

Protection and Affordable Care Act of 2010 and previous legislation have established bonus payments available to certain physicians and other health professionals. They are listed below:

- Since 1991, physicians and other health professionals who practice in designated health professional shortage areas (HPSAs) automatically receive a 10 percent bonus (relative to the fee schedule amount) on all Medicare services they provide.[18]
- Starting in 2011 and ending in 2016, primary care practitioners who meet certain criteria receive a 10 percent increase in payments for selected fee schedule services, as will general surgeons practicing in HPSAs. For primary care practitioners, this adjustment complements other payment increases that CMS has implemented through regulation, such as increases to the physician work values of the fee schedule in 2007.[19]
- Under the Physician Quality Reporting System (PQRS), qualifying physicians and other health professionals received a 1 percent bonus on all Medicare services they provided in 2011 and will receive a 0.5 percent bonus in 2012 through 2014. Starting in 2015, those who do not satisfactorily report PQRS measures will be subject to a financial penalty starting at 1.5 percent of their Medicare fees.
- The electronic health record (EHR) incentive program provides payments to physicians when they adopt EHRs and demonstrate their use in specified ways to improve quality, safety, and effectiveness of care. Physicians may receive up to $44,000 over five years, starting with $18,000 in 2011. EHR bonuses for physicians in HPSAs are 10 percent higher. Starting in 2015, eligible physicians who do not satisfy the EHR criteria will be subject to a financial penalty starting at 1 percent of their Medicare fees.
- Prescribing physicians and health professionals who do not participate in the EHR incentive program are eligible for an electronic prescribing (eRx) bonus of 1 percent on all their Medicare fees if they use a

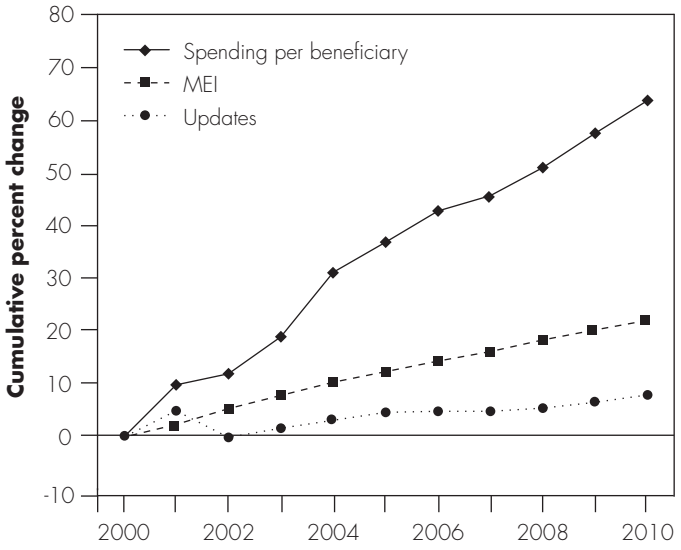
qualified eRx system. This program began in 2009. Starting in 2012, eligible professionals who have not yet satisfied the eRx criteria and cannot demonstrate "hardship" exemptions will be subject to a financial penalty starting at 1 percent of their Medicare fees.

Input costs for physician and other health professional practices are expected to increase in 2012

CMS's 2012 forecast of the MEI—a measure of changes in the market basket of input prices for physician and other health professional services, adjusted for productivity growth in the national economy—is revised quarterly and has ranged from 1.0 percent (most recent) to 0.7 percent. For these forecasts, CMS collects pricing data from various data sets and surveys. Additionally, CMS calculates a weighted average of expected input price changes from survey data for 2006 collected by the AMA in 2007 and 2008. These weights were updated recently in CMS's final rule updating the Medicare physician fee schedule.

Medicare's total payments to physicians and other health professionals have increased faster than both the MEI and updates to the fee schedule's conversion factor (Figure 4-5). From 2000 to 2010, the updates rose 8 percent cumulatively, while the MEI rose 22 percent cumulatively. Over the same period, however, Medicare spending for physician and other health professional services—per beneficiary—increased by 64 percent. Volume growth accounts for the difference between the fee schedule updates and spending growth. Aggregate Medicare payments to practices from this spending growth are a function of volume growth and fee schedule updates. ■

FIGURE 4–5 **Volume growth has caused spending to increase faster than input prices and physician updates, 2000–2010**



Note: MEI (Medicare Economic Index).

Source: 2011 Trustees' report, Global Insight 2010q4 MEI forecast, and Office of the Actuary 2011.

Endnotes

1 See http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_Physician.pdf.

2 The 2011 survey included an oversample of African Americans, Hispanics, and other minorities—including Native Americans, Alaskan Natives, Asian Americans, and Hawaiian and Pacific Islanders. All respondents had the opportunity to take the survey in English or Spanish.

3 Within that population, our survey results do not distinguish Medicare FFS enrollees from those in Medicare Advantage (MA) plans because of the technical difficulty in obtaining reliable self-identification of FFS or MA enrollment from surveyed individuals. Similarly, we do not distinguish by type of private coverage among the non-Medicare population in our survey.

4 The 2012 final rule on the fee schedule also discusses review of the relative value units (RVUs) for primary care services. CMS had proposed that the Relative Value Scale Update Committee review the RVUs for all evaluation and management (E&M) services. The agency has withdrawn this proposal, however, given concerns expressed by commenters about possible inadequacies of the current E&M coding and documentation structure to address evolving chronic care management. Instead, CMS will allow time for consideration of findings of the Comprehensive Primary Care Initiative, research by the Assistant Secretary for Planning and Evaluation on balancing incentives and evaluating payments for primary care, demonstrations the agency has undertaken on care coordination, and other initiatives.

5 When physicians who were in closed practices—practices that no longer accepted any new patients (regardless of insurance type)—were excluded from this calculation, the share of physicians accepting new Medicare patients increased to 96 percent overall, with 94 percent of primary care physicians and 98 percent of specialists accepting new Medicare patients.

6 These percentages include practices with potentially small shares of Medicare patients, such as pediatrics.

7 In 2010, 97 percent of allowed charges were for services provided by participating physicians, and another 2 percent were for services provided by nonparticipating physicians who decided to accept assignment. Only 0.6 percent of allowed charges were for services provided by nonparticipating physicians who did not accept assignment.

8 Participation agreements do not require physicians to accept new Medicare patients.

9 CMS changed the policy on billing for consultations with the rationale that the relaxation of consultation documentation requirements over time had brought the effort involved in consultations to levels comparable to those of visits.

10 Although allowed amounts include patient cost-sharing liabilities, they do not include balance billing amounts that would exceed the fee schedule amounts.

11 Our analysis relies on data from one large national insurer to determine a national average of the relationship between Medicare and private PPO payer rates. While we report a national average, the data show that payment rates vary substantially from one geographic area to another, within geographic areas, across providers within a given market, and by the type of service across and within markets. For E&M services, specifically, the ratio of Medicare to private fees was 87 percent. The ratio for all other services was 80 percent.

12 In simple terms, simulated compensation was calculated in two steps. Step 1 was annual total RVUs for the services furnished by a physician multiplied by the Medicare conversion factor. Step 2 was the result of Step 1 multiplied by a ratio that was the physician's actual compensation divided by collections (revenues) from the physician's professional services and collections from other sources attributable to the physician such as laboratory services and injectable drugs. Further details are in the contractor's report.

13 The 2010 data predate payment of a 10 percent bonus for eligible primary care practitioners and general surgeons (general surgeons practicing in health professional shortage areas) started on January 1, 2011.

14 The 17 percent difference between simulated compensation and actual compensation does not mean that Medicare's payments for physician services are 17 percent lower than private payers' payments for those services. The compensation estimates include compensation attributable to physician services and to services other than physician services, such as laboratory services and injectable drugs. In addition, the comparison is simulated Medicare compensation relative to actual compensation that is attributable to private payers' payments but also some Medicare payments.

15 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.

16 The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.

17 To account for differences among specialties in hours worked per week, the contractor's earlier initial analysis for the Commission—with MGMA data for 2007—included comparisons of hourly compensation. The results were similar to those from the analysis of the 2010 data on annual compensation: Hourly compensation for nonsurgical, procedural specialties and radiology was more than double the hourly compensation rate for primary care. Analysis of hourly compensation was not possible with the 2010 data because the newer MGMA survey did not include questions about hours worked.

18 This bonus started at 5 percent in 1989 and was limited to rural areas. In 1991, the bonus payment was raised to 10 percent and urban HPSAs were included.

19 See the text box on page 91 in our March 2011 *Report to the Congress: Medicare payment policy* for more examples.

References

Agency for Healthcare Research and Quality, Department of Health and Human Services. 2011. *National healthcare disparities report 2010.* Publication no. 11–0005. Rockville, MD: AHRQ.

American Medical Association. 2011. *2011 national health insurer report card.* Washington, DC: AMA.

Andrus, B. W., and H. G. Welch. 2012. Medicare services provided by cardiologists in the United States: 1999–2008. *Circulation Cardiovascular Quality and Outcomes* 5, no. 1 (January 1): 31–36.

Bach, P. B., H. H. Pham, D. Schrag, et al. 2004. Primary care physicians who treat blacks and whites. *New England Journal of Medicine* 351, no. 6 (August 5): 575–584.

Berenson, R., S. Zuckerman, K. Stockley, et al. 2010. *What if all physician services were paid under the Medicare fee schedule: An analysis using Medical Group Management Association data.* A study conducted for the Medicare Payment Advisory Commission by staff from the Urban Institute and the Medical Group Management Association Center for Research. Washington, DC: MedPAC.

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2010. *2010 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds.* Washington, DC: Boards of Trustees.

Boukus, E., A. Cassil, and A. S. O'Malley. 2009. *A snapshot of U.S. physicians: Key findings from the 2008 Health Tracking Physician Survey.* Data bulletin no. 35. Washington, DC: HSC.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2011. Medicare program; payment policies under the physician fee schedule, five-year review of work relative value units, clinical laboratory fee schedule: signature on requisition, and other revisions to Part B for CY 2012. Final rule. *Federal Register* 76, no. 228 (November 28): 73026–73474.

Cherry, D., National Center for Health Statistics, Department of Health and Human Services. 2011. E-mail communication with MedPAC staff, November 17.

Claxton, G., and L. Leavitt. 2011. The economy and medical care. *Notes on Health Insurance and Reform*. November 15. http://healthreform.kff.org/notes-on-health-insurance-and-reform/2011/november/the-economy-and-medical-care.aspx.

Codespote, S. M., W. J. London, and J. D. Shatto. 1998. *Physician volume and intensity response.* Baltimore, MD: CMS. http://www.cms.gov/ActuarialStudies/downloads/PhysicianResponse.pdf.

Cunningham, P. 2008. E-mail communication with MedPAC staff, November 10 and 25, regarding the following surveys funded by the Robert Wood Johnson Foundation: the 1996–1997 and 2003 HSC Community Tracking Study Household Surveys and the HSC 2007 Health Tracking Household Survey.

Elton, E. 2009. Changing the patterns of medical care. Letter to the editor. *New York Times,* June 20.

Everett, C. M., J. R. Schumacher, A. Wright, et al. 2009. Physician assistants and nurse practitioners as a usual source of care. *Journal of Rural Health* 25, no. 4 (Fall): 407–414.

Government Accountability Office. 2009. *Medicare physician services: Utilization trends indicate sustained beneficiary access with high and growing levels of service in some areas of the nation.* GAO–09–559. Washington, DC: GAO.

Hendel, R. C., M. Cerqueira, P. S. Douglas, et al. 2010. A multicenter assessment of the use of single-photon emission computed tomography myocardial perfusion imaging with appropriateness criteria. *Journal of the American College of Cardiology* 55, no. 2 (January 12): 156–162.

Hillman, B. J., and J. C. Goldsmith. 2010. The uncritical use of high-tech medical imaging. *New England Journal of Medicine* 363, no. 1 (July 1): 4–6.

Holohan, E. 2011. When docs own MRIs, back pain scans increase: Study. *HealthDay,* April 28.

Hooker, R. S., and L. F. McCaig. 2001. Use of physician assistants and nurse practitioners in primary care, 1995–1999. *Health Affairs* 20, no. 4 (July–August): 231–238.

Institute of Medicine. 2002. *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press.

Johnson, L. A. 2008. Health insurers limit advanced scans. *USA Today,* March 23.

Juahar, S. 2008. Many doctors, many tests, no rhyme or reason. *New York Times,* March 11.

Kaiser Family Foundation and Health Research & Educational Trust. 2011. *Employer health benefits: 2011 annual survey.* Menlo Park, CA: Kaiser Family Foundation HRET.

Keehan, S. P., A. M. Sisko, C. J. Truffer, et al. 2011. National health spending projections through 2020: Economic recovery and reform drive faster spending growth. *Health Affairs* 30, no. 8 (August): 1594–1605.

Keyhani, S., and A. Federman. 2009. *Physician views on the public health insurance option and Medicare expansions.* Princeton, NJ: Robert Wood Johnson Foundation. September. http://www.rwjf.org/files/research/48408physician.pdf.

Koh, H. K., G. Graham, and S. A. Glied. 2011. Reducing racial and ethnic disparities: The action plan from the Department of Health and Human Services. *Health Affairs* 30, no. 10 (October): 1822–1829.

Kolata, G. 2011. Law may do little to curb unnecessary care. *New York Times,* March 29.

Laugesen, M. J., and S. A. Glied. 2011. Higher fees paid to US physicians drive higher spending for physician services compared to other countries. *Health Affairs* 30, no. 9 (September): 1647–1656.

Mahar, M. 2011. Medicare spending slows sharply. *Taking Note*. August 25. http://www.takingnote.tcf.org/2011/08/medicare-spending-slows-sharply-2.html.

Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

National Committee for Quality Assurance. 2011. *The state of health care quality 2011: Continuous improvement and the expansion of quality measurement.* Washington, DC: NCQA.

Palfrey, S. 2011. Daring to practice low-cost medicine in a high-tech era. *New England Journal of Medicine* 364, no. 11 (March 17): e21.

Redberg, R., M. Katz, and D. Grady. 2011. Diagnostic tests: Another frontier for less is more: Or why talking to your patient is a safe and effective method of reassurance. *Archives of Internal Medicine* 171, no. 7 (April 11): 619.

Reschovsky, J. D., and A. S. O'Malley. 2008. Do primary care physicians treating minority patients report problems delivering high-quality care? *Health Affairs* 27, no. 3 (May–June): w222–231.

The Advisory Board Company. 2010. Lessons from growing imaging programs in 2010. The Reading Room. October 22. http://www.advisory.com/Research/Imaging-Performance-Partnership/The-Reading-Room/2010/10/Lessons-from-Growing-Imaging-Programs-in-2010.

Trude, S., and P. B. Ginsburg. 2005. *An update on Medicare beneficiary access to physician services.* Issue brief no. 93. Washington, DC: Center for Studying Health System Change. February.

Welch, H. G., L. M. Schwartz, and S. Woloshin. 2011. *Overdiagnosed: Making people sick in the pursuit of health.* Boston, MA: Beacon Press.

Williams, M. E., C. C. Pulliam, R. Hunter, et al. 2004. The short-term effect of interdisciplinary medication review on function and cost in ambulatory elderly people. *Journal of the American Geriatrics Society* 52, no. 1 (January): 93–98.