CHAPTER 4

Physician and other health professional services

RECOMMENDATIONS

4-1 For calendar year 2024, the Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

4-2 The Congress should enact a non-budget-neutral add-on payment, not subject to beneficiary cost sharing, under the physician fee schedule for services provided to low-income Medicare beneficiaries. These add-on payments should equal a clinician's allowed charges for these beneficiaries multiplied by:

- 15 percent for primary care clinicians and
- 5 percent for non–primary care clinicians.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 4

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In this chapter

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- How should Medicare payments change in 2024?
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Chapter summary

Medicare's physician fee schedule pays for about 8,000 different types of medical services provided across a variety of care settings. These services range from office visits to surgical procedures, imaging, and tests and are delivered in physician offices, hospitals, nursing homes, and other settings. The clinicians who are paid to deliver these services include not only physicians, nurse practitioners, and physician assistants but also podiatrists, physical therapists, psychologists, and other types of health professionals. In 2021, the Medicare program and its beneficiaries paid $92.8 billion for services provided by almost 1.3 million clinicians, accounting for just under 18 percent of spending in Medicare's traditional fee-for-service (FFS) program.

Assessment of payment adequacy

In 2021 and 2022, most physician payment adequacy indicators remained positive or improved, but clinicians' input costs grew at rates not seen for many years.

Beneficiaries' access to care—In the 2022 fielding of the Commission's annual survey, Medicare beneficiaries continued to report access to clinician services that was equal to, or better than, that of privately insured people. Other national surveys and our annual focus groups with

beneficiaries and privately insured people also suggest that beneficiaries have relatively good access to care. Surveys also indicate that the share of clinicians accepting Medicare is comparable to the share accepting private insurance, despite private health insurers paying higher rates. An extremely high share of the clinicians who bill Medicare accept physician fee schedule amounts as payment in full and do not seek to obtain higher payments from patients.

The supply of most types of clinicians has been growing in recent years, although the composition of the clinician workforce continues to change. Over the last several years, there has been a rapid increase in the number of advanced practice registered nurses and physician assistants, a steady increase in the number of specialists, and a slow decline in the number of primary care physicians. This has coincided with our annual survey finding that both Medicare beneficiaries and privately insured people report more problems obtaining a new primary care provider than a new specialist.

While the overall number of clinicians has grown in recent years, the number of clinicians per Medicare beneficiary (including those in FFS Medicare and Medicare Advantage) has remained steady due to beneficiary enrollment growth.

The number of clinician encounters per beneficiary dropped sharply in the early months of the coronavirus pandemic (causing an 11 percent decline in 2020). The overall number of encounters then increased in 2021 but did not return to its prepandemic level.

***Quality of care*—**The quality of care provided by clinicians is difficult to assess in the best of circumstances. In 2021, those difficulties were compounded by the pandemic. While we report 2021 rates of ambulatory care–sensitive hospitalizations and emergency department visits and 2021 patient experience data, we have not used these results to assess the quality of care provided to Medicare beneficiaries.

***Medicare payments and providers' costs*—**In 2021, total spending on clinician services (by the Medicare program and beneficiaries) was $8.1 billion higher than it was in 2020 but $4.4 billion lower than in 2019. In 2021, per beneficiary spending on evaluation and management (E&M) services and on treatments was higher than it was in 2019, while spending on tests, imaging, procedures, and anesthesia was lower. The increase in E&M spending primarily reflects large increases to the payment rates for certain E&M services in 2021, while

changes in other service categories were driven by a combination of smaller changes in payment rates and reductions in service volume.

In 2021, payment rates paid by preferred provider organization (PPO) health plans for clinician services were 134 percent of FFS Medicare's payment rates, down from 138 percent in 2020. Between 2017 and 2021, physicians' median all-payer compensation grew by an average of 3 percent per year. However, compensation remained much lower for primary care physicians than for most specialists—underscoring our long-standing concerns about the mispricing of physician fee schedule services and its impact on the number of physicians choosing to practice primary care.

Clinicians' input costs—as measured by the Medicare Economic Index (MEI)—grew by 2.6 percent in 2021 and are estimated to have grown 4.7 percent in 2022, substantially higher than the recent historical norm of 1 percent to 2 percent per year. Growth in clinicians' input costs is projected to remain high in 2023 (3.9 percent) and 2024 (2.9 percent), though these projections are subject to change.

How should payment rates change in 2024?

Given the recent growth in inflation, cost increases could be difficult for clinicians to absorb. However, current payments to clinicians appear adequate on the basis of our indicators. Therefore, for calendar year 2024, the Commission recommends that the Congress update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the MEI. Because clinicians' practice expenses account for about half of the MEI, this recommendation would help ensure that payment rates keep pace with the growth of clinicians' practice costs. Based on CMS's MEI projections at the time of publication, the recommended update for 2024 would be equivalent to 1.45 percent. Our recommendation would be a permanent update that would be built into subsequent years' payment rates, in contrast to the temporary update specified in current law, which will increase payment rates in 2024 by 1.25 percent and then expire at the end of that year. In addition, under our second recommendation, payments would increase for clinicians to the extent that they provide care for low-income beneficiaries (described next).

Supporting Medicare safety-net clinicians

To promote adequate access to care for all Medicare beneficiaries, the Commission has determined that providing additional financial support for

clinicians who furnish care to Medicare beneficiaries with low incomes is warranted. Clinicians often receive less revenue when treating low-income beneficiaries because of the way Medicare's cost-sharing policies interact with state Medicaid payment policies, which likely makes beneficiaries with low incomes less profitable to care for and could put some clinicians at financial risk. At the same time, low-income beneficiaries report having more difficulty accessing needed care than other beneficiaries. The Commission recommends that Medicare make targeted add-on payments of 15 percent to primary care clinicians and 5 percent to all other clinicians for physician fee schedule services provided to Medicare beneficiaries enrolled in the Part D low-income subsidy program. ■

Background

Clinicians who bill under Medicare's physician fee schedule deliver a wide range of services, including office visits, surgical procedures, and diagnostic and therapeutic services, in a variety of settings. (When clinician services are provided in certain settings, such as hospitals or skilled nursing facilities, CMS also makes payments to these facilities through other Medicare payment systems, which are discussed in separate chapters of this report.) In 2021, the Medicare program and its beneficiaries paid $92.8 billion for clinician services, which is $8.1 billion more than was paid in 2020 but $4.4 billion less than was paid in 2019. Physician fee schedule spending constitutes just under 18 percent of spending in traditional fee-for-service (FFS) Medicare (Boards of Trustees 2022).[1] In 2021, almost 1.3 million clinicians, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners, billed FFS Medicare for at least one beneficiary.

To determine Medicare payment rates for clinician services, CMS uses a fee schedule, known as the physician fee schedule, which consists of relative values for about 8,000 services. These relative values are multiplied by the physician fee schedule's conversion factor (a fixed dollar amount equal to $33.89 in 2023) to produce a total payment amount.[2]

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a schedule of annual updates to the physician fee schedule's payment rates and replaced the sustainable growth rate (SGR) formula for updating payments to clinicians. Under MACRA's original framework, payment rates were to be updated by zero percent from 2020 to 2025, but this was coupled with (1) an annual 5 percent bonus for clinicians who participate in advanced alternative payment models (A–APMs), available through 2024, and (2) an annual performance-based payment adjustment for non–A–APM clinicians under the Merit-based Incentive Payment System (MIPS), which does not expire (Table 4-1, p. 114).[3,4] MACRA specified updates to payment rates starting in 2026 of 0.75 percent per year for clinicians in A–APMs and 0.25 percent for clinicians not in A–APMs.

Subsequent legislation has amended MACRA's framework, providing temporary increases to the fee schedule's payment rates in 2021 through 2024 (shown in the second-to-last row of Table 4-1, p. 114). These increases differ from traditional updates in that they each apply for one year only and are not built into subsequent years' base payment rates. The Congress provided these temporary increases to partially offset a 10.2 percent reduction to the fee schedule's conversion factor that was scheduled to take effect in 2021. The conversion factor reduction was required to offset the cost of increasing payment rates for certain evaluation and management (E&M) visits and of adding a new E&M add-on payment (which the Congress later delayed).[5] Subsequent legislation also provided a 3.5 percent bonus for clinicians who participate in A–APMs in 2025.

Focusing on 2024, current law calls for the fee schedule's payment rates to be increased by 1.25 percent that year. This increase is relative to what payment rates would have otherwise been that year, including budget-neutrality adjustments that have been implemented in recent years and not including temporary one-year payment rate increases in 2021, 2022, and 2023.

In 2024, clinicians qualifying for the A–APM incentive payment will also receive a lump-sum payment worth 5 percent of their annual Medicare professional services payments. (As a point of reference, about 240,000 clinicians received this bonus in 2022.) Meanwhile, non–A–APM clinicians subject to MIPS will receive adjustments to their Medicare payment rates; historically, these adjustments have never exceeded 2 percent. (In 2022, about 850,000 clinicians received a positive MIPS adjustment of up to 1.87 percent, depending on their performance.) A very small proportion of clinicians will receive negative adjustments under MIPS (e.g., because they failed to report MIPS measure data). (In 2022, about 19,000 clinicians received negative MIPS adjustments of up to −9 percent.) And hundreds of thousands of clinicians will receive no bonuses and no payment adjustments because they do not participate in an A–APM and are exempt from MIPS (e.g., because they are a newly enrolled clinician or an ineligible clinician type) (Centers for Medicare & Medicaid Services 2022d, Centers for Medicare & Medicaid Services 2019).

Figure 4-1 (p. 115) shows the cumulative effect of legislated changes in the fee schedule's payment rates since 2017. (The figure does not show additional increases or decreases to the fee schedule's conversion

TABLE 4–1

Physician fee schedule updates, one-year increases, bonuses, adjustments, and sequestration reductions

	2021	2022	2023	2024	2025	2026 and later
A–APM clinicians						
Update	0%	0%	0%	0%	0%	0.75%
A–APM bonus (one time)	5%	5%	5%	5%	3.5%	N/A
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
MIPS adjustments (one time)*	(–7% to +7%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)
Additional MIPS adjustments for "exceptional" performance (one time)	$500 million	$500 million	$500 million	$500 million	N/A	N/A
All clinicians						
Payment increase (one time)	3.75%	3.0%	2.5%	1.25%	N/A	N/A
Sequestration (one time)	0%	0% (3 months), –1% (3 months), –2% (6 months)	–2%	–2%	–2%	–2%

Note: A–APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System), N/A (not applicable). One-time adjustments apply in a given year only and are not included in subsequent years' payment rates. The annual change to the conversion factor (a fixed dollar amount) for Medicare's physician fee schedule is based on the statutory payment updates listed above and an adjustment to ensure that changes to the fee schedule's work relative value units are budget neutral (not shown). A–APM bonuses and MIPS adjustments are based on clinicians' A–APM participation and quality-measure performance from two years prior.
* Although CMS is legally allowed to apply MIPS adjustments of up to +7 percent in 2021 and +9 percent from 2022 on, CMS's actual MIPS adjustments have never exceeded +2 percent.

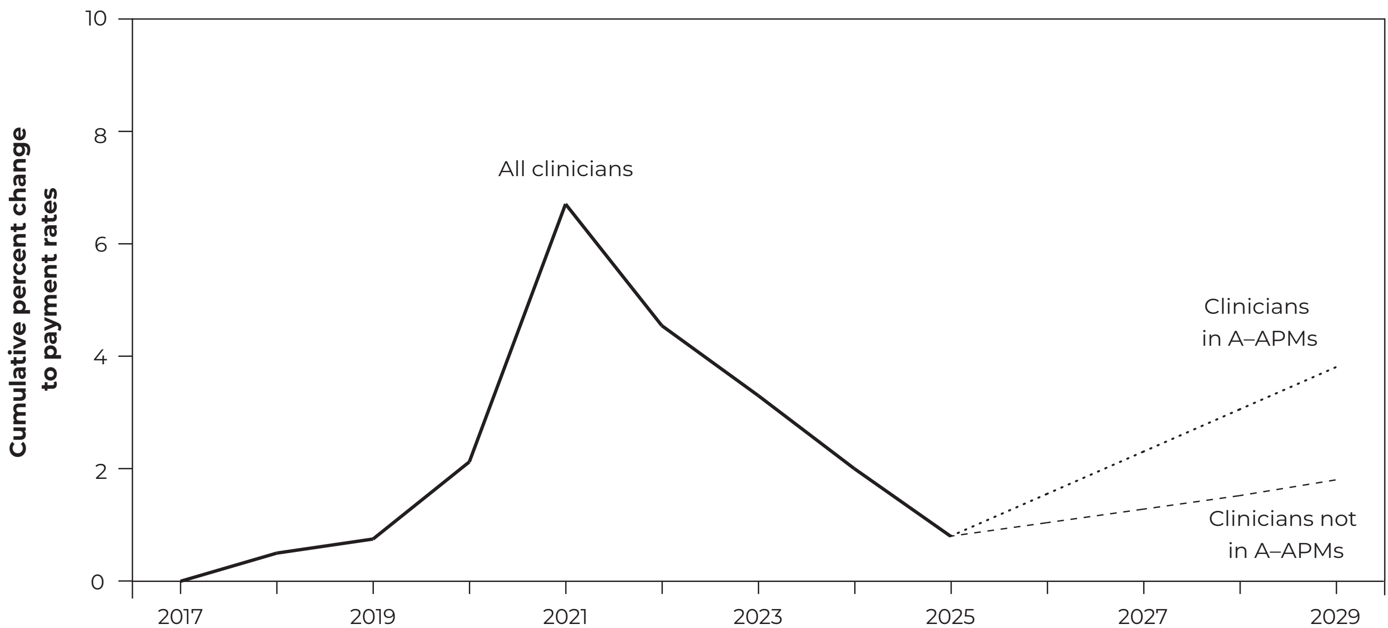
Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015; the Coronavirus Aid, Relief, and Economic Security (CARES) Act; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes; the Protecting Medicare and American Farmers from Sequester Cuts Act; and the Consolidated Appropriations Act, 2023.

factor that are implemented by CMS to maintain budget neutrality when it revalues payment rates for individual services.) In 2020, in response to the pandemic, the Congress suspended Medicare's "sequestration" policy that reduces Medicare's payments to providers by 2 percent. In 2021, the Congress continued to suspend sequestration and provided a temporary 3.75 percent increase to payment rates (to help offset the reduction to the conversion factor prompted when CMS increased payment rates for E&M services that year). In 2022, the Congress reinstated the 2 percent sequester and provided a 3.0 percent temporary increase to payment rates.[6] The Congress then provided a 2.5 percent temporary increase to 2023 payment rates and a 1.25 percent temporary increase to 2024 payment rates.

Although payment rates for most services in the fee schedule will decline from 2020 to 2025, payment rates for a small set of widely used services—E&M office/outpatient visits—were substantially increased by CMS in 2021. As a result, we expect Medicare payments to clinicians who primarily deliver E&M services to increase, payments to other clinicians to decline, and the income gap between specialists and primary care providers to be reduced. The Commission strongly

FIGURE 4–1

Statutory changes to the physician fee schedule's payment rates since 2017



Note: A–APM (advanced alternative payment model). Figure shows changes to payment rates in nominal terms. Figure does not show CMS changes to payment rates to ensure that changes to the values of individual billing codes are budget neutral. Figure also does not show Merit-based Incentive Payment System (MIPS) adjustments or A–APM bonuses because these are not built into subsequent years' payment rates.

Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015; the Bipartisan Budget Act of 2018; the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes; the Protecting Medicare and American Farmers from Sequester Cuts Act; and the Consolidated Appropriations Act, 2023.

supports this rebalancing of the fee schedule since it helps correct a mispricing of E&M services relative to other types of services in the fee schedule (Medicare Payment Advisory Commission 2022b, Medicare Payment Advisory Commission 2018a, Medicare Payment Advisory Commission 2011).

Are Medicare payments adequate in 2023?

To assess whether FFS Medicare payments for clinician services are adequate, we examine indicators in three categories: beneficiaries' access to care, the quality of care, and clinicians' revenues and costs. In 2021 and 2022, most physician payment adequacy indicators remained positive or improved, but clinicians' input costs grew at rates not seen for many years.

Beneficiaries' access-to-care indicators remain positive

Medicare beneficiaries continued to report access to clinician services that was equal to, or better than, that of privately insured people. The share of clinicians accepting Medicare is comparable to the share accepting private insurance, despite private health insurers paying higher rates, and almost all clinicians who bill Medicare accept physician fee schedule amounts as payment in full. The overall supply of clinicians has grown in recent years, although the number of clinicians per Medicare beneficiary (including those in FFS Medicare and Medicare Advantage) has remained steady due to beneficiary enrollment growth. The composition of the clinician workforce continues to change, with the number of advanced practice registered nurses and physician assistants growing rapidly and the number of primary care physicians slowly declining. After dropping sharply in the early

months of the coronavirus pandemic, the number of clinician encounters per beneficiary increased in 2021 but did not return to its prepandemic level.

Most beneficiaries report good access to clinician services

One way we assess Medicare beneficiaries' access to care is by examining data from national surveys and local focus groups that have asked beneficiaries about their experiences obtaining health care.[7] According to these sources, the vast majority of beneficiaries report good access to clinician services. For example, our analysis of CMS's 2020 Medicare Current Beneficiary Survey (MCBS) finds that 93 percent of beneficiaries reported having a usual source of care that was not a hospital emergency department or an urgent care center, 94 percent felt their usual care provider usually or always spent enough time with them, and 93 percent were satisfied with the availability of care by specialists. A relatively small share of beneficiaries (8 percent) reported experiencing trouble getting health care in the past year—primarily due to the cost of care, as opposed to clinicians not accepting Medicare. Beneficiaries who report trouble accessing care are disproportionately non-elderly disabled beneficiaries.[8]

Other surveys have found that Medicare-aged people report better access to care than non-elderly adults, which could mean that gaining Medicare coverage makes it easier for some people to afford health care. For example, the Medical Expenditure Panel Survey has found that around age 65, when most people gain eligibility for Medicare, there is a reduction in reports of being unable to get necessary care and being unable to get needed care because of cost (Jacobs 2021). The National Health Interview Survey has found that delaying or forgoing needed care due to cost was more common among adults under the age of 65 than adults over the age of 65 (National Center for Health Statistics 2021). And the Behavioral Risk Factor Surveillance System survey has found that, compared with people with employer-sponsored or individually purchased health insurance, Medicare beneficiaries are more likely to have a personal physician, less likely to have medical debt, and more likely to be very satisfied with their care (Wray et al. 2021).

Consistent with these findings, the Commission's annual survey (fielded in August 2022) found that Medicare beneficiaries ages 65 and over reported access to care that is as good as, or better than, access reported by privately insured people ages 50 to 64. It also found that among those Medicare beneficiaries and privately insured people looking for a new clinician, higher shares reported problems finding a new primary care provider than a new specialist. These results are consistent with Commission survey results since 2004, although this year higher shares of respondents reported negative experiences accessing care—particularly among the privately insured (see Table 4A-1 in this chapter's appendix, p. 144). These shifts may be caused by recent changes to our survey methodology.[9] They may also be due to real changes in the U.S. health care delivery system; for example, some beneficiaries in our focus groups this year described longer wait times during the coronavirus pandemic for access to specialty care than before the start of the pandemic.[10] Our 2023 survey results will be of particular interest, in that they will help us understand whether the care experiences observed in our 2022 survey should be thought of as anomalous findings caused by the pandemic or a new baseline caused by the change in our survey methodology.

Nearly all Medicare beneficiaries have a primary care provider In the Commission's 2022 survey, 96 percent of Medicare beneficiaries reported having a primary care provider (higher than the 92 percent of privately insured people who reported this). This is consistent with our focus group findings, in which nearly all beneficiaries reported having a usual source of primary care.

Our 2022 survey also found that Medicare beneficiaries were slightly less likely to receive most or all of their primary care from a nurse practitioner (NP) or a physician assistant (PA) compared with privately insured people (17 percent of Medicare beneficiaries reported this, compared with 20 percent of privately insured people).[11] Among both Medicare beneficiaries and privately insured people, higher shares of rural and low-income respondents reported receiving most or all of their care from an NP or PA.[12] (Use of NPs and PAs is one of the few substantive differences our survey finds between urban and rural Medicare beneficiaries' experiences accessing care; see Table 4A-2 in the appendix, p. 145, for a comparison of other survey results for urban and rural Medicare beneficiaries.)

More problems finding a new primary care provider than a new specialist This year's survey found that 11 percent of Medicare beneficiaries looked for a new primary

care provider in the past year. The most common reason beneficiaries gave for looking was that their primary care provider had retired or stopped practicing, which about half of the beneficiaries looking reported (equivalent to 5 percent of all Medicare beneficiaries). Among Medicare beneficiaries who tried to find a new primary care provider, about half of this subset reported a problem finding one (equivalent to 6 percent of all Medicare beneficiaries). Compared with Medicare beneficiaries, higher shares of privately insured people reported looking for a new primary care provider and experienced problems finding one in 2022.

In our focus groups, several Medicare beneficiaries had sought a new source of primary care in recent years, and their experiences varied in terms of their ease in identifying a new clinician. Some privately insured individuals in our focus groups also reported challenges finding a new primary care provider and long wait times to schedule a first appointment. Across clinicians in our focus groups, most were accepting new patients, including Medicare patients. Among those who were not, the reason was full patient panels, and generally their practices would open to new patients again when capacity allowed.

Both Medicare beneficiaries and privately insured people reported fewer problems finding a specialist than a primary care provider. In our 2022 survey, 26 percent of Medicare beneficiaries reported looking for a new specialist, and a third of these beneficiaries reported a problem finding one (equivalent to 8 percent of all beneficiaries). Compared with Medicare beneficiaries, higher shares of privately insured people reported problems finding a specialist. We also found that urban respondents were more likely to look for a new specialist than rural respondents, and higher-income respondents were more likely to look for a new specialist than lower-income respondents. In our focus groups, beneficiaries' access to specialty care varied, with wait times to see a new specialist ranging from a few days to months. Clinicians in our focus groups reported that some patients could wait up to six months to see certain specialists.

One of the only statistically significant differences in the care experiences of Medicare beneficiaries of different races and ethnicities in our 2022 survey related to the use of specialists: we found that White beneficiaries were more likely to see multiple specialists compared with Black and Hispanic beneficiaries. (See Table 4A-3 in the appendix, p. 146, for other survey results broken out by race/ethnicity.) We also found that more urban respondents reported seeing multiple specialists compared with rural respondents, and more higher-income Medicare beneficiaries reported seeing multiple specialists compared with lower-income beneficiaries.

Shorter waits for appointments for an illness or injury compared with routine care Among Medicare beneficiaries who needed appointments for regular or routine care in the past year, nearly half (45 percent) reported ever having to wait longer than they wanted to get this type of appointment.[13] Medicare beneficiaries were less likely to report unwanted waits for appointments for an illness or injury (with only 33 percent of those needing this type of appointment reporting such waits). Most of the beneficiaries who reported unwanted waits for appointments said they only "sometimes" experienced such waits—it was rare for a beneficiary to report that they "usually" or "always" waited longer than they wanted to get an appointment.[14] For both appointments for routine care and appointments for an illness or injury, higher shares of privately insured people reported waiting longer than they wanted for these appointments compared with Medicare beneficiaries.

In our focus groups, most beneficiaries described having timely access to primary care, especially when they had an acute care issue. Beneficiaries said that for acute issues, they could usually be seen quickly—sometimes the same day, and usually within a few days.

Patients sometimes forgo care, but not necessarily due to difficulties accessing care In this year's Commission survey, 18 percent of Medicare beneficiaries reported that they had had a health problem or condition in the past year that they thought they should have seen a doctor for but did not (less than the 24 percent of privately insured people who reported this). A fifth of the beneficiaries who reported forgoing care did so because they couldn't get an appointment soon enough (equivalent to 4 percent of all Medicare beneficiaries)—suggesting that beneficiaries' access to appointments with clinicians is sufficient to meet the vast majority of beneficiaries' care needs. Other common reasons survey respondents gave for not obtaining care were that they didn't think their problem was serious or they

TABLE 4–2

The number of clinicians billing Medicare's physician fee schedule increased and the mix of clinicians changed, 2016–2021

	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
Year	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total
2016	142	446	198	162	948	2.7	8.6	3.8	3.1	18.2
2017	141	454	218	168	981	2.6	8.5	4.1	3.1	18.4
2018	140	461	237	174	1,012	2.6	8.4	4.3	3.2	18.5
2019	139	467	258	180	1,045	2.5	8.3	4.6	3.2	18.7
2020	136	467	268	172	1,044	2.4	8.1	4.7	3.0	18.2
2021	135	471	286	180	1,073	2.3	8.1	4.9	3.1	18.4

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

Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries and 2022 annual report of the Boards of Trustees of the Medicare trust funds.

"just put it off," which half of care forgoers reported (equivalent to 9 percent of all Medicare beneficiaries).

In our focus groups, many beneficiaries reported delayed or canceled primary care appointments during the coronavirus pandemic, though most have since received that care.

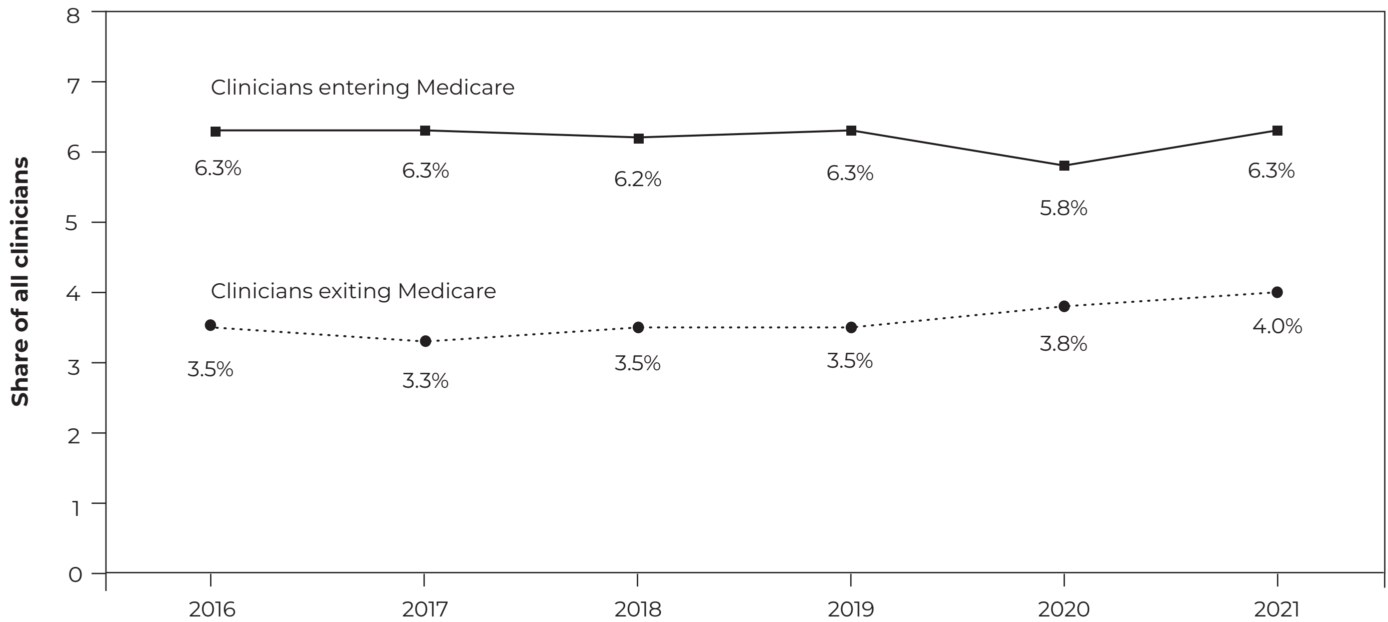
The number of clinicians billing Medicare has increased

From 2016 to 2019, the total number of clinicians billing the fee schedule per Medicare beneficiary grew commensurate with growth in the overall Medicare population, which suggests that clinicians had sufficient incentive to serve Medicare beneficiaries. After declining in 2020 (likely due to the pandemic), the total number of clinicians per beneficiary increased in 2021, although it has not fully returned to prepandemic levels. The mix of clinicians has changed over time.

We limited this part of our analysis of clinicians to those who billed for more than 15 Medicare beneficiaries in a given year. This minimum threshold helps us (1) better measure clinicians who substantially participate in Medicare and are therefore likely critical to ensuring beneficiary access to care and (2) avoid year-to-year variability in clinician counts (i.e., because we exclude clinicians who billed for one or two beneficiaries in one year but may not have billed for any beneficiaries the following year).[15] (As a point of reference, studies suggest that primary care physicians' patient panels range from 1,200 to 2,500 patients per physician (Dai et al. 2019, Raffoul et al. 2016).)

We found that the number of clinicians billing the fee schedule between 2016 and 2021 grew from about 948,000 to 1,073,000, after declining somewhat in 2020 (Table 4-2). Over the 2016 to 2019 period, the total number of clinicians per 1,000 beneficiaries increased from 18.2 to 18.7 before falling to 18.2 in 2020 and increasing again to 18.4 in 2021.[16] We also see a decline and then rebound during the pandemic in Bureau of Labor Statistics employment data for physician offices

FIGURE 4–2 **Trends in the share of clinicians entering and exiting FFS Medicare, 2016–2021**



Note: FFS (fee-for-service). Clinicians entering Medicare are defined as clinicians who billed the physician fee schedule for more than 15 beneficiaries in a year who did not bill the fee schedule for any beneficiaries in the prior year. Clinicians exiting Medicare are defined as clinicians who did not bill the fee schedule for any beneficiaries in a year but who billed for more than 15 beneficiaries in the prior year. The number of entering clinicians declined in 2020 due to the coronavirus pandemic.

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

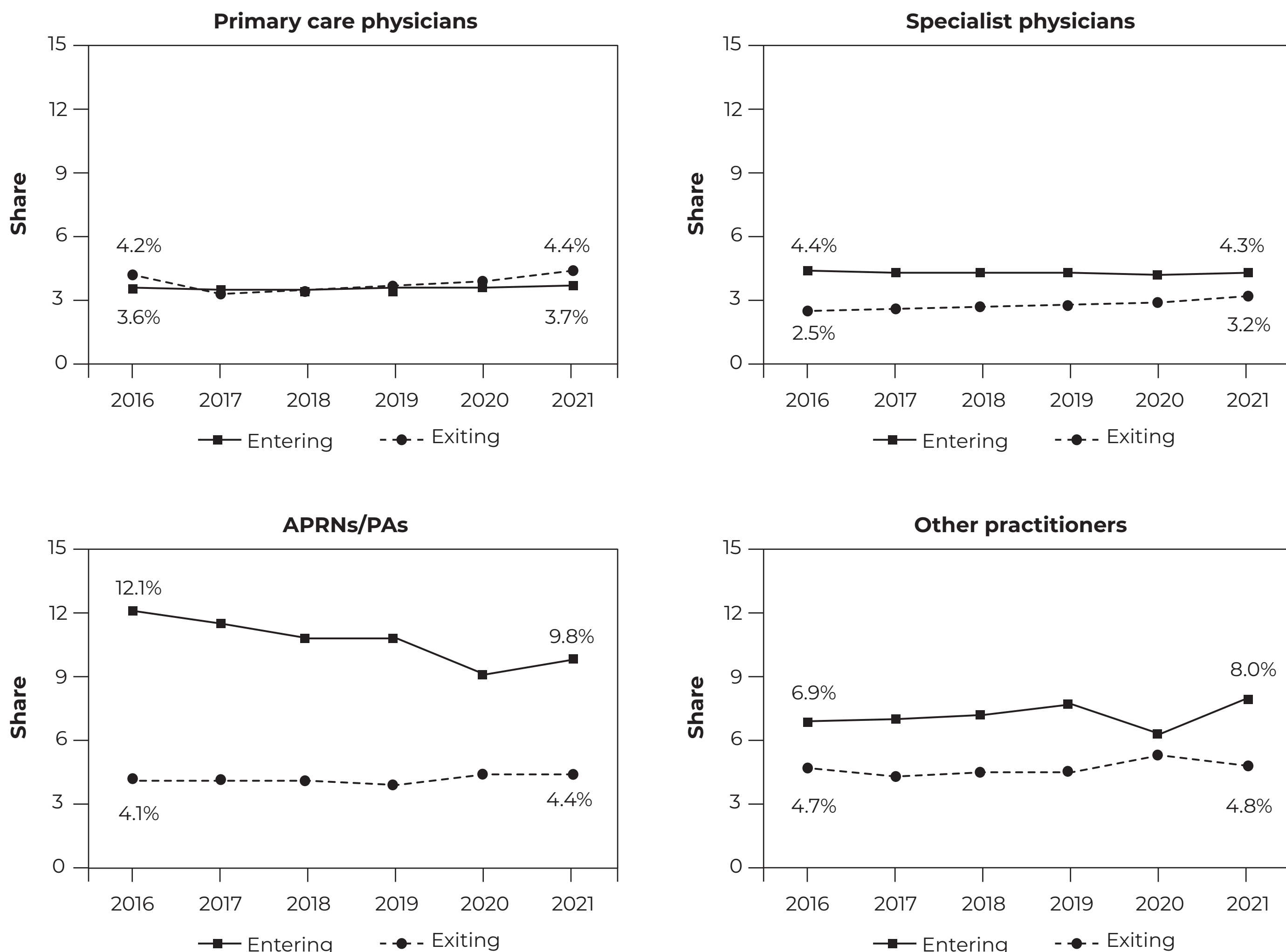
(which is just one care setting where clinicians work); these data indicate that the number of employed workers in these offices (including support staff) declined by about 10 percent in the first few months of the pandemic but had returned to prepandemic levels one year into the pandemic and was 5 percent higher than prepandemic levels by August 2022 (Frogner 2022).

While the total number of clinicians billing the fee schedule rose between 2016 and 2021, trends varied by type and specialty of clinicians. Since 2016, the number of primary care physicians billing the fee schedule has slowly declined—yielding a net loss of about 7,000 primary care physicians by 2021. As such, the number of primary care physicians per Medicare beneficiary declined from 2.7 to 2.3. Over the same five-year period, the number of advanced practice registered nurses (APRNs) and PAs billing the fee schedule grew rapidly from about 198,000 to 286,000.[17] On a per beneficiary basis, the number of APRNs and PAs billing the fee schedule increased from 3.8 in 2016 to 4.9 in 2021. Meanwhile, the number of specialist physicians and other practitioners, such as physical therapists and podiatrists, also increased.

The number of clinicians entering Medicare exceeded the number of clinicians exiting Medicare between 2016 and 2021 Annual changes in the number of clinicians who stop billing the physician fee schedule (exiting clinicians) and start billing the fee schedule (entering clinicians) could signal future access problems for beneficiaries if the number of exiting clinicians exceeds the number of entering clinicians or if there is a large increase in exiting clinicians. For each year between 2016 and 2021, the number of entering clinicians, as a share of all clinicians, was larger than the number of exiting clinicians (Figure 4-2).[18] In addition, the number of clinicians exiting Medicare did not sharply increase during this period. Net growth in the number of clinicians suggests that there is an adequate supply of clinicians to treat beneficiaries (Table 4-2).

FIGURE 4–3

Trends in the share of clinicians entering and exiting FFS Medicare, by type of clinician, 2016–2021



Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). Clinicians entering Medicare are defined as clinicians who billed the physician fee schedule for more than 15 beneficiaries in a year but did not bill the fee schedule for any beneficiaries in the prior year. Clinicians exiting Medicare are defined as clinicians who did not bill the fee schedule for any beneficiaries in a year but who billed for more than 15 beneficiaries in the prior year. "Primary care specialties" includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "specialist physicians." "Other practitioners" includes clinicians such as physical therapists, psychologists, social workers, and podiatrists. Numbers exclude nonperson providers, such as clinical laboratories and independent diagnostic testing facilities.

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

Compared with all clinicians, entering and exiting clinicians billed for fewer beneficiaries, on average. In 2019, for example, all clinicians billed for 327 beneficiaries, on average, compared with 109 beneficiaries for entering clinicians and 133 beneficiaries for exiting clinicians (data not shown).[19] This difference suggests that entering clinicians are ramping up their practice during their first year billing Medicare while exiting clinicians are scaling back their practice during their final year billing Medicare.

Although entering clinicians billed for a lower average number of beneficiaries than exiting clinicians, the number of entering clinicians exceeded the number of exiting clinicians, so the total number of beneficiaries treated by entering clinicians was higher than the total number of beneficiaries treated by exiting clinicians during the prior year. In 2019, for example, entering clinicians billed for a total of 7.2 million beneficiaries, while exiting clinicians billed for a total of 5.3 million beneficiaries in 2018.

Trends in clinician exit and entry varied by type of clinician (Figure 4-3). For each type of clinician, the share of clinicians who were entering Medicare exceeded the share who were exiting Medicare—except for primary care physicians, for whom exiting physicians exceeded entering physicians in each year except for 2017. This trend is consistent with the decline in the total number of primary care physicians between 2016 and 2021 (shown earlier in Table 4-2, p. 118). APRNs and PAs had the largest gap between the share who were entering clinicians and the share who were exiting clinicians during this period, which corresponds with rapid growth in the total number of APRNs and PAs (Table 4-2, p. 118). Among specialists, the gap between the share of physicians who were entering Medicare and the share who were exiting Medicare narrowed between 2016 and 2021, a trend that we will continue to monitor (Figure 4-3).

Most clinicians accept Medicare

Although Medicare payment rates are usually lower than private health insurers' payment rates, several data sources suggest that the share of clinicians who accept Medicare is comparable to the share who accept private health insurance. From 2014 to 2019, the share of nonpediatric office-based physicians who accepted Medicare was only 0 to 2 percentage points lower than the share who accepted private health insurance, according to the CDC's National Electronic Health Records Survey (Ochieng et al. 2022). Meanwhile, the 2020 National Ambulatory Medical Care Survey found that among nonpediatric office-based physicians who reported accepting new patients, 86 percent said they accepted new Medicare patients while only 84 percent said they accepted new privately insured patients (Myrick and Schappert 2022). And in the Commission's 2022 survey of patients, only 1 percent of Medicare beneficiaries encountered a primary care provider or a specialist's office that did not accept Medicare, while 2 percent of privately insured people encountered a primary care provider's office that did not accept their insurance and 4 percent encountered a specialist's office that did not accept their insurance.[20]

Clinicians may choose to accept Medicare, despite payment rates that are usually lower than commercial rates, for several reasons. For example, a substantial share of most clinicians' patients are covered by Medicare, and if these clinicians opted to accept only commercially insured patients, they would lose revenue due to having fewer patients. In addition, while Medicare has lower payment rates, commercial insurers often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to complete insurers' prior authorization paperwork and requiring them to use insurers' provider directories to identify in-network providers when making patient referrals. In contrast, the administrative simplicity of billing Medicare helps offset the program's lower payment rates.

There are several different ways for clinicians to bill Medicare, which yield different payment amounts. In 2021, 98 percent of clinicians billing the physician fee schedule were participating providers, meaning they agreed to accept Medicare's fee schedule amount as payment in full. Clinicians who wish to collect somewhat higher payments (of up to 109.25 percent of Medicare's payment rates) can "balance bill" patients for additional cost sharing if they sign up as a nonparticipating provider and choose not to "take assignment" on a claim, but very few clinicians choose to do this: in 2021, 99.7 percent of fee schedule claims were paid at Medicare's standard payment rate. If they elect to opt out of the program, clinicians can charge patients any price and bill beneficiaries directly for their services. The number of clinicians who opted out of Medicare as of September 2022, 29,000, was comparable to the number of clinicians who opted out in previous years; these clinicians were concentrated in the specialties of behavioral health (43 percent),[21] oral health (29 percent),[22] and primary care (11 percent)[23] (Centers for Medicare & Medicaid Services 2022c).

The number of clinician encounters per beneficiary grew from 2020 to 2021

We use the quantity of beneficiaries' encounters with clinicians as another measure of access to care. We use

TABLE 4–3

Total encounters per FFS beneficiary was higher in 2021 compared with 2016 and the mix of clinicians furnishing them changed

	Encounters per FFS beneficiary				Percent change	
Specialty and clinician category	**2016**	**2019**	**2020**	**2021**	**Average annual (2016–2019)**	**2019–2021**
Total (all clinicians)	21.4	22.3	19.8	21.6	1.3%	–2.8%
Primary care physicians	3.8	3.5	3.1	3.2	–2.6	–9.3
Specialists	12.7	12.9	11.4	12.3	0.4	–4.7
APRNs/PAs	1.8	2.5	2.4	2.7	11.0	11.0
Other practitioners	3.1	3.4	2.9	3.5	3.4	1.1

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

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and 2022 annual report of the Boards of Trustees of the Medicare trust funds.

a claims-based definition of encounters.[24] Clinicians submit a claim when they furnish one or more services to a beneficiary in FFS Medicare. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would count that as one encounter. About 97 percent of beneficiaries enrolled in FFS Medicare had at least one encounter in 2021.[25]

The total number of encounters per FFS Medicare beneficiary grew modestly from 2016 to 2019, when it peaked at 22.3, before dropping 11.1 percent in 2020 to 19.8 encounters per beneficiary in response to the coronavirus pandemic (Table 4-3). Encounters per beneficiary rebounded somewhat the next year, rising to 21.6 in 2021 (a 9.4 percent increase). The overall decline in encounters from 2019 to 2021 is largely related to the pandemic, and some effects are likely to be temporary.

Change in the number of encounters per beneficiary varied by specialty and type of provider Between 2016 and 2021, the number of encounters furnished by primary care physicians and specialist physicians declined and the number of encounters provided by other types of clinicians increased (with encounters with APRNs and PAs growing the fastest) (Table 4-3).

Slightly different trends have emerged during the pandemic, however. Between 2019 and 2021, the number of encounters per beneficiary with APRNs or PAs increased by an average of 11 percent per year, and encounters with other practitioners (e.g., physical therapists) grew by an average of 1.1 percent per year. The number of encounters per beneficiary with primary care physicians fell by an average of 9.3 percent per year, while the number of encounters with specialist physicians (who account for a majority of all encounters) fell by an average of 4.7 percent per year.

The decline in beneficiary encounters with primary care physicians occurred across a broad range of services. From 2016 to 2021, the average annual change in the number of encounters per beneficiary with primary care physicians for E&M services, other procedures, treatments, imaging services, and tests was –3.3 percent, –4.1 percent, –7.8 percent,

TABLE 4–4

Total encounters per FFS beneficiary across service types, 2016–2021

	Encounters per FFS beneficiary				Percent change	
Type of service	**2016**	**2019**	**2020**	**2021**	**Average annual (2016–2019)**	**2019–2021**
Total (all services)	21.4	22.3	19.8	21.6	1.3%	–2.8%
Evaluation and management	12.3	13.1	11.9	12.7	0.9	–3.0
Major procedures	0.2	0.2	0.2	0.2	1.1	–5.5
Other procedures	2.3	2.4	2.0	2.3	1.3	–4.9
Treatments	2.4	2.7	2.3	2.7	4.0	0.4
Imaging	4.0	4.2	3.6	4.0	1.1	–4.7
Tests	2.1	2.1	1.8	2.0	1.1	–6.7
Anesthesia	0.5	0.6	0.5	0.5	4.2	–5.0

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

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and 2022 annual report of the Boards of Trustees of the Medicare trust funds.

–5.6 percent, and –9.8 percent, respectively (data not shown).[26] Recent research has documented that similar drops in encounters with primary care physicians also occurred among the privately insured population (Ganguli et al. 2019). This trend suggests that primary care physicians have not filled their patient panels with privately insured patients in lieu of Medicare beneficiaries.

Despite the rapid growth in encounters with APRNs and PAs, we are likely undercounting the number of fee schedule encounters provided by these clinicians due to "incident to" billing.[27] The Commission has previously recommended that the Congress require APRNs and PAs to bill Medicare directly, eliminating "incident to" billing for services they provide, which would allow us to more accurately report the number of beneficiary encounters with different types of clinicians (Medicare Payment Advisory Commission 2019). These changes would also enable us to better understand whether services provided by APRNs and PAs are disproportionately substituting for primary care services or are substituting for both primary care and specialty care services to an equal degree.

Examining beneficiary encounters with clinicians by service type, E&M encounters per beneficiary rose by an annual average of 0.9 percent from 2016 to 2019 before declining in 2020 (Table 4-4). E&M encounters increased in 2021 but were still 3 percent below prepandemic levels. Similar patterns were observed for other types of services except in beneficiaries' use of treatments (which includes physical therapy, treatment for cancer, and dialysis), which declined in 2020 but was back to its prepandemic level in 2021.

Quality of care is difficult to assess

Quality of care provided by clinicians is difficult to assess even in the best of circumstances. We are limited in our ability to assess the quality of clinicians' care because Medicare does not collect FFS beneficiary-level clinical information (e.g., blood pressure, lab results) or patient-reported outcomes (e.g., improving or maintaining physical and mental

TABLE 4–5

Distribution of risk-adjusted rates of ambulatory care–sensitive hospitalizations and emergency department visits across hospital service areas, 2021

	Risk-adjusted rate per 1,000 FFS beneficiaries			
	10th percentile (high performing)	50th percentile	90th percentile (low performing)	Ratio of 90th to 10th percentile
Ambulatory care–sensitive hospitalizations	22.1	31.6	43.3	**2.0**
Ambulatory care–sensitive ED visits	33.5	60.5	88.4	**2.6**

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

Source: Analysis of 2021 fee-for-service Medicare claims data.

health). CMS measures the performance of clinicians using the Merit-based Incentive Payment System, which, in March 2018, MedPAC recommended eliminating because it is fundamentally flawed (Medicare Payment Advisory Commission 2018b). In 2020 and 2021, difficulties assessing quality were compounded by the effects of the coronavirus pandemic on beneficiaries and providers. In previous years, we tracked changes in quality measures and determined whether they had improved, worsened, or stayed the same. While we report 2021 results for these quality measures, we have not used the results to inform our conclusions about trends in the quality of care provided to Medicare beneficiaries. The 2021 results may reflect temporary changes in the delivery of care and data limitations unique to the coronavirus pandemic rather than trends in quality of care.

We report on the quality of the ambulatory care environment for beneficiaries in FFS Medicare using outcome measures assessing ambulatory care–sensitive (ACS) hospitalizations and emergency department visits, as well as patient experience measures (measured using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®)).[28] This approach is consistent with the Commission's principles for quality measurement (Medicare Payment Advisory Commission 2018a).

Effectiveness and timeliness of care outside the hospital: Ambulatory care–sensitive hospitalizations and emergency department visits

Many factors related to the coronavirus pandemic affected rates of hospitalizations, including both higher demand for beds by patients diagnosed with COVID-19, which strained hospital capacity at times, and lowered demand for beds by other patients as nonemergency surgeries were canceled or delayed and patients avoided visiting emergency departments due to fears of infection. Further, the Commission's quality metrics rely on risk-adjustment models that use performance from previous years to predict beneficiary risk. COVID-19 is a new diagnosis and is not included in the current risk-adjustment models, though many associated conditions are. As a result, our models may not adequately represent the acuity and mix of patients receiving care in 2021. Therefore, we report 2021 quality measure results but do not draw conclusions about whether overall quality has improved, worsened, or stayed the same.

The Commission developed two claims-based outcome measures—ACS hospitalizations and emergency department (ED) visits—to compare quality of care within and across different populations (i.e., FFS Medicare in different local market areas), given the adverse impact on beneficiaries and high cost of these

events. Two categories of ACS conditions are included in the measures: chronic (e.g., diabetes, asthma, hypertension) and acute (e.g., bacterial pneumonia, cellulitis). Conceptually, an ACS hospitalization or ED visit refers to hospital use that could have been prevented with timely, appropriate, high-quality care. For example, if a diabetic patient's primary care physician or specialist has an effective system to allow for urgent visits, the patient may be able to avoid a visit to the ED. If a diabetic patient's primary care physician and overall care team work effectively to control the patient's condition, an ED visit for a diabetic crisis could be avoidable.

In 2021, the distribution of risk-adjusted rates of avoidable hospitalizations and ED visits per 1,000 FFS Medicare beneficiaries varied widely across Dartmouth-defined hospital service areas (HSAs). This variation signals opportunities to improve the quality of ambulatory care, even with the measurement issues related to the pandemic (Table 4-5).[29] The HSA at the 90th percentile of ACS hospitalizations had a rate that was two times the HSA at the 10th percentile. The HSA at the 90th percentile of ACS ED visits had a rate that was 2.6 times the HSA in the 10th percentile. Relatively poor performance on a local market's ACS hospitalization and ED visit measures can identify opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can identify best practices for ambulatory care systems.

Although the 2021 ratios of HSAs at the 90th to 10th percentiles are about the same as for prepandemic years, the risk-adjusted rates per 1,000 FFS beneficiaries went down (improved) substantially in 2021 compared with 2019. For example, in 2019 the median HSA ACS ED visit rate was 98.6 per 1,000 FFS beneficiaries (Medicare Payment Advisory Commission 2021) compared with a median rate of 60.5 per 1,000 FFS beneficiaries in 2021 (Table 4-5). There has been an overall decline in ED visits for non–COVID-19-related services since the start of the coronavirus pandemic, so we would expect some accompanying decline in ACS ED visits. Also, the national influenza rate during the 2020–2021 flu season was lower than prepandemic years because of isolating and social distancing, so there were likely fewer ED visits for the flu (which is an ambulatory care–sensitive ED visit). It is difficult to untangle whether and how much of the decline in ACS ED visit rates is because of these and other changes in ED use versus improved quality of care.

Patient experience scores

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

CMS annually fields a CAHPS survey among a subset of FFS beneficiaries. The survey questions relate to the beneficiary's experience of care with Medicare and their FFS providers. The *getting needed care and seeing specialists* measure score based on 2021 FFS CAHPS survey responses was 81 (score on a scale of 0 to 100) and the score for *getting appointments and care quickly* was 75 (Table 4-6, p. 126). These scores have decreased since 2017. The *rating of health plan (FFS Medicare)* measure score was 83, which has been stable. The *rating of health care quality* score was 87, which has improved since 2017. In 2021, 77 percent of beneficiaries reported receiving an annual flu vaccine, which was an increase from 74 percent in 2017 (Table 4-6).

Clinicians' revenues and costs

We report on changes in clinicians' Medicare payments, all-payer compensation, and input costs to understand clinicians' financial incentives to provide services to Medicare beneficiaries.

Allowed charges per beneficiary grew over the 2016 to 2021 period

Allowed charges are the total payments a clinician receives (including beneficiary cost sharing)

TABLE 4–6

Medicare FFS CAHPS® performance scores, 2017–2021

CAHPS composite measure	2017	2018	2019	2020	2021
Getting needed care and seeing specialists	84%	83%	–	83%	81%
Getting appointments and care quickly	77	77	–	78	75
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	86	85	–	85	85
Rating of health plan (FFS Medicare)	83	83	–	84	83
Rating of health care quality	85	85	–	86	87
Annual flu vaccine	74	74	–	77	77

Note: FFS (fee-for-service), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). Questions in rows 1 to 3 have responses of "Never," "Sometimes," "Usually," and "Always." CMS converts these to a linear mean score on a 0 to 100 scale. Questions in rows 4 and 5 have responses of 1 to 10, which CMS converts to a linear mean score on a 0 to 100 scale. The question in row 6 is a yes/no response. "Plan" in row 4 refers to the Medicare FFS program. CMS halted collection of the 2019 beneficiary experience survey at the start of the coronavirus pandemic.

Source: FFS CAHPS mean scores provided by CMS.

from providing physician fee schedule services to beneficiaries enrolled in FFS Medicare. Allowed charges are a function of the physician fee schedule's relative value units (RVUs), the fee schedule's conversion factor, and other payment adjustments, such as those determined by geographic practice cost indexes. Allowed charges per beneficiary grew modestly from 2016 to 2019 (at an average of 2.4 percent per year) before dropping sharply in 2020 as beneficiaries put off care in the early months of the pandemic (Table 4-7). With a large increase in 2021, average spending per beneficiary recovered in 2021 and exceeded the 2019 level (Figure 4-4).

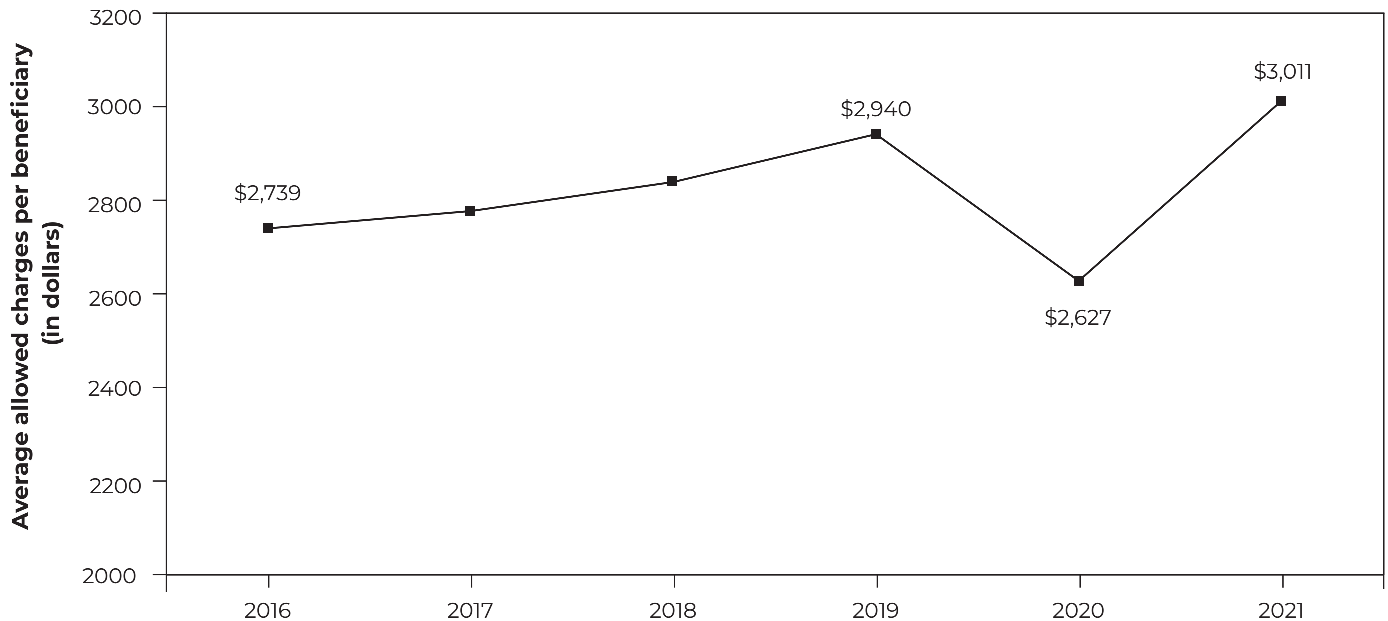
To ensure that clinicians remained viable sources of care during the pandemic, the Congress provided clinicians with an estimated $40 billion in 2020 and $13.5 billion in 2021 through the Provider Relief Fund and the Paycheck Protection Program—more than offsetting clinicians' pandemic-related revenue losses (Centers for Medicare & Medicaid Services 2022a, Hartman et al. 2022, Martin et al. 2023).

We typically observe changes in spending on different categories of services over time, as particular services' utilization rates and/or payment rates change.[30] Between 2019 and 2021, allowed charges per beneficiary rose by 6.1 percent for E&M services and by 4.8 percent for treatments. Meanwhile, allowed charges for tests fell by 10.3 percent; for anesthesia services, by 7.3 percent; for major procedures, by 6.9 percent; for imaging services, by 2.4 percent; and for other procedures, by 1.5 percent (Table 4-7).

We also present changes in units of service (i.e., service volume as opposed to spending) per beneficiary. The number of units of service per beneficiary had been growing across all service categories before the pandemic—overall annual growth was 1.6 percent from 2016 to 2019. Volume declined sharply in 2020 in response to the pandemic, with the number of units for all services falling by 11.8 percent that year (data not shown). Volume across all service categories increased in 2021, but the total number of service units per capita was 1.7 percent lower in 2021 compared with 2019. Some variation existed across different types of service.

FIGURE 4–4

Average physician fee schedule allowed charges per beneficiary, 2016–2021



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

TABLE 4–7

Allowed charges per FFS beneficiary varied by type of service, 2016–2021

	Change in units of service per beneficiary		Change in allowed charges per beneficiary		
Type of service	**Average annual 2016–2019**	**2019–2021**	**Average annual 2016–2019**	**2019–2021**	**Share of 2021 allowed charges**
All services	**1.6%**	**–1.7%**	**2.4%**	**2.4%**	**100.0%**
Evaluation and management	0.5	–3.4	2.1	6.1	51.8
Imaging	0.3	–3.8	2.4	–2.4	10.5
Major procedures	0.8	–4.7	3.0	–6.9	7.4
Other procedures	1.6	–3.1	2.5	–1.5	12.8
Treatments	5.4	5.3	4.2	4.8	9.7
Tests	1.6	–6.4	1.2	–10.3	4.5
Anesthesia	1.9	–5.2	1.8	–7.3	2.6

Note: FFS (fee-for-service). We use the number of FFS Medicare beneficiaries enrolled in Part B to define units of service and allowed charges per beneficiary.

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and 2022 annual report of the Boards of Trustees of the Medicare trust funds.

TABLE 4–8

Allowed charges per unit of service grew for E&M services in 2021

Type of service	Change in allowed charges per unit of service (on a per beneficiary basis), 2020–2021
All services	**2.9%**
Evaluation and management	10.3
Imaging	–0.8
Major procedures	–2.8
Other procedures	0.8
Treatments	–4.8
Tests	–2.4
Anesthesia	0.7

Note: E&M (evaluation and management). We use the number of beneficiaries enrolled in fee-for-service Medicare Part B to define units of service and allowed charges per beneficiary.

Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries and 2022 annual report of the Boards of Trustees of the Medicare trust funds.

For example, between 2019 and 2021, service volume for E&M services fell by 3.4 percent while it grew for treatments by 5.3 percent (Table 4-7, p. 127)

Changes in volume can cause increases or decreases in allowed charges, as can changes in the intensity of certain services (e.g., substituting computed tomography for standard X-rays), and movement of services from freestanding offices to hospitals. Given the complex nature of factors that contribute to changes in allowed charges, it can be challenging to explain why spending has changed over time. One way to better understand changes in spending trends is to calculate changes in allowed charges per unit of service. When calculated on a per beneficiary basis, such an approach removes changes in volume (but not changes in intensity) as a factor driving changes in spending. From 2020 to 2021, spending per unit of services across all types of service increased by 2.9 percent (Table 4-8). The change in total spending per unit of service varies across different types of service. Overall growth in spending per service is largely attributable to E&M services, which grew by 10.3 percent. Charges per unit of service in other service categories experienced small growth or declined in 2021.

The growth in spending per unit of service within the E&M category was largely driven by increases in Medicare payment rates for a relatively small number of services that account for a large proportion of spending within that category. For instance, in 2021, Medicare's payment rates for several types of office/outpatient E&M visits for established patients (which accounted for almost 40 percent of total E&M spending) increased by between 20 and 25 percent. These higher rates are attributable to substantial increases in the RVUs of these services. Owing to budget neutrality requirements, CMS offset the increase to rates for E&M office/outpatient visits by reducing rates for all fee schedule services, which at least partly explains the reductions in spending per unit of service among other services.

Private PPO payment rates remain higher than Medicare payment rates for clinician services, but the gap diminished in 2021

We compare rates paid by private insurance plans with Medicare rates for clinician services because extreme disparities in payment rates might create an incentive for clinicians to focus primarily on patients with private insurance and avoid those with FFS Medicare. For this

analysis, we used data on paid claims for enrollees of preferred provider organization (PPO) health plans that are part of a large national insurer that covers a wide geographic area across the United States.[31] In 2021, the PPO payment rates for clinician services were 134 percent of FFS Medicare's payment rates, down from 138 percent in 2020. This decline was driven by a drop in the ratio of private insurance rates to Medicare rates for E&M office/outpatient visits; private insurance rates were 127 percent of Medicare rates for these services in 2020 but 114 percent of Medicare rates in 2021. This change was probably due to CMS's substantial increase in Medicare payment rates for E&M office/outpatient visits in 2021, which appears to have not yet been matched by private plans.

The ratio in 2021, as in prior years, varied by type of service. For example, private insurance rates were 106 percent of Medicare rates for annual wellness visits but 201 percent of Medicare rates for CT scans of the chest.

Despite the decline in 2021, the gap between private insurance rates and Medicare rates has grown over the last decade as private insurance rates have risen while Medicare rates have remained relatively stable (except for the growth in rates for E&M office/outpatient visits in 2021). In 2011, private insurance rates were 122 percent of Medicare rates. Nevertheless, as we note earlier, the vast majority of clinicians continue to participate in the Medicare program.

The growth in private insurance prices is probably a result of greater consolidation of physician practices and hospitals' acquisition of physician practices, which gives providers greater leverage to negotiate higher prices for clinician services with private plans. In recent years, the number of physicians joining larger groups, hospitals, and health systems has risen sharply. For example, between 2016 and 2018, the share of all physicians who were vertically affiliated with health systems climbed from 40 percent to 51 percent (Furukawa et al. 2020).

Studies show that private insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation (Capps et al. 2018, Clemens and Gottlieb 2017, Neprash et al. 2015). Similarly, our own research has found that independent practices with larger market shares and hospital-owned practices received higher private insurance prices for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017).

Median physician compensation grew 3 percent per year from 2017 to 2021; compensation remains much higher for certain specialties than for primary care

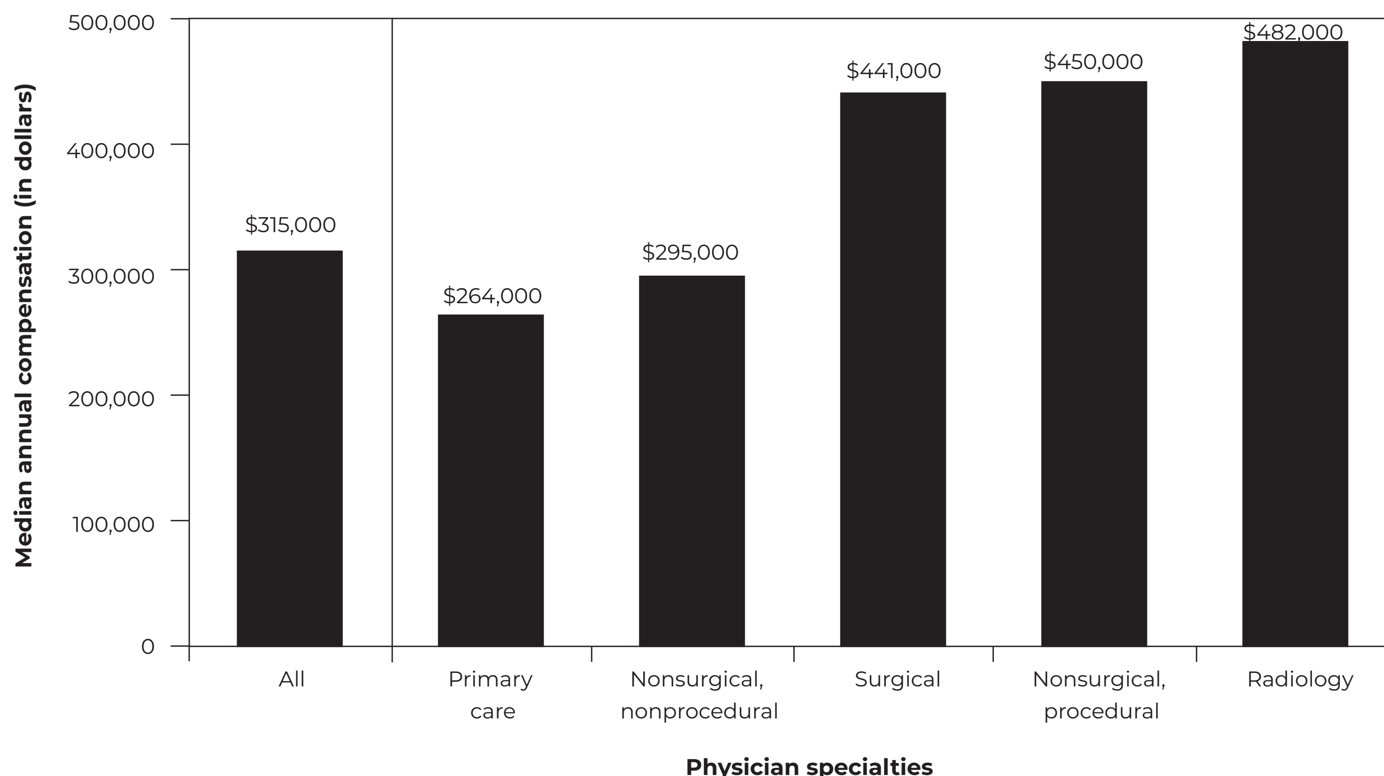
To examine the compensation that clinicians receive from all payers, we analyze data from SullivanCotter's Physician Compensation and Productivity Survey; most of the clinician practices in this survey are affiliated with a large hospital or health system. From 2017 to 2021, median compensation across all physician specialties grew at an average annual rate of 3.0 percent and in 2021 was $315,000. From 2017 to 2021, median compensation for primary care physicians increased at an average annual rate of 3.6 percent, faster than nonsurgical, procedural specialties (3.4 percent), nonsurgical, nonprocedural specialties (2.6 percent), surgical specialties (2.4 percent), and radiology (2.3 percent).[32]

Compensation is much higher for certain specialties than for primary care As in prior years, compensation was much higher for many specialists than for primary care physicians in 2021. Specialties with the highest median compensation were radiology ($482,000); nonsurgical, procedural specialties ($450,000); and surgical specialties ($441,000) (Figure 4-5, p. 130).[33] Median compensation for radiology was 83 percent higher than median compensation for primary care ($264,000), and median compensation for nonsurgical, procedural specialties was 71 percent higher than that for primary care.[34] Psychiatry—which is in the nonsurgical, nonprocedural group—had median compensation of $262,000.[35] By comparison, nurse practitioners had median compensation of $125,000 and physician assistants had median compensation of $123,000 (data not shown).

There is no consistent relationship between compensation and practice ownership Due to the growth in hospital employment of physicians and hospitals' acquisition of physician practices, we examined whether physicians in hospital-owned practices earn more or less than physicians in physician-owned practices. In our review of the literature, we did not find a consistent relationship

FIGURE 4–5

Compensation for primary care physicians is much lower than for most specialists, 2021



Note: Figure includes all physicians who reported their annual compensation in the survey (*n* = 106,522). The primary care group includes family medicine, internal medicine, and general pediatrics. The nonsurgical, nonprocedural group includes psychiatry, emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The nonsurgical, procedural group includes cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.

Source: SullivanCotter's Physician Compensation and Productivity Survey, 2022.

between practice ownership and physician compensation, however. According to 2020 data from the Medical Group Management Association, primary care physicians who worked at physician-owned practices received higher compensation than their counterparts who worked at practices owned by hospitals or health systems, regardless of compensation method (e.g., 100 percent salary, 100 percent productivity, mix of productivity and quality metrics) (Medical Group Management Association 2022). Meanwhile, the relationship between practice ownership and compensation for surgical and nonsurgical specialists varied depending on compensation method. For example, nonsurgical specialists who were employed by hospital-owned practices earned higher compensation than those employed by physician-owned practices if they were salaried but not if their compensation was based on productivity metrics. Similarly, Whaley and colleagues found that practice ownership did not have a consistent impact on physician compensation (Whaley et al. 2021). Employment in practices owned by hospitals or health systems was associated with slightly lower income for nonsurgical specialists, slightly higher income for surgical specialists, and no difference in income for primary care physicians.

Medicare's physician fee schedule influences differences in physician compensation from all payers Physician compensation from all payers reflects the structure of Medicare's physician fee schedule because many private insurers base their payment rates on the fee schedule's relative prices (Clemens and Gottlieb 2017, Congressional Budget Office 2018). Therefore, physician compensation from all payers likely reflects the fee schedule's historical underpricing of ambulatory E&M visits relative to other services, such as procedures (Medicare Payment Advisory Commission 2018a).[36] Ambulatory E&M visits make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology). The fee schedule's underpricing of these services has contributed to an income disparity between primary care physicians and certain specialists, which may be a substantial factor in the decline of primary care physicians since 2016.

For many years, the Commission has expressed concern about the accuracy of the physician fee schedule, the underpricing of primary care services relative to other services, and the impact of these problems on the pipeline of future primary care physicians (Medicare Payment Advisory Commission 2022b). We have made several recommendations to improve the accuracy of the fee schedule and increase payments for primary care services (Medicare Payment Advisory Commission 2022b, Medicare Payment Advisory Commission 2018a, Medicare Payment Advisory Commission 2011).

In 2021, CMS substantially increased the payment rates for E&M office/outpatient visits—the most common type of ambulatory E&M visit. The Commission strongly supported this action because it is an important first step in addressing the long-term devaluation of these services (Medicare Payment Advisory Commission 2020). We also supported CMS's decision to implement this change in a budget-neutral manner because doing so will help to rebalance the fee schedule from services that have become overvalued (e.g., procedures, imaging, and tests) to services that have become undervalued—thus improving payment accuracy (Centers for Medicare & Medicaid Services 2020). Maintaining budget neutrality could also help to reduce the large gap in compensation between primary care physicians and certain specialists, which could increase the supply of primary care physicians.

Input costs for clinicians are projected to increase at rates not seen for many years

The Medicare Economic Index (MEI) measures the average annual price change for the market basket of inputs used by clinicians to furnish services, after adjusting for economy-wide productivity. The MEI consists of two main categories: (1) physicians' compensation and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, rent, equipment, and professional liability insurance). The index's cost categories (e.g., physician compensation, medical equipment) and cost weights (each category's share of total costs) were previously based on data on physicians' expenses from 2006.[37] However, CMS recently updated the MEI's cost categories and cost weights using data on physician offices from 2017 from the Census Bureau's Services Annual Survey, along with data from other sources (Centers for Medicare & Medicaid Services 2022b).

Between 2010 and 2022, the MEI increased cumulatively by 23 percent—far exceeding the 6 percent cumulative increase in annual updates to physician fee schedule payment rates (Figure 4-6, p. 132). However, the volume and intensity of clinician services delivered each year has increased, which has resulted in fee schedule spending per FFS beneficiary keeping pace with growth in the MEI through 2021 (Boards of Trustees 2022).

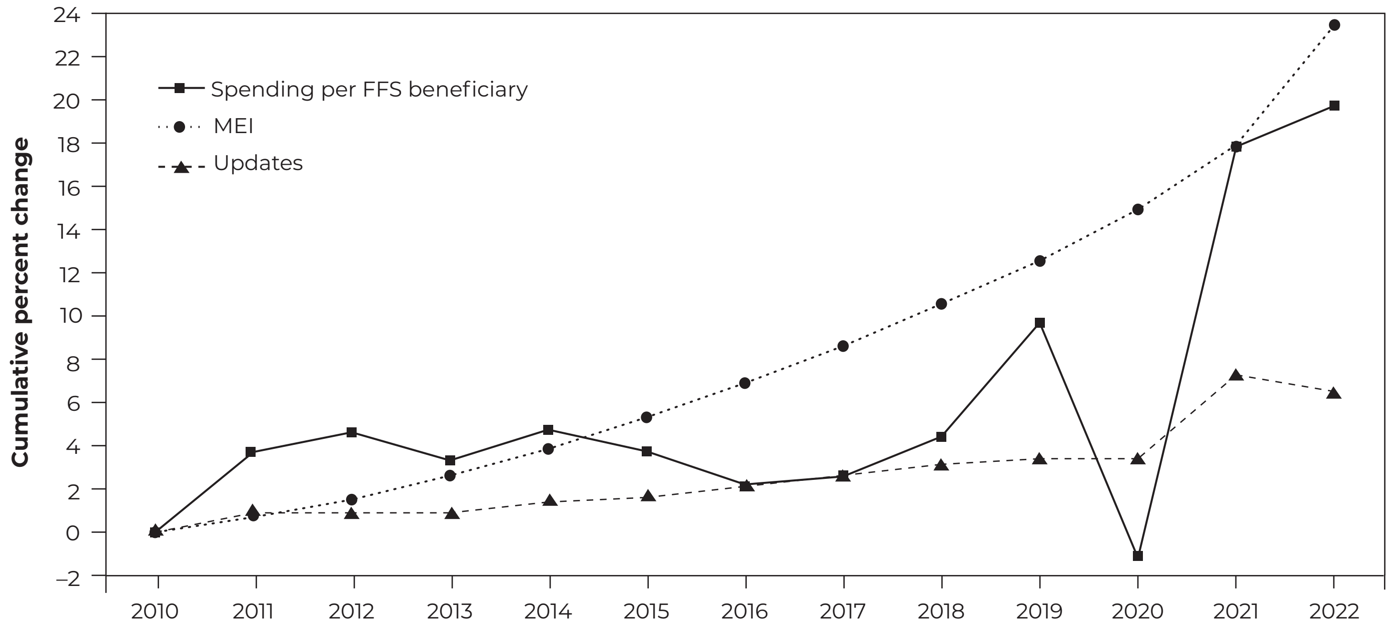
Clinicians are now experiencing higher growth in their input costs than in recent years. After growing by 1 to 2 percentage points per year in recent prepandemic years, the MEI grew by 2.6 percent in 2021 and is estimated to have grown by 4.7 percent in 2022. CMS projects continued high growth in clinicians' input costs in the next few years, with the MEI currently projected to grow by 3.9 percent in 2023 and by 2.9 percent in 2024.[38]

How should Medicare payments change in 2024?

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

FIGURE 4–6

The MEI grew faster than updates to physician payment rates, but spending per FFS beneficiary largely kept pace with MEI growth, 2010–2022



Note: FFS (fee-for-service), MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. Figure shows increases to payment rates in nominal terms. Figure does not show annual Merit-based Incentive Payment System (MIPS) adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or advanced alternative payment model bonuses, because these adjustments are one-time and not built into subsequent years' payment rates. Figure also does not show adjustments to payment rates to ensure that changes to the relative values of individual billing codes are budget neutral. Figure shows the temporary 3.75 percent increase to fee schedule rates in 2021 and the temporary 3.0 percent increase in 2022. The MEI and spending per beneficiary numbers for 2022 are projected.

Source: 2022 annual report of the Boards of Trustees of the Medicare trust funds; MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015.

aggregate payments appear adequate. However, clinicians' input costs grew at a faster rate in 2021 than in previous years and are projected to continue rising rapidly through 2024.

RECOMMENDATION 4-1

For calendar year 2024, the Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index.

RATIONALE 4-1

Overall, access to clinician services for Medicare beneficiaries appears stable and comparable to—or even better than—that of privately insured individuals. Quality of care has always been difficult to assess in the clinician sector; these difficulties have been exacerbated by the coronavirus pandemic. Although physician fee schedule spending per beneficiary dropped sharply in 2020 due to the pandemic, spending largely recovered in 2021 and was higher than in 2019. However, clinicians' input costs grew faster in 2021 than in previous years and are projected to continue rising rapidly through 2024. We are concerned that clinicians may not be able to absorb these cost increases at current payment levels. However, aggregate payments appear adequate on the basis of our indicators. Therefore, we recommend

that the Congress raise the base payment rate in 2024 by half of the projected increase in the MEI. Because clinicians' practice expenses account for about half of the MEI, this recommendation would help ensure that payment rates keep pace with the growth of clinicians' practice costs.

The MEI is currently projected to grow by 2.9 percent in 2024, so our recommendation is currently estimated to yield an increase in payment rates of 1.45 percent (50 percent × 2.9 percent = 1.45 percent). The MEI is updated quarterly, and the MEI at the time CMS finalizes the 2024 physician fee schedule payment rates could be larger or smaller than the current projection. The Consolidated Appropriations Act, 2023, provides a temporary increase to base payment rates of 1.25 percent in 2024, which will expire after 2024. By contrast, the Commission's recommendation would be factored into payment rates beyond 2024.

In addition to this recommendation for an across-the-board increase to the base payment rate for services paid under the physician fee schedule, the Commission contends that it is important to provide additional financial support to clinicians who furnish care to low-income beneficiaries. A separate discussion of how Medicare can better support safety-net clinicians follows.

IMPLICATIONS 4-1

Spending

- This recommendation would increase program spending relative to current law by $750 million to $2 billion in 2024 and by $5 billion to $10 billion over five years.

Beneficiary and provider

- The Commission's recommendation should maintain beneficiaries' access to care and providers' willingness and ability to furnish care.

Supporting Medicare safety-net clinicians

The Commission has undertaken a body of work to examine safety-net providers and develop ways that the Medicare program can best support their mission. In our June 2022 report to the Congress, we described frameworks that could be used across multiple health care sectors to identify safety-net providers and applied those frameworks to acute care hospitals (Medicare Payment Advisory Commission 2022a). Specifically, we identified safety-net providers as those that disproportionately serve (1) low-income Medicare beneficiaries who are less profitable to care for than the average beneficiary, or (2) uninsured patients or patients with public insurance who are not materially profitable to treat, meaning—without supplemental payments—the profit margins for these patients are negative or too low to sustain a health care organization. Next, we developed a conceptual framework for determining whether the Medicare program should allocate new funding to support identified safety-net providers. We asserted that Medicare should spend additional funds to support safety-net providers only if:

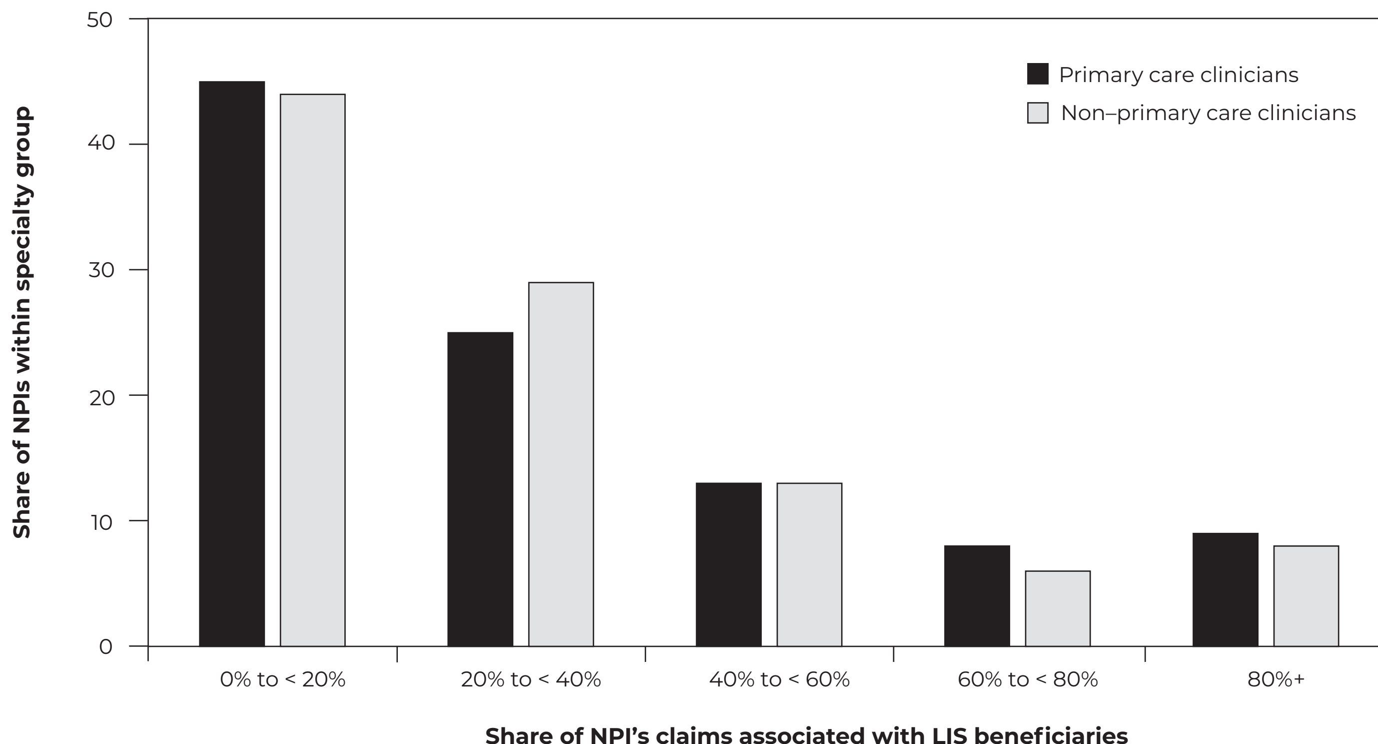
- Low-income Medicare beneficiaries are at risk of negative effects (e.g., access problems due to provider closures) without additional funding;
- Medicare is not a materially profitable payer in the sector; and
- Current payment adjustments cannot be redesigned to adequately support safety-net providers.

As described in Chapter 3 of this report, the Commission has determined that additional Medicare payments to Medicare safety-net hospitals are warranted and recommends adding $2 billion to Medicare's current safety-net payments (disproportionate share hospital and uncompensated care payments) and then redistributing those funds using a Commission-developed Medicare Safety-Net Index for hospitals. This recommendation would better target scarce Medicare resources to support hospitals that are key sources of care for low-income Medicare beneficiaries and are at high risk of closure.

In this chapter, we consider a new Medicare safety-net policy to support clinicians who care for low-income beneficiaries. As in Chapter 3, our definition of low-income Medicare beneficiaries includes all those who receive full or partial Medicaid benefits and those who do not qualify for Medicaid benefits in their state but who receive the Part D low-income subsidy (LIS)

FIGURE 4–7

A small share of clinicians had a high portion of claims from LIS beneficiaries, 2019



Note: LIS (low-income subsidy), NPI (national provider identifier). "LIS beneficiaries" includes all beneficiaries who receive full or partial Medicaid benefits, as well as those who do not qualify for Medicaid benefits in their state but who receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level. Nurse practitioners (NPs) and physician assistants (PAs) who practiced in primary care are included in the primary care category; the remaining NPs and PAs are included in the non–primary care category.

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

because they have limited assets and an income below 150 percent of the federal poverty level. (Collectively, we refer to this population as "LIS beneficiaries" because those who receive full or partial Medicaid benefits are automatically eligible to receive the LIS.) We find that certain clinicians treat a disproportionate share of LIS beneficiaries, and that doing so can generate reduced revenues, even though the costs required to treat them likely are the same as for other beneficiaries, if not more.

The combination of lower revenues and potentially higher treatment costs can put a financial strain on safety-net clinicians and make it more difficult for low-income beneficiaries to access needed care. Given that FFS Medicare does not have an existing set of policies that support safety-net clinicians, the Commission contends that Medicare should provide additional financial support to clinicians who care for low-income beneficiaries. Specifically, for covered services furnished to LIS beneficiaries, the Commission supports a policy that would increase Medicare physician fee schedule payment rates by 15 percent for primary care clinicians and 5 percent for non–primary care clinicians. Medicare safety-net add-on payments would be available to any clinician who furnishes services to LIS beneficiaries under the physician fee schedule, but clinicians who provide care for more LIS beneficiaries would receive relatively more in safety-net payments—thus providing an incentive for all clinicians to maintain or improve access for low-income beneficiaries.

TABLE 4–9

Nurse practitioners in primary and specialty care, as well as other primary care clinicians, had a higher share of allowed charges associated with LIS beneficiaries, 2019

	Share of allowed charges by type of clinician							
	Primary care			Specialty care				
Type of beneficiary	Physicians	NPs	PAs	Physicians	NPs	PAs	Other APRNs	Other clinicians
All LIS	28%	41%	28%	25%	36%	25%	23%	23%
Non-LIS	72	59	72	75	64	75	78	77
Total	100	100	100	100	100	100	100	100

Note: LIS (low-income subsidy), APRN (advanced practice registered nurse), NP (nurse practitioner), PA (physician assistant). "All LIS" beneficiaries includes all beneficiaries who receive full or partial Medicaid benefits, as well as those who do not qualify for Medicaid benefits in their state but who receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level. "Other APRNs" predominantly comprises certified registered nurse anesthetists but also includes certified nurse midwives and clinical nurse specialists. "Other clinicians" includes practitioners such as podiatrists, physical and occupational therapists, psychologists, and chiropractors.

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

Certain clinicians treat a disproportionate share of low-income beneficiaries

Certain clinicians treat a large share of low-income beneficiaries.[39] In 2019, 9 percent of primary care clinicians and 8 percent of non–primary care clinicians who billed the physician fee schedule had more than 80 percent of their claims associated with LIS beneficiaries (Figure 4-7).[40] The majority of clinicians had less than 40 percent of their claims associated with LIS beneficiaries.

To better understand the extent to which these patterns varied across different types of clinicians, we analyzed billing patterns by clinician specialty across the full range of clinicians who billed the physician fee schedule, including sorting nurse practitioners (NPs) and physician assistants (PAs) into primary care and specialty care categories. We used allowed charges to measure how low-income beneficiaries are distributed among different types of providers (as opposed to measuring the number of clinicians) to prevent clinicians who treat relatively few beneficiaries from skewing the results.

We found that, among all clinician types, NPs on average had the highest share of allowed charges associated with LIS beneficiaries (Table 4-9). In 2019, 41 percent of the allowed charges billed by NPs who practiced in primary care were for LIS beneficiaries, as were 36 percent for NPs who practiced in specialty care compared with 28 percent for primary care physicians and PAs and 25 percent for specialty care physicians and PAs.

While specialist physicians had slightly lower shares of their allowed charges associated with LIS beneficiaries compared with primary care physicians, they still billed for a majority (64 percent) of LIS beneficiaries' allowed charges (latter not shown). This higher percentage reflects the fact that specialist physicians bill for a large majority of all fee schedule services.

The share of specialist physicians' allowed charges associated with LIS beneficiaries varied substantially among specialists. Among the top 20 specialist physician specialties (ranked by allowed charges), nephrologists had the highest share (49 percent) and dermatologists had the lowest share (6 percent).

We also examined the extent to which clinicians in rural or urban areas disproportionately treated LIS beneficiaries. We found that rural clinicians billed for a slightly higher share of LIS beneficiaries' allowed charges (10 percent) in 2019 compared with urban clinicians (8 percent).[41] Rural providers were also more

likely to have LIS beneficiaries account for a moderate share of their fee schedule claims compared with urban providers who were more likely to treat very low shares of LIS beneficiaries. In 2019, about 22 percent of urban clinicians had fewer than 10 percent of their claims associated with LIS beneficiaries compared with only 12 percent of clinicians practicing in rural micropolitan areas.

Treating beneficiaries with low income often generates less revenue for clinicians

For most fee schedule services, the Medicare program pays 80 percent of the fee schedule rate, and the beneficiary (or their supplemental insurer) is responsible for the remaining 20 percent. However, clinicians are prohibited from seeking cost-sharing payments from most LIS beneficiaries. Clinicians generally cannot collect cost sharing from beneficiaries who have full Medicaid benefits or for most beneficiaries who receive partial Medicaid benefits—specifically, those eligible for the Qualified Medicare Beneficiary (QMB) program.[42] These two groups of beneficiaries accounted for about 85 percent of the LIS population in 2019.

For beneficiaries who are enrolled in full Medicaid benefits or the QMB program and are exempt from paying cost sharing, clinicians can seek payment for the 20 percent coinsurance from state Medicaid programs. However, state Medicaid programs are allowed to pay less than the full Medicare cost-sharing amount if paying the full Medicare cost sharing would lead a provider to receive more than the state's Medicaid payment rate for the service (Medicaid and CHIP Payment and Access Commission 2015). These policies are referred to as "lesser-of" policies because state Medicaid programs pay the lesser of (1) Medicare's cost-sharing amount or (2) the difference between the state Medicaid fee schedule and the Medicare program's payment for a service. Due to the prohibition on collecting cost-sharing payments from most Medicaid beneficiaries and widespread adoption of policies that reduce or eliminate state payment of cost sharing for those beneficiaries, clinicians who care for low-income beneficiaries are often paid effective rates that are 20 percent below Medicare's standard physician fee schedule rates.

Most states have Medicaid payment rates for clinician services that are below Medicare rates and have implemented "lesser-of" policies. One study found that in 2019, state Medicaid rates for clinician services averaged 72 percent of Medicare rates for 27 common procedures, and this ratio was even lower (67 percent) for primary care services (Zuckerman et al. 2021). Another study found that, between 2004 and 2018, the number of states that limited Medicaid payments of Medicare cost sharing when Medicaid's fee schedule was lower than Medicare's rate increased from 36 states to 42 states (Roberts et al. 2020). These studies find that clinicians are routinely paid substantially less for furnishing the same care to dual-eligible beneficiaries than they are for other Medicare beneficiaries.

To estimate the magnitude of a lack of cost-sharing payments, we calculated the total physician fee schedule–allowed charges billed for services furnished to beneficiaries eligible for full Medicaid benefits or the QMB program in 2019. Using the state Medicaid payment rates published by Zuckerman et al. and the "lesser-of" state policies published by Roberts et al., we then estimated the dollar amount of cost sharing that clinicians did not collect.

We estimate that in 2019, providers did not collect about $3.6 billion in physician fee schedule–allowed charges for beneficiaries eligible for full Medicaid benefits and those in the QMB program due to the combination of the prohibition on collecting cost-sharing payments and state "lesser-of" Medicaid policies. While this estimate has limitations, the magnitude of our estimate—which amounts to nearly 15 percent of all allowed charges billed for fee schedule services furnished to LIS beneficiaries—strongly suggests that treating LIS beneficiaries is less profitable than treating other beneficiaries.

Clinicians are not prohibited from collecting cost-sharing payments from beneficiaries who receive the Part D LIS but are not dually eligible for Medicaid in their state of residence, nor are clinicians prohibited from collecting cost-sharing payments from partially dual beneficiaries who are not in the QMB program. However, these patients may have difficulty meeting their cost-sharing requirements, so providers may be less likely to collect cost sharing from them. Medicare

does not pay clinicians for bad debt associated with an inability to collect cost-sharing payments. Since clinicians do not submit cost reports, it is difficult to quantify the magnitude of any bad debt.

Similarly, without cost reports it is difficult to assess clinicians' treatment costs, but there is little reason to believe that the costs of treating low-income beneficiaries are less than the costs of treating higher-income beneficiaries. Indeed, studies have shown that patients with lower income tend to be sicker and more costly to treat compared with higher-income patients (Cunningham et al. 2018, Kabir et al. 2022). Given the combination of lower revenue for low-income beneficiaries and treatment costs that are at least as much as for other beneficiaries, we believe it is reasonable to infer (despite the lack of cost report data) that LIS beneficiaries are less profitable for clinicians than non-LIS patients.

LIS beneficiaries report having greater difficulty accessing care than other beneficiaries

As outlined earlier in this chapter, the Commission has consistently found that Medicare beneficiaries have good access to clinician care overall. However, our analysis of the Medicare Current Beneficiary Survey (MCBS) suggests that low-income beneficiaries face greater challenges accessing care than other beneficiaries. While many low-income beneficiaries are exempt from the financial burden of cost sharing, challenges in accessing care can arise from a variety of other factors. These could include difficulty finding an available provider, the cost of transportation, and difficulty taking time away from work or caring for family members. Among FFS beneficiaries in 2019, we found that LIS beneficiaries were three times more likely to not receive care for a health problem (18 percent for LIS beneficiaries compared with 6 percent of non-LIS beneficiaries) (Table 4-10, p. 138). Low-income beneficiaries also reported having more trouble getting needed health care and higher rates of not being satisfied with the ease with which they can get to a doctor from where they live. We analyzed 2018 MCBS data and found similar results (data not shown).

The MCBS also asks a series of questions about the reasons beneficiaries had difficulty accessing care. Beneficiaries commonly reported that the cost of care created difficulties for them in accessing care. For example, in 2019, MCBS data suggest that about 8 percent of non-LIS FFS beneficiaries delayed care in the past year because of cost compared with 10 percent of those eligible for full Medicaid benefits, 19 percent of those with partial Medicaid benefits, and 29 percent of LIS-only beneficiaries. (LIS-only beneficiaries do not qualify for full or partial Medicaid benefits in their state but receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level.)

One recent study also found that low-income beneficiaries who do not qualify for cost-sharing assistance had greater challenges accessing care. The study compared the service use of beneficiaries for whom Medicaid paid their cost sharing with those who had low incomes but who just missed the income threshold to qualify for cost-sharing assistance. The research found that beneficiaries who were just above the income threshold used 55 percent fewer outpatient E&M services (Roberts et al. 2021). Another study found that in states that reduced cost-sharing payments by implementing "lesser-of" payment policies, there were significant reductions in the number and intensity of visits to physicians among dual-enrolled Medicare beneficiaries (Hayford et al. 2023). The reductions were larger for new patient visits than for visits with established patients and larger for primary care physicians than for other clinicians, which suggests that reducing total clinician revenue through "lesser-of" policies has a deleterious effect on access to care, especially among duals seeking care from a new primary care clinician.

A new Medicare safety-net add-on payment for clinicians treating beneficiaries with low incomes

Given that lower revenues and potentially higher treatment costs may create financial strain on clinicians who care for beneficiaries with low incomes and may make it difficult for such beneficiaries to access needed care, the Commission supports instituting a new Medicare safety-net (MSN) add-on payment for clinicians who treat LIS beneficiaries. Specifically, clinicians should receive add-on payments based on a percentage of allowed charges for physician fee schedule services furnished to LIS beneficiaries. The Commission supports options that would provide a higher add-on percentage for services furnished by

TABLE 4–10

FFS beneficiaries with low incomes report having more difficulty accessing care, 2019

	Non-LIS	Fully dual-eligible	Partially dual-eligible	LIS-only
Share of FFS beneficiaries	76%	17%	4%	3%
Had a health problem that they thought they should see a doctor for but didn't	6	10*	14*	18*
Had trouble getting needed health care	6	12*	18*	18*
Not satisfied with ease with which they can get to a doctor from where they live	4	8*	8*	8*
Not satisfied with the quality of medical care in the past year	4	7*	7*	4
Had problem paying medical bill	7	13*	28*	30*
Delayed care because of cost in the past year	8	10*	19*	29*

Note: FFS (fee-for-service), LIS (low-income subsidy). "Non-LIS" beneficiaries do not receive any Medicaid benefits or Part D's LIS. "Fully dual-eligible" Medicare beneficiaries receive full Medicaid benefits. "Partially dual-eligible" Medicare beneficiaries receive partial Medicaid benefits. "LIS-only" beneficiaries do not qualify for full or partial Medicaid benefits in their state but receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level.
*Statistically significantly different (p = 0.05) compared with non-LIS beneficiaries.

Source: MedPAC analysis of Medicare Current Beneficiary Survey data.

primary care clinicians than for services furnished by non–primary care clinicians. This approach recognizes that all clinicians who furnish care to beneficiaries with lower income are in need of additional financial support, but that primary care clinicians generally receive less total compensation than specialists and have an even greater need for safety-net payments.

For primary care clinicians (including NPs and PAs who practice as primary care providers), the add-on should equal 15 percent of fee schedule–allowed charges for LIS beneficiaries, while the add-on for other clinicians (including NPs and PAs who do not practice as primary care providers) should equal 5 percent of allowed charges. Because Medicare does not have an existing program to provide financial support to safety-net clinicians, and clinician payments are subject to relatively low statutory annual updates in the near term, the Commission asserts that the MSN add-on should be funded with new spending and not offset by reductions in fee schedule payment rates.

The approach for including a clinician safety-net add-on payment in FFS Medicare offers several benefits. The add-on would be relatively easy for clinicians to understand and for CMS to administer. Total add-on payments received by a clinician would be a simple function of total fee schedule–allowed charges for all services furnished to LIS beneficiaries multiplied by a fixed percentage. There are no cliffs, cutoffs, or complex exclusions that would affect add-on payments in unexpected ways. Clinicians who furnish care to more LIS beneficiaries would tend to receive higher total MSN add-on payments than clinicians who see fewer LIS beneficiaries. As such, the policy would provide predictable financial support for safety-net clinicians whose revenues are reduced by state payment policies for dually eligible beneficiaries

and a straightforward financial incentive for clinicians to provide access to care for beneficiaries with lower incomes.

MSN add-on payments would not increase administrative burdens on clinicians; Medicare administrative contractors (the entities that process FFS claims) would calculate the add-on payments based on standard claims submissions and make payments to clinicians without the need for clinicians to complete additional forms or paperwork. Add-on payments themselves would not be subject to beneficiary cost sharing and could be paid to clinicians on a periodic lump-sum basis rather than adjusting payments for each eligible claim. Quarterly MSN payments would be consistent with the way payments under the Health Professional Shortage Area (HPSA) program are administered. Lump-sum payments are likely to be less burdensome for CMS to administer, and easier for clinicians to understand, than adjustments made on a claim-by-claim basis.

Applying a higher add-on adjustment to payments for services furnished by primary care clinicians will necessitate definitive classification of clinicians. In our analyses, we used the specialty designation that appears on a plurality of each clinician's claims. We classified physicians whose specialties are internal medicine, family medicine, geriatric medicine, or pediatric medicine (with an adjustment to exclude clinicians who are serving as hospitalists) as "primary care clinicians." Claims data do not indicate the specialty in which nurse practitioners or physician assistants practice. Therefore, we developed an algorithm to sort these clinicians into primary care or specialty care categories based on (1) the location and types of services they billed, (2) the specialties of the physicians with whom they practiced, and (3) the types of conditions they treated. All clinicians who did not meet any of the criteria for primary care were designated as "non–primary care." Other methodologies could also be used to designate primary care clinicians and identify specialties for nurse practitioners and physician assistants.

We considered whether an MSN add-on policy should be extended to services furnished by federally qualified health centers (FQHCs) and rural health clinics (RHCs). FQHCs are outpatient clinics that predominantly furnish primary care and must offer free or reduced-cost care to low-income individuals, among other requirements. RHCs are outpatient clinics that mainly furnish primary care but also offer specialist care. RHCs must initially be located in an area that is considered underserved, but they are not required to offer free or reduced-cost care to patients. RHCs can be physician owned or owned by a larger entity and are very similar to traditional physician offices. In 2020, Medicare spending for services furnished in FQHCs and RHCs totaled $1.4 billion and $1.6 billion, respectively.

There are two important differences between traditional physician offices and FQHCs and RHCs that should be considered when evaluating whether supplemental safety-net payments are needed. First, FQHCs and RHCs are already paid substantially higher rates than clinicians in office-based settings. Medicare's payment systems for FQHCs and RHCs generally bundle all professional services furnished in a single day into one payment, with limited exceptions. Most claims are for E&M visits. On average, Medicare's payment rates for FQHCs and RHCs are higher than if the same services were billed under the physician fee schedule, although the exact rates vary. For example, in 2022 Medicare paid approximately $92 for a mid-level office visit in a freestanding physician office compared with $180 for the same service in a FQHC and $263 in certain types of provider-based RHCs.[43]

The second difference is that if the RHC or FQHC does not receive cost sharing for a visit, they can declare what would have been received through cost sharing as bad debt on their cost report and be paid 65 percent of those bad debts by Medicare. For example, if a state Medicaid program does not pay cost sharing for its dual-eligible Medicare beneficiaries, that cost sharing would be fully lost by a clinician who practices at a traditional physician clinic, but that clinician would recoup 65 percent of their bad debt if the physician owned and operated their practice as an RHC. The higher payment rates for RHCs and FQHCs, coupled with the differences in bad-debt treatment, suggest that the payment rates received by RHCs and FQHCs are sufficient without additional Medicare safety-net funds.[44]

Impact of Medicare safety-net add-on payments for clinicians

We have estimated the high-level impact of MSN add-on payments for all fee schedule services

TABLE 4–11

Simulated effect of a 15 percent safety-net add-on for primary care clinicians and a 5 percent add-on for non–primary care clinicians, 2019

Clinician type	FFS add-on (in billions)	Percent of total add-on	Annual mean add-on per clinician
Primary care (15% add-on)	$0.7	40%	$2,870
Non–primary care (5% add-on)	1.0	60	990
All clinicians	1.7	100	1,340

Note: FFS (fee-for-service). Estimates were calculated using 2019 data. Nurse practitioners (NPs) and physician assistants (PAs) who practiced in primary care are included in the primary care category; the remaining NPs and PAs are included in the non–primary care category.

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

furnished to LIS beneficiaries enrolled in FFS Medicare (Table 4-11). The estimate shows that a 15 percent add-on for primary care clinicians and a 5 percent add-on for non–primary care clinicians would increase Medicare spending by about $1.7 billion annually, about 40 percent of which would go to primary care clinicians and 60 percent to other clinicians. On a per clinician basis, primary care providers would receive an average safety-net payment of $2,870 per year and other clinicians would receive an average of $990 per year.

Since some clinicians furnish a disproportionate amount of care to LIS beneficiaries (Figure 4-7, p. 134), we show how MSN add-on payments would be distributed among clinicians depending on how many LIS beneficiaries they care for (Table 4-12). We classified clinicians billing the fee schedule in 2019 into five equally sized cohorts, depending on how many unique LIS beneficiaries they furnished services to that year. For each quintile, we estimated what the average annual MSN add-on payment would be. Primary care clinicians in the highest quintile (i.e., those who treated an average of 171 LIS beneficiaries) would receive an estimated average MSN add-on payment of $10,467 per year. Among non–primary care clinicians treating the highest number of LIS beneficiaries, safety-net add-on payments would average $3,304. Primary care and non–primary care clinicians with the smallest number of LIS beneficiaries would receive average MSN payments of $62 and $34, respectively.

Recommendation

To promote adequate access to care, additional financial support for clinicians who furnish care to Medicare beneficiaries with low incomes is warranted. Medicare should make add-on safety-net payments for physician fee schedule services provided to low-income beneficiaries, with a higher percentage add-on for primary care clinicians.

RECOMMENDATION 4-2

The Congress should enact a non-budget-neutral add-on payment, not subject to beneficiary cost sharing, under the physician fee schedule for services provided to low-income Medicare beneficiaries. These add-on payments should equal a clinician's allowed charges for these beneficiaries multiplied by:

- **15 percent for primary care clinicians and**
- **5 percent for non–primary care clinicians.**

Clinicians should receive an MSN add-on payment for all physician fee schedule services furnished to Medicare beneficiaries who are dually enrolled in Medicaid and/or the LIS program. MSN payments would be based on applying an add-on rate to the allowed charge (also known as the Medicare payment amount) for fee schedule services furnished to those beneficiaries. Clinicians who are designated as primary care providers should receive a higher MSN add-on rate (15 percent) than non-primary clinicians

TABLE 4–12

Medicare safety-net add-on payments increase as the number of LIS beneficiaries a clinician treats increases

Quintile of clinicians (by number of LIS beneficiaries treated)	Primary care clinicians: Average annual safety-net add-on payment	Primary care clinicians: Average number of LIS beneficiaries per clinician	Non–primary care clinicians: Average annual safety-net add-on payment	Non–primary care clinicians: Average number of LIS beneficiaries per clinician
First (lowest)	$62	2	$34	1
Second	409	11	176	9
Third	1,082	27	455	27
Fourth	2,412	54	1,024	64
Fifth (highest)	10,467	171	3,304	272

Note: LIS (low-income subsidy). "LIS beneficiaries" includes all beneficiaries who receive full or partial Medicaid benefits, as well as those who do not qualify for Medicaid benefits in their state but who receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level. Estimates were calculated using 2019 data. Nurse practitioners (NPs) and physician assistants (PAs) who practiced in primary care are included in the primary care category; the remaining NPs and PAs are included in the non–primary care category.

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

(5 percent). Policymakers would need to determine how best to define "primary care providers."[45]

MSN add-on payments could be made quarterly on a lump-sum basis, similar to the method used for HPSA payments, rather than applied to payments for individual claims. Spending on MSN add-on payments should not be subject to beneficiary cost sharing, and the increase in Medicare spending should not be offset by reducing other fee schedule spending.

MSN add-on payments should not be extended to Medicare Advantage (MA) plans. More than 60 percent of dually enrolled beneficiaries in MA are in dual-eligible special needs plans (D–SNPs), which are specifically designed for beneficiaries enrolled in both Medicare and Medicaid. MA plans can operate their own initiatives to support safety-net clinicians, including making up for lost cost-sharing revenue when they contract with clinicians. Given the contracting flexibilities that MA plans already have, safety-net payments should not be made directly to clinicians who treat low-income MA enrollees, nor should FFS spending on MSN add-on payments be included in MA benchmarks.

RATIONALE 4-2

Clinicians often receive less revenue when treating low-income beneficiaries because of the way Medicare's cost-sharing policies interact with state Medicaid payment policies. Given that the cost to clinicians of treating low-income beneficiaries is at least as much as, if not higher than, the cost of treating other beneficiaries, caring for low-income beneficiaries is likely less profitable and may put clinicians at financial risk. Surveys consistently find that low-income beneficiaries report having more difficulty accessing needed care than other beneficiaries. Since there is no existing Medicare policy that directly supports safety-net clinicians who serve low-income beneficiaries, addressing these issues requires a new payment mechanism. Applying an MSN add-on to physician fee schedule payments would help to make up for a portion of clinicians' lost cost-sharing revenue when they treat low-income beneficiaries and reduce their financial risk for doing so. By making caring for low-income beneficiaries less of a financial risk, the MSN add-on could encourage clinicians to maintain or improve access for this population.

IMPLICATIONS 4-2

Spending

- This recommendation would increase program spending relative to current law by greater than $2 billion in one year and by greater than $10 billion over five years.

Beneficiaries and providers

- This recommendation should maintain or improve access to care for low-income beneficiaries while not affecting access for other beneficiaries. Clinicians who furnish care for low-income beneficiaries would receive additional payments, thus providing them with an incentive to maintain or improve access for low-income beneficiaries. ■

APPENDIX 4-A

Key findings from the Commission's 2022 access-to-care survey

TABLE 4A–1

Medicare beneficiaries' access to care was equal to, or better than, that of privately insured people in the Commission's 2022 survey

Survey question	Medicare beneficiaries (ages 65 and older)					Privately insured (ages 50–64)				
	2018	**2019**	**2020**	**2021**	**2022**	**2018**	**2019**	**2020**	**2021**	**2022**
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	70%[a]	72%[b]	69%[a]	67%[a]	55%[a]	64%[ab]	74%[b]	73%[ab]	78%[a]	40%[a]
Sometimes	20[ab]	20[b]	22[a]	23[a]	32[a]	26[ab]	19	20[ab]	17[a]	40[a]
Usually	5	3[b]	3[b]	5[a]	8[a]	5[b]	4[b]	4[b]	3[a]	12[a]
Always	3[a]	3	3	3[a]	4[a]	4[ab]	3[b]	3[b]	2[a]	8[a]
For illness or injury										
Never	79[a]	80	79	78[a]	67[a]	74[ab]	81	80[b]	83[a]	58[a]
Sometimes	15[a]	14	15	16[a]	26	19[ab]	15	15	13[a]	29
Usually	2	2	2	2	4[a]	3[b]	2	3	2	8[a]
Always	2	2	2	2	3[a]	2	1	2	1	5[a]
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"										
Share answering "Yes"	11[a]	9	10	10	18[a]	14[ab]	10	11[b]	9	24[a]
Looking for a new provider: "In the past 12 months, have you tried to get a new…?" (Share answering "Yes")										
Primary care provider	10[b]	8	8	8	11[a]	10[b]	9[b]	7	6	14[a]
Specialist	19[ab]	17[b]	15	14[a]	26	21[ab]	15[b]	13[b]	11[a]	29
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it…"										
Primary care provider										
No problem	71[b]	72[ab]	60	57	46	67	62[a]	57	59	38
Share of total insurance group	*7[b]*	*5*	*5*	*4*	*5*	*7[b]*	*5[b]*	*4*	*4*	*5*
Small problem	13[b]	13[ab]	16[a]	23	32	16[b]	20[a]	24[a]	25	33
Share of total insurance group	*1*	*1[ab]*	*1*	*2*	*4*	*2*	*2[a]*	*2*	*2*	*5*
Big problem	14	14	22	18	22	16	17	18	15	29
Share of total insurance group	*1*	*1*	*2*	*1*	*2[a]*	*2[b]*	*2*	*1*	*1*	*4[a]*
Specialist										
No problem	84[b]	85[ab]	79[b]	73	68[a]	80	79[a]	77	76	59[a]
Share of total insurance group	*16[b]*	*14[ab]*	*12*	*10[a]*	*18*	*17[b]*	*12[ab]*	*10[b]*	*8[a]*	*17*
Small problem	7[b]	6[ab]	9[b]	16	22	9[b]	11[ab]	11[b]	17	26
Share of total insurance group	*1[b]*	*1[b]*	*1[b]*	*2*	*6*	*2*	*2*	*1*	*2*	*7*
Big problem	8	8	11	11	10[a]	10	9	11	8	15[a]
Share of total insurance group	*1*	*1*	*2*	*2[a]*	*3[a]*	*2[b]*	*1[b]*	*2[b]*	*1[a]*	*4[a]*

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Each year's sample consists of approximately 4,000 Medicare beneficiaries and 4,000 privately insured people, but sample sizes for individual questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Results from 2022 are not directly comparable to prior years due to a change in our survey methodology (e.g., switching from an interviewer-administered survey to a self-administered survey).
[a] Statistically significant difference between Medicare beneficiaries and the privately insured in a given year (at a 95 percent confidence level).
[b] Statistically significantly difference between 2021 and a prior year within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored access-to-care surveys conducted from 2018 to 2022.

TABLE 4A–2

Few differences between urban and rural Medicare beneficiaries are statistically significant in the Commission's 2022 survey

Survey question	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
	Urban	Rural	Urban	Rural
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"				
For routine care				
Never	54%[a]	59%[a]	39%[ab]	49%[ab]
Sometimes	33[a]	30	40[a]	35
Usually	9[a]	7	12[a]	9
Always	4[a]	4	9[a]	7
For illness or injury				
Never	67[a]	70[a]	58[a]	61[a]
Sometimes	26	25	29	29
Usually	5[a]	3	8[a]	6
Always	3[a]	2	5[a]	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?"				
Share answering "Yes"	18[a]	21	24[a]	24
Looking for a new provider: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")				
Primary care provider	11	12	14	12
Specialist	28[b]	20[b]	30[b]	21[b]
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it..."				
Primary care provider				
No problem	49	35	37	44
Share of total geographic group with this insurance	*6*	*4*	*5*	*5*
Small problem	32	33	34	29
Share of total geographic group with this insurance	*4*	*4*	*5*	*4*
Big problem	19	32	29	27
Share of total geographic group with this insurance	*2*[a]	*4*	*4*[a]	*3*
Specialist				
No problem	70[a]	59	59[a]	56
Share of total geographic group with this insurance	*20*[b]	*12*[b]	*18*[b]	*12*[b]
Small problem	21	26	25	32
Share of total geographic group with this insurance	*6*	*5*	*8*	*7*
Big problem	9[a]	14	15[a]	11
Share of total geographic group with this insurance	*3*[a]	*3*	*5*[a]	*2*

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample consists of approximately 4,000 Medicare beneficiaries and 4,000 privately insured people, but sample sizes for individual questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. "Urban" respondents reside in an urban or suburban part of a metropolitan statistical area (MSA); the Census Bureau defines MSAs as having at least one urbanized area with a population of 50,000 or more and including adjacent territory that has a high degree of social and economic integration as measured by commuting ties. "Rural" respondents reside outside of an MSA.
[a] Statistically significant difference between Medicare beneficiaries and the privately insured within the same area type (at a 95 percent confidence level).
[b] Statistically significant difference by area type within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored access-to-care survey conducted in August 2022.

TABLE 4A–3

Few differences between White, Black, and Hispanic Medicare beneficiaries are statistically significant in the Commission's 2022 survey

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	White	**Black**	**Hispanic**	**White**	**Black**	**Hispanic**
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	56%[a]	57%	54%[a]	39%[a]	48%	37%[a]
Sometimes	32[a]	33	31	39[a]	42	43
Usually	8[a]	6	8	13[ab]	6	8[b]
Always	3[a]	4	7	9[ab]	4	12[b]
For illness or injury						
Never	68[a]	73	63	58[a]	64	57
Sometimes	26	21	27	29	29	28
Usually	4[a]	4	7	8[a]	5	9
Always	2[a]	2	3	5[a]	2	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?"						
Share answering "Yes"	18[a]	16	18	24[a]	21	26
Looking for a new provider: "In the past 12 months, have you tried to get a new…?" (Share answering "Yes")						
Primary care provider	12	9	12	14	9	16
Specialist	27	19	25	29	26	27
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it…"						
Primary care provider						
No problem	48	58	27	38	57	30
Share of total racial group with this insurance	*5*	*5*	*3*	*5*	*5*	*5*
Small problem	27	37	54	33	15	28
Share of total racial group with this insurance	*3*	*3*	*6*	*5*	*1*	*5*
Big problem	25	5	19	28	27	42
Share of total racial group with this insurance	*3*	*0*	*2*	*4*	*2*	*7*
Specialist						
No problem	69[a]	74	57	59[a]	70	59
Share of total racial group with this insurance	*19*	*14*	*14*	*17*	*18*	*15*
Small problem	21	18	28	26	22	24
Share of total racial group with this insurance	*6*	*4*	*7*	*8*	*6*	*6*
Big problem	10	8	15	14	8	17
Share of total racial group with this insurance	*3[a]*	*2*	*4*	*4[a]*	*2*	*4*

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample consists of approximately 4,000 Medicare beneficiaries and 4,000 privately insured people, but sample sizes for individual questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. "White" refers to non-Hispanic White respondents, "Black" refers to non-Hispanic Black respondents, and "Hispanic" refers to Hispanic respondents of any race.
[a] Statistically significant difference between Medicare beneficiaries and the privately insured within the same race/ethnicity category (at a 95 percent confidence level).
[b] Statistically significant difference by race/ethnicity within the same insurance group (at a 95 percent confidence level).

Source: MedPAC-sponsored access-to-care survey conducted in August 2022.

Endnotes

1 Although most clinician services are paid under the physician fee schedule, some are paid under the payment systems for federally qualified health centers and rural health clinics.

2 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_Physician_FINAL_SEC.pdf.

3 A–APM bonuses and MIPS adjustments are based on clinicians' participation or performance two years prior.

4 Examples of A–APMs include accountable care organization models that require providers to take on some financial risk.

5 Whenever the payment rate for a particular billing code in the physician fee schedule is changed or services are added or dropped through administrative action, the changes are required by law to be budget neutral. Budget neutrality is typically achieved by increasing or decreasing the fee schedule's conversion factor.

6 Sequestration applies only to Medicare program payments and does not affect the conversion factor or reduce the size of payments clinicians collect through beneficiaries' cost sharing.

7 The Commission's beneficiary survey and focus groups include all Medicare beneficiaries, including those in Medicare Advantage (MA) plans. We also report MCBS findings for all Medicare beneficiaries, including those in MA plans. We believe this is a reasonable proxy for the experiences of FFS beneficiaries, because in separate analyses of MCBS data (not shown), we find that MA enrollees and FFS beneficiaries with both Part A and Part B report comparable access to care.

8 Our analysis of the experiences of various subgroups of Medicare beneficiaries (who varied based on their sex, age, race/ethnicity, income, education, urban vs. rural residence, and type of Medicare insurance) found that non-elderly beneficiaries—most of whom are disabled—reported trouble accessing care at notably higher rates (see Chapter 1) than other subgroups of beneficiaries.

9 We continue to survey 4,000 Medicare beneficiaries ages 65 and over and 4,000 privately insured people ages 50 to 64 each year, but in 2022 we changed survey firms, adopted a new sampling approach, switched from a telephone survey to a web- and mail-based survey, and started using a different weighting approach. Research has found that interviewer-administered surveys (which we previously used) tend to yield more extreme, positive responses to attitudinal questions and more socially desirable responses, compared with self-administered surveys (which we are now using) (de Leeuw 2005, Dillman et al. 1996). For this reason, our 2022 survey results may best be thought of as a reset rather than a continuation of our prior time trend and may reflect more candid, nuanced views from survey respondents.

10 We annually conduct focus groups with beneficiaries and clinicians and interviews with providers in different parts of the country to provide more qualitative descriptions of beneficiary and clinician experiences with the Medicare program. During these discussions, we hear from beneficiaries and providers about variation in experiences accessing care. In the summer of 2022, we conducted three focus groups with Medicare beneficiaries in each of three different urban markets. Two of the groups in each market were composed of beneficiaries dually eligible for Medicare and Medicaid. New for this year, we also conducted one focus group in each market with privately insured individuals ages 55 to 64 years old. We also conducted three virtual focus groups with beneficiaries residing in rural areas. In addition, we conducted three focus groups with clinicians in each of the three urban markets: primary care physicians, specialist physicians, and primary care nurse practitioners and physician assistants. In some of the markets, we also interviewed several hospital and clinician groups.

11 This appears to have been driven by the age of survey respondents: comparable shares of privately insured people ages 50 to 64 and Medicare beneficiaries ages 65 to 74 reported seeing an NP or PA for most or all of their primary care, but lower shares of Medicare beneficiaries ages 75 and over reported getting most or all of their primary care from an NP or PA.

12 Specifically, 27 percent of rural Medicare beneficiaries reported receiving most or all of their primary care from an NP or PA, compared with 14 percent of urban beneficiaries; a similar trend was observed among the privately insured. In addition, 24 percent of beneficiaries with annual household incomes below $25,000 reported receiving most or all of their care from an NP or PA, compared with 16 percent of beneficiaries with household incomes between $25,000 and $49,999 and 14 percent of beneficiaries with household incomes of $50,000 or more; again, a similar trend was observed among the privately insured.

13 Higher-income Medicare beneficiaries were more likely than lower-income beneficiaries to report unwanted waits for routine care and were more likely to take the appointment date offered to them rather than cancel the appointment or seek care from a hospital emergency department.

14 For example, among beneficiaries needing an appointment for an illness or injury, 26 percent said they "sometimes" had to wait longer than they wanted, while only 4 percent said they "usually" had to wait longer than they wanted and only 3 percent said they "always" had to wait longer than they wanted.

15 A substantial number of clinicians billed for 15 or fewer beneficiaries in a given year, but they accounted for a small share of services and allowed charges. For example, in 2019, about 17 percent of clinicians who billed the fee schedule billed for 15 or fewer beneficiaries, but these clinicians billed for less than 1 percent of total allowed charges. Further, we note that this threshold does not account for whether clinicians are practicing on a full- or part-time basis.

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

17 APRNs include clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.

18 We defined a clinician who exits Medicare as one who did not bill the physician fee schedule for any beneficiaries in a year but who billed for more than 15 beneficiaries in the previous year. We defined a clinician who enters Medicare as one who billed the fee schedule for more than 15 beneficiaries in a year but did not bill the fee schedule for any beneficiaries in the previous year. We also use a threshold of 15 beneficiaries for our analysis of changes in the number of clinicians billing Medicare. We tested alternative definitions but they did not substantially change the number of exiting or entering clinicians.

19 The average number of beneficiaries billed for by all clinicians includes entering clinicians, exiting clinicians, and those who billed the physician fee schedule in 2018 and continued to do so in 2020.

20 In the Commission's 2022 survey, among the subset of Medicare beneficiaries who looked for a new primary care provider and had a problem finding one, 17 percent encountered a primary care provider's office that did not accept Medicare (equivalent to 1 percent of Medicare beneficiaries overall). Among beneficiaries who looked for a new specialist and had a problem finding one, 15 percent encountered a specialist's office that did not accept Medicare (equivalent to 1 percent of Medicare beneficiaries).

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

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

23 The primary care specialties referenced here are family medicine, internal medicine, and pediatric medicine.

24 Specifically, we define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers (NPIs) of the clinicians who billed for the service.

25 This number is based on our count of beneficiaries who had at least one encounter recorded in claims data and the total number of FFS Medicare beneficiaries enrolled in Part B from the 2022 Medicare Trustees report.

26 Primary care physicians billed for very few services classified as "major procedures" or "anesthesia," so these categories of services were excluded from this analysis.

27 Under "incident to" billing, Medicare allows APRNs and PAs to bill under the NPI of a supervising physician if certain conditions are met.

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

29 The roughly 3,400 Dartmouth-defined HSAs are a collection of ZIP codes whose residents receive most of their hospitalizations from that area's hospitals.

30 For this analysis, we grouped individual billing codes into broad service categories that are clinically meaningful (e.g., E&M, major procedures). MedPAC has changed the way we group individual services into aggregated service categories. Previously, we grouped clinically similar services into service categories using a taxonomy developed in conjunction with the Urban Institute. We are now using a new grouping taxonomy developed by CMS called the Restructured BETOS Classification System (RBCS). More information about RBCS is available here: https://data.cms.gov/provider-summary-by-type-of-service/provider-service-classifications/restructured-betos-classification-system.

31 The private insurer's payments reflect the insurer's allowed amount (including allowed cost sharing). The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments. Only services paid under Medicare's physician fee schedule were included, and anesthesia services were excluded.

32 To control for annual changes in survey respondents, we based the percentage change on a cohort analysis in which the sample was restricted to physicians who were present in both the 2017 and 2021 data.

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

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

35 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics.

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

37 CMS uses price proxies (such as the consumer price index and employment cost index) to calculate annual changes in the MEI.

38 MEI projections in this chapter are as of the third quarter of 2022 and are subject to change.

39 In this section, we count clinicians using unique national provider identifiers (NPIs).

40 To determine physician specialty, we use the specialty designation that appears on a plurality of each NPI's claims. We classified physicians whose specialties are internal medicine, family medicine, geriatric medicine, or pediatric medicine (with an adjustment to exclude clinicians that are serving as hospitalists) as "primary care physicians." Claims data do not indicate the specialty in which nurse practitioners or physician assistants practice. Therefore, we developed an algorithm to sort these clinicians into primary care or specialty care categories based on (1) the location and types of services they billed, (2) the specialties of the physicians with whom they practiced, and (3) the types of conditions they treated.

41 While more than 20 percent of FFS LIS beneficiaries live in rural areas, only 10 percent of LIS beneficiaries' allowed charges were billed by clinicians practicing in rural areas in 2019. This suggests that many rural beneficiaries travel to urban areas to receive care.

42 States may impose limited cost-sharing requirements for beneficiaries eligible for full Medicaid benefits. However, those cost-sharing amounts are nominal.

43 The limit on payment rates among independent RHCs (i.e., those not owned by a provider) is scheduled to increase from $113 in 2022 to $190 by 2028.

44 As mandated by the Consolidated Appropriations Act, 2021, payment rates for RHCs will increase sharply from 2024 through 2028; by 2028, Medicare's rate for an office visit at an RHC will be about twice the rate paid under the physician fee schedule.

45 From 2011 through 2016, CMS provided incentive payments to primary care clinicians through the Primary Care Incentive Payment (PCIP) program. Under the PCIP program, primary care clinicians were defined as practitioners with a specialty designation of family medicine, geriatric medicine, pediatric medicine, internal medicine, nurse practitioner, clinical nurse specialist, or physician assistant where at least 60 percent of the practitioner's allowed charges paid under the fee schedule were for certain primary care services.

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