CHAPTER 4

Physician and other health professional services

RECOMMENDATION

4 The Congress should:

- for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index; and
- enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

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

CHAPTER 4

Physician and other health professional services

Chapter summary

Medicare's physician fee schedule pays for about 8,000 medical services provided across a variety of care settings. These services include office visits, 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, advanced practice registered nurses (APRNs), and physician assistants (PAs) but also podiatrists, physical therapists, psychologists, and other types of health professionals. In 2022, the Medicare program and its beneficiaries paid $91.7 billion for fee schedule services provided by almost 1.3 million clinicians, accounting for just under 17 percent of spending in Medicare's traditional fee-for-service (FFS) program.

Assessment of payment adequacy

In 2022 and 2023, most clinician payment adequacy indicators remained positive or improved, but clinicians' input costs are estimated to have grown faster than the historical trend.

***Beneficiaries' access to care*—**In the Commission's annual survey, Medicare beneficiaries reported access to clinician services in 2023 that was comparable with, or better than, that of privately insured people. Our findings are consistent with several recent national surveys that have

In this chapter

found that people aged 65 and older (almost all of whom have Medicare coverage) report better access to care than younger adults and that Medicare beneficiaries of any age are more likely than privately insured people to rate their insurance coverage positively. Surveys also indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers paying higher rates. Almost all 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 billing Medicare's physician fee schedule has been growing in recent years, although the composition of the clinician workforce continues to change. Over the last several years, the number of APRNs and PAs has increased rapidly, and the number of specialists has steadily increased, but the number of primary care physicians has slowly declined. Although 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 increasing beneficiary enrollment.

The number of clinician encounters per FFS beneficiary has increased over time, with faster growth from 2021 to 2022 (3.1 percent) compared with the average annual growth rate from 2017 to 2021 (0.7 percent). Growth rates varied by clinician specialty and type of service. From 2021 to 2022, the number of encounters per FFS beneficiary with primary care physicians declined by 0.3 percent while encounters per FFS beneficiary with specialist physicians increased by 1.3 percent and encounters with APRNs and PAs increased by 10.4 percent.

Quality of care—We report three population-based measures of quality of clinician care: risk-adjusted ambulatory care–sensitive (ACS) hospitalization rates, risk-adjusted ACS emergency department (ED) visits, and patient experience measures. In 2022, risk-adjusted rates of ACS hospitalizations and ED visits continued to vary across health care markets. Between 2021 and 2022, patient experience scores in FFS Medicare were relatively stable.

Clinicians' revenues and costs—Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries. Instead, we rely on indirect measures of how FFS Medicare payments compare with the costs of providing services. We find that updates to fee schedule payments have grown more slowly than clinicians'

input cost growth, but increases in the volume and intensity of services furnished by clinicians have resulted in higher physician fee schedule spending per FFS beneficiary. Physicians' compensation has increased at rates similar to the general rate of inflation, which may be partially due to growth in private insurance payment rates and to growth in the volume and intensity of services clinicians have furnished per FFS beneficiary over time.

From 2021 to 2022, physician fee schedule spending per FFS beneficiary grew for most types of services. Among broad service categories, growth rates were 2.2 percent for evaluation and management services, 3.0 percent for imaging, 2.5 percent for other (i.e., nonmajor) procedures, 5.7 percent for treatments, and 6.8 percent for tests. Spending per FFS beneficiary declined by 0.2 percent for major procedures.

In 2022, spending on clinician services by FFS Medicare and its beneficiaries was $1.1 billion lower than it was in 2021. This decline represents a 1.2 percent decrease in fee schedule spending and is attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare, as enrollment in Medicare Advantage continued to grow.

In 2022, private health insurance preferred provider organization (PPO) payment rates for clinician services were, on average, 136 percent of FFS Medicare's payment rates—up from 134 percent in 2021. Survey data suggest that providers are increasingly consolidating into larger organizations to improve their ability to negotiate higher payment rates from private insurers (and to gain access to costly resources and help complying with payers' regulatory and administrative requirements). Compensation and productivity data indicate that, while clinicians who work in hospital-owned practices do not necessarily earn more than those working in clinician-owned practices, they do tend to see fewer patients and bill for fewer services.

All-payer clinician compensation appears to be increasing at rates similar to general inflation. According to SullivanCotter's annual compensation surveys, we found that, from 2021 to 2022, median compensation for physicians grew by 9 percent—a little faster than inflation, which was 8 percent; median compensation for advanced practice providers (e.g., nurse practitioners, PAs) grew by 5 percent. Over a longer, four-year period that includes the recent coronavirus pandemic (2018 to 2022), median compensation for physicians grew by an average of 3.4 percent per year—a little less than inflation, which grew by an average of 3.9 percent per year over this period; median

compensation for advanced practice providers grew by 4.0 percent per year over this period.

Compensation remained much lower for primary care physicians than for most specialists in 2022; we are concerned that comparatively low payment rates for the services that primary care physicians tend to provide may be reducing the appeal of a career in primary care. Starting in 2024, a new add-on payment is available to primary care clinicians (and some specialists) for visits furnished to patients with whom a clinician has an ongoing relationship.

Clinicians' costs, as measured by the Medicare Economic Index (MEI), grew by 1 percent to 2 percent per year for several years before the coronavirus pandemic. MEI growth then increased to 2.5 percent in 2021 and to 4.6 percent in 2022. However, MEI growth is expected to moderate: It is projected to be 4.1 percent in 2023, 3.1 percent in 2024, and 2.6 percent in 2025, although these projections are subject to change. These expected increases in clinicians' input costs are larger than the increases in FFS Medicare payment rates scheduled under current law.

How should fee schedule payment rates change in 2025?

Under current law, Medicare fee schedule payment rates are expected to decline in 2025, due to the expiration of a 1.25 percent pay increase that will apply in 2024 only and a 0 percent update scheduled for 2025. Given recent high inflation, cost increases could be difficult for clinicians to continue to absorb. Yet current payments to clinicians appear to be adequate, based on many of our indicators.

Given these mixed findings, for calendar year 2025, the Commission recommends that the Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the MEI. Based on CMS's MEI projections at the time of this publication, the recommended update for 2025 would be equivalent to 1.3 percent above current law. Our recommendation would be a permanent update that would be built into subsequent years' payment rates, in contrast to the temporary updates specified in current law for 2021 through 2024, which have each increased payment rates for one year only and then expired.

To promote adequate access to care for all Medicare beneficiaries, the Commission also recommends that the Congress establish new permanent safety-net add-on payments for clinician services furnished to FFS Medicare

beneficiaries with low incomes. (We define "low-income" beneficiaries as those dually enrolled in Medicaid and Medicare or receiving the Part D low-income subsidy.) This policy should be consistent with the Commission's March 2023 clinician safety-net recommendation, which called for add-on payments of 15 percent for primary care clinicians and 5 percent for all other clinicians for fee schedule services furnished to low-income FFS Medicare beneficiaries. The Commission determined last year that providing this additional financial support is warranted since clinicians often receive less revenue for treating low-income beneficiaries because of how Medicare's cost-sharing policies interact with state Medicaid payment policies. Yet the cost to clinicians of treating low-income Medicare beneficiaries is likely to be at least as much as, if not higher than, the cost of caring for other beneficiaries. As a result of less revenue and potentially higher treatment costs, these beneficiaries are likely to be less profitable to care for, and therefore could have difficulty accessing care.

We estimate that the Commission's recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by 1.7 percent. The increase for each clinician would vary by their specialty and share of services furnished to low-income beneficiaries. Because primary care clinicians would receive higher add-on payments than non–primary care providers, safety-net payments would increase fee schedule revenue for primary care clinicians by an average of 4.4 percent and for non–primary care clinicians by an average of 1.2 percent.

We estimate that the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3 percent. The effects would differ by provider specialty, with fee schedule revenue increasing by an estimated 5.7 percent, on average, for primary care clinicians and by an estimated 2.5 percent, on average, for other clinicians. ■

Background

To determine fee-for-service (FFS) Medicare payment rates for clinician services, CMS uses a list of relative values for about 8,000 services, known as the physician fee schedule. These relative values are multiplied by the physician fee schedule's conversion factor (a fixed dollar amount equal to $32.74 in 2024) to produce a total payment amount for each service.[1] Medicare's physician fee schedule pays for a wide range of clinician services for FFS beneficiaries, including office visits, surgical procedures, and diagnostic and therapeutic services. When these services are delivered in certain facilities, such as hospitals or ambulatory surgical centers, CMS makes an additional payment through that facility's payment system to pay for nonclinician costs like nursing services, medical supplies, equipment, and rooms (discussed in separate chapters of this report). In such instances, the physician fee schedule payment rate is reduced, but it is normally more than offset by the additional fee Medicare pays through the other payment system (e.g., through the hospital outpatient prospective payment system).

Physician fee schedule spending constitutes just under 17 percent of spending in FFS Medicare (Boards of Trustees 2023).[2] In 2022, the FFS Medicare program and its beneficiaries paid $91.7 billion for physician fee schedule services, which is $1.1 billion less than in 2021. This decline represents a 1.2 percent decrease in fee schedule spending and is largely attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare, as enrollment in Medicare Advantage (MA) continues to grow.

In 2022, almost 1.3 million clinicians, including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), therapists, chiropractors, and other practitioners, billed the Medicare physician fee schedule for services. The number of clinicians billing the fee schedule in 2022 was the same as in the previous year.

Are Medicare fee schedule payments adequate in 2024?

To assess whether FFS Medicare payments for clinician services are currently adequate, we examine indicators in three categories: beneficiaries' access to care, the quality of their care, and clinicians' revenues and costs. In 2022 and 2023, most physician payment adequacy indicators remained positive or improved, but clinicians' input costs grew faster in this period than the historical trend.

Beneficiaries' access-to-care indicators remain relatively positive

Although we cannot say that *all* Medicare beneficiaries have timely access to the care they need, in the Commission's 2023 survey, Medicare beneficiaries continued to report access to care that is comparable with, or better than, that of privately insured people. The share of clinicians accepting Medicare is high and comparable with the share accepting private insurance. Almost all clinicians who treat FFS Medicare beneficiaries accept the physician fee schedule's payment rates as payment in full, despite having the option to balance-bill beneficiaries for higher amounts as a "nonparticipating" provider or to forgo all Medicare payments and choose the price they charge patients by electing to "opt out" of the program. The overall number of clinicians billing FFS Medicare has grown in recent years; adjusting for growth in the number of Medicare beneficiaries (including those in FFS Medicare and MA), the number of clinicians billing Medicare has remained steady. The composition of the clinician workforce continues to change, with the number of APRNs and PAs growing rapidly, the number of specialists growing at a more modest rate, and the number of primary care physicians slowly declining. The number of clinician encounters per beneficiary increased in 2022 to above prepandemic levels for most types of services.

Most beneficiaries reported relatively good access to clinician services in surveys and focus groups

One way we assess Medicare beneficiaries' access to care is by examining data from our annual survey of Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64. Our 2023 survey was completed by over 10,000 respondents in the summer of 2023 and, as with prior years, was weighted to produce nationally representative results.[3] We also draw on findings from local focus groups that we conduct to ask beneficiaries and clinicians about their experiences with health care.[4]

The Commission's survey and focus groups include Medicare beneficiaries in both FFS Medicare and in MA plans. We believe this group is representative of the experiences of FFS beneficiaries because in our analyses of data from the Medicare Current Beneficiary Survey (MCBS) and in research by others, MA enrollees and FFS beneficiaries tend to report comparable experiences accessing care (Koma et al. 2023, Ochieng and Fuglesten Biniek 2022).

Although we cannot say that all Medicare beneficiaries have timely access to the care they need, consistent with last year, our 2023 survey found that Medicare beneficiaries reported access to care that was comparable with, or better than, that of privately insured people (see Table 4A-1 in this chapter's appendix for some of our key findings for Medicare beneficiaries vs. privately insured people, p. 118). (Throughout this section, the shares of Medicare beneficiaries and privately insured people who reported a given experience are statistically significantly different from each other at the 95 percent confidence level unless otherwise noted, in keeping with prior years.)

Relatively high satisfaction with overall access to care Our 2023 survey found that the vast majority of Medicare beneficiaries ages 65 and over (94 percent) and privately insured people ages 50 to 64 (91 percent) had received some kind of health care in the past 12 months. Among these survey respondents, a higher share of Medicare beneficiaries was satisfied with their ability to find health care providers who accepted their insurance (96 percent) compared with privately insured people (91 percent). In addition, among beneficiaries who had received health care, a higher share of Medicare beneficiaries was satisfied with their ability to find health care providers that had appointments when they needed them (87 percent) compared with privately insured people (77 percent). (We included these questions in our survey for the first time this year.) In our focus groups, Medicare beneficiaries also reported high satisfaction with their insurance coverage, with the vast majority of participants rating their coverage as "excellent" or "good" (Campanella et al. 2023).

Nearly all Medicare beneficiaries have a primary care provider Our 2023 survey found that 96 percent of Medicare beneficiaries reported having a primary care provider, compared with 92 percent of privately insured people. This finding is consistent with what we gathered from our focus groups, in which nearly all beneficiaries we spoke to reported having a usual source of primary care. Only a few beneficiaries we spoke to reported not having a primary care provider, often because their provider had retired or left the practice and the beneficiary had not yet found a replacement.

Our survey found that a slightly lower share of Medicare beneficiaries reported receiving most or all of their primary care from a nurse practitioner (NP) or PA (19 percent) compared with privately insured people (22 percent). In our focus groups, although most beneficiaries had a physician as their designated primary care provider, a few beneficiaries saw an NP or PA as their primary care provider. Those who had an NP or PA as their regular primary care provider cited a variety of reasons, including switching from a physician to an NP or PA as their primary care provider when their physician retired, choosing to see an NP in their practice when they had communication issues with their physician, or generally preferring NPs and/or PAs to physicians.

Medicare beneficiaries report fewer problems finding a new clinician than privately insured people In our 2023 survey, 12 percent of Medicare beneficiaries and 15 percent of privately insured people reported looking for a new primary care provider. Among those respondents, a smaller share of Medicare beneficiaries reported a "big problem" finding one (23 percent) compared with privately insured people (33 percent); an additional third of each group reported a "small problem" finding one. These amounts are equivalent to 7 percent of all Medicare beneficiaries and 10 percent of all privately insured people experiencing some kind of problem finding a new primary care provider.

In our focus groups, many beneficiaries reported seeking a new primary care provider in recent years, and the ease of getting a new clinician varied. Beneficiaries we spoke to who were seeking a new primary care provider described looking online; calling new practices to try to make an appointment; asking a current provider or friends for referral; and, in a few cases, seeking out NPs and PAs, who often have more availability than physicians. Across clinicians in our focus groups, nearly all were accepting new Medicare patients. Those clinicians who were not accepting

new patients said that they had full patient panels, and generally their practices would open to new patients again when capacity allowed.

About a third of respondents reported looking for a new specialist in the past 12 months, and among those looking, a smaller share of Medicare beneficiaries reported a "big problem" finding a new specialist (13 percent) compared with privately insured people (18 percent). An additional quarter of each group reported a "small problem" finding a new specialist. These figures are equivalent to 11 percent of Medicare beneficiaries and 15 percent of privately insured people experiencing some kind of problem finding a specialist. In our focus groups, beneficiaries' experiences accessing specialty care varied, with reported wait times ranging from a few days to six months, depending on the specialty, location, and demand for the provider.

Most patients looking for a new mental health professional experience problems finding one This year, we included questions in our survey about access to mental health professionals. We found that only a small share of people tried to get a new mental health professional in the past 12 months—3 percent of Medicare beneficiaries and 7 percent of privately insured people. However, among those looking for a mental health professional, a majority experienced problems finding one (63 percent of Medicare beneficiaries and 70 percent of privately insured people—not a statistically significant difference, given how few people looked for this type of clinician). These figures are equivalent to an estimated 2 percent of Medicare beneficiaries and 5 percent of privately insured people experiencing a problem finding a mental health professional.

Shorter waits for appointments for an illness or injury compared with routine care Among survey respondents who needed an appointment for regular or routine care, a smaller share of Medicare beneficiaries reported that they "usually" or "always" had to wait longer than they wanted to get such an appointment (13 percent) compared with privately insured people (23 percent). People had less difficulty getting an appointment for an illness or injury; only 8 percent of Medicare beneficiaries reported "usually" or "always" waiting longer than they wanted to get this type of appointment, compared with 15 percent of privately insured people. One possible theory for our finding that fewer Medicare beneficiaries reported excessive waits for appointments is that Medicare beneficiaries are more likely to be retired and thus may have more scheduling flexibility, which might allow them to be seen sooner than privately insured people working full-time.[5]

In our focus groups, most beneficiaries described having timely access to primary care. For a routine checkup or follow-up visit, beneficiaries reported wait times ranging from a few days to 30 days. Many focus group participants reported that they can often be seen by their primary care provider within a few days for acute issues or sick visits. Some beneficiaries across groups reported going to urgent care instead of seeing their primary care provider when they had acute but nonemergency health needs. Using urgent care outside of their clinician's business hours was a common scenario shared by beneficiaries.

Patients sometimes forgo care, but not necessarily due to difficulties accessing care In our 2023 survey, a smaller share of Medicare beneficiaries reported forgoing care that they thought they should have gotten in the past 12 months (20 percent) compared with privately insured people (27 percent). The most common reasons Medicare beneficiaries did not obtain such care were that they did not think the problem was serious (reported by 5 percent of beneficiaries overall); they just put it off (which another 5 percent reported); or they could not get an appointment soon enough (which 4 percent reported). Only 1 percent of Medicare beneficiaries said they put off care because they could not find a doctor who would treat them, and only 1 percent said they put off care because they thought it would cost too much.

Beneficiaries with lower incomes report obtaining less care In our 2023 survey, Medicare beneficiaries with household incomes of less than $50,000 per year reported obtaining less care than beneficiaries with household incomes of $80,000 or more. Lower-income beneficiaries were less likely than higher-income beneficiaries to have obtained any type of health care in the past 12 months (91 percent vs. 97 percent) and more likely to have forgone care that they thought they should have gotten (23 percent vs. 17 percent). They were also less likely to have seen multiple

specialists (44 percent vs. 64 percent) and less likely to have tried to find a new specialist (26 percent vs. 38 percent) in the past 12 months.

Lower-income beneficiaries were also more likely to get most or all of their primary care from an NP or PA (22 percent vs. 14 percent of higher-income beneficiaries), and they were less likely to report that they usually or always had to wait longer than they wanted for appointments for regular or routine care (11 percent vs. 15 percent of higher-income beneficiaries, among those needing this type of appointment) or for illness or injury care (7 percent vs. 10 percent of higher-income beneficiaries, among those needing this type of appointment). Since our survey questions ask for a subjective assessment of whether a wait was longer than a respondent wanted and not for an objective count of the number of days or weeks a respondent had to wait for an appointment, we cannot discern whether lower-income beneficiaries actually experienced shorter waits for appointments or whether they simply had different expectations about how quickly they should be able to be seen.[6]

There were no statistically significant differences in the shares of Medicare beneficiaries of lower and higher incomes who had the following experiences: were satisfied with their ability to find providers that accepted Medicare and were satisfied with their ability to find providers that had appointments when they needed them (among respondents who received care in the past 12 months); had a primary care provider; looked for a new primary care provider or mental health professional; or had problems finding a new primary care provider or mental health professional (among those looking). (See Table 4A-2, p. 119, in this chapter's appendix for key survey results broken out by beneficiaries' household income.)

Concerns about access to care among low-income beneficiaries prompted the Commission to recommend in March 2023 that the Congress enact a safety-net add-on payment for fee schedule services delivered to these beneficiaries (see text box on supporting clinicians who furnish care to Medicare beneficiaries with low incomes, pp. 114–115).

Differences in access by race/ethnicity in our survey Black and Hispanic Medicare beneficiaries had care experiences similar to those of White beneficiaries, according to most questions in our survey.[7] We did, however, find some differences by race and ethnicity related to obtaining care. Smaller shares of Hispanic beneficiaries (86 percent) and Black beneficiaries (92 percent) reported receiving any health care in the past year compared with White beneficiaries (95 percent). Smaller shares of Hispanic beneficiaries (35 percent) and Black beneficiaries (44 percent) reported seeing multiple specialists compared with White beneficiaries (55 percent). And a smaller share of Black beneficiaries reported looking for a new specialist (23 percent) compared with White beneficiaries (33 percent). (See Table 4A-3, p. 120, in the appendix for additional survey results for White, Black, and Hispanic beneficiaries.)

Mix of clinicians seen by beneficiaries in rural and urban areas varies somewhat Urban and rural Medicare beneficiaries reported comparable experiences and satisfaction levels on most questions in our survey, but we observed differences between them in the mix of clinicians they saw. A higher share of rural Medicare beneficiaries reported receiving all or most of their primary care from an NP or PA (29 percent) compared with urban beneficiaries (17 percent). A smaller share of rural beneficiaries reported seeing multiple specialists in the past year (42 percent) compared with urban beneficiaries (55 percent). And a smaller share of rural beneficiaries reported trying to find a new specialist in the past 12 months (23 percent) compared with urban beneficiaries (34 percent). (See Table 4A-4, p. 121, in this chapter's appendix for additional survey results for rural and urban beneficiaries.)

Other surveys also find that Medicare beneficiaries have relatively good access to care Our 2023 survey's overall finding that Medicare beneficiaries reported access to care that is comparable with, or better than, that of privately insured people is consistent with a 2023 KFF survey that compared the experiences of Medicare beneficiaries (of any age) with individuals who had employer-sponsored insurance, Marketplace plans, and other coverage. KFF's survey found that, compared with privately insured people, Medicare beneficiaries were more likely to rate their insurance positively, less likely to report issues affording medical bills, and less likely to report delaying or forgoing a visit to a doctor's office because of the cost (Pollitz et al. 2023).

Our survey findings are also consistent with several federally funded surveys that find that Medicare-aged

people report better access to care than younger adults—which could mean that gaining Medicare coverage makes it easier for some people to access health care. For example, the Medical Expenditure Panel Survey has found that around age 65, when most people gain eligibility for Medicare, there are fewer reports of being unable to access 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 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).

CMS's 2021 MCBS produced findings similar to those of the Commission's survey. For example, 93 percent of FFS beneficiaries (of all ages, not just those ages 65 and over) reported having a usual source of care that was not a hospital emergency department or an urgent care center, 95 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 (6 percent) reported experiencing trouble getting care in the past year—more often due to cost, as opposed to clinicians not accepting Medicare.

Beneficiaries under age 65 report worse access to care than beneficiaries ages 65 and over One subgroup of Medicare beneficiaries that reports notably worse access to care in CMS's survey is beneficiaries under age 65 (most of whom are disabled). For example, our analysis of the 2021 MCBS found that these beneficiaries were twice as likely as beneficiaries ages 65 and over to report having trouble getting health care (14 percent vs. 6 percent) and to report forgoing care that they thought they should have gotten (12 percent vs. 6 percent). They were four times more likely to report having a problem paying a medical bill (20 percent vs. 5 percent). Part of the reason for these difficulties may be that beneficiaries under age 65 tend to require more health care services than beneficiaries ages 65 and over, yet have lower incomes than beneficiaries ages 65 and over (Cubanski et al. 2016, Medicare Payment Advisory Commission 2023a).

We saw a number of other, smaller differences between beneficiaries under age 65 and beneficiaries ages 65 and over on MCBS questions. For example, beneficiaries under age 65 were somewhat less likely to report having a usual source of care that is not a hospital emergency department or an urgent care clinic compared with beneficiaries ages 65 and over (90 percent vs. 94 percent). They were also less likely to report that their usual care provider spent enough time with them (92 percent vs. 95 percent). Beneficiaries under age 65 were less likely to report seeing their usual care provider in the past 12 months compared with beneficiaries ages 65 and over (88 percent vs. 92 percent) despite being much more likely to report being in "poor" or "fair" health (49 percent vs. 16 percent). Beneficiaries under age 65 were also less likely to report being satisfied with the availability of care by specialists (87 percent vs. 93 percent) and less likely to report being satisfied with the ease with which they can get to a doctor from where they live (91 percent vs. 96 percent).

The number of clinicians billing Medicare has increased, but the mix has changed

From 2017 to 2022, the total number of clinicians billing the fee schedule increased by an average of 2.4 percent per year. This increase ensured that the number of clinicians serving the Medicare population grew commensurately with Medicare enrollment (including those in FFS Medicare and MA). Therefore, the number of total clinicians per Medicare beneficiary remained stable, although the mix of clinicians has changed over time.

We limited this part of our analysis to clinicians 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 therefore are 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).[8] 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).

TABLE 4–1

The number of clinicians billing Medicare's physician fee schedule has increased and the mix of clinicians has changed, 2017–2022

	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
Year	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total
2017	140	455	218	168	981	2.6	8.5	4.1	3.1	18.4
2018	139	462	237	174	1,012	2.5	8.4	4.3	3.2	18.5
2019	138	468	258	180	1,045	2.5	8.4	4.6	3.2	18.7
2020	135	468	268	172	1,044	2.4	8.2	4.7	3.0	18.2
2021	134	473	286	180	1,073	2.3	8.1	4.9	3.1	18.4
2022	133	477	308	185	1,103	2.2	8.0	5.2	3.1	18.5

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialty" 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. This table includes only physicians with a caseload of more than 15 fee-for-service 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. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2023 annual report of the Boards of Trustees of the Medicare trust funds.

Using our threshold, we found that the total number of clinicians billing the fee schedule between 2017 and 2022 grew from about 981,000 to 1,103,000 (Table 4-1). Over the same period, the total number of clinicians per 1,000 beneficiaries (including those in FFS Medicare and MA) increased slightly from 18.4 to 18.5.[9] (In 2020, the ratio of all clinicians to beneficiaries declined to 18.2 due to the effects of the pandemic.[10])

While the total number of clinicians billing the fee schedule rose between 2017 and 2022, trends varied by type and specialty of clinician. Since 2017, 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 2022. As a result, the number of primary care physicians per Medicare beneficiary declined over the period from 2.6 to 2.2. The total number of specialist physicians increased over the 2017 to 2022 period from 455,000 to 477,000, but because of growth in the number of Medicare beneficiaries, the ratio of specialist physicians to beneficiaries decreased from 8.5 to 8.0. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 218,000 to 308,000, or from 4.1 per 1,000 beneficiaries to 5.2 per 1,000 beneficiaries.[11] Meanwhile, the number of other practitioners, such as physical therapists and podiatrists, also increased, but the ratio of these practitioners per 1,000 beneficiaries was stable.

Most clinicians accept Medicare Several data sources suggest that the share of clinicians who accept Medicare is relatively high and comparable with the share who accept private health insurance, even though Medicare payment rates are usually lower than private health insurers' payment rates.

In a 2022 survey by the American Medical Association (AMA), among nonpediatric physicians accepting new patients, 96 percent reported accepting new Medicare patients; 2 percent said they accepted only

new privately insured patients (American Medical Association 2023b). The AMA survey found that acceptance of Medicare varied by clinical setting and by medical specialty. Among those accepting new patients, larger shares of physicians in hospital-owned practices accepted Medicare (98.6 percent) compared with physicians in private practice (94.1 percent), although both shares were high. And among those accepting new patients, larger shares of specialists accepted Medicare (e.g., 99.6 percent of internal medicine subspecialists, 99.4 percent of general surgeons, 98.7 percent of radiologists) compared with family medicine physicians (94 percent)—but again, all of these rates were high. (One specialty with notably low acceptance of Medicare was psychiatry: Among those taking new patients, only 80.7 of psychiatrists accepted new Medicare patients.)

A survey that focuses on the subset of physicians who work in office-based settings also found that comparable shares of physicians accepted Medicare and private insurance. In 2021, the National Ambulatory Medical Care Survey found that, among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, 89 percent accepted new Medicare patients and 88 percent accepted new privately insured patients (Schappert and Santo 2023).

Looking from the perspective of patients trying to find a new provider, a 2023 KFF survey confirmed that health care providers accept privately insured patients and Medicare beneficiaries at similar rates. This survey specifically found that similar shares of people with Medicare, employer-sponsored insurance, and Marketplace coverage encountered a doctor or hospital that was not covered by their insurance or encountered a doctor who is covered by their insurance but did not have available appointments (Pollitz et al. 2023).

CMS administrative data also confirm that a high share of clinicians accept Medicare. In 2022, 98 percent of clinicians billing the physician fee schedule were participating providers, meaning that 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 this option: In 2022, 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 choose the price they charge patients and bill beneficiaries directly for their services but receive no payment from Medicare. Consistent with prior years, the number of clinicians who opted out of Medicare as of September 2023 (31,600) was extremely low compared with the 1.3 million clinicians who participated in the program in 2022 (Centers for Medicare & Medicaid Services 2023c).[12]

There are many reasons that clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A substantial share of most clinicians' patients are covered by Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their patient panels. In addition, physicians who are employed by hospitals or health plans may be required to accept Medicare as a condition of employment, and some hospitals may require physicians to participate in Medicare to receive admission and clinical privileges. At the same time, though commercial rates may be comparatively high, commercial insurers often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to appeal denied claims and complete insurers' prior authorization paperwork. A recent AMA survey found that physicians complete an average of 45 prior authorization requests per week, requiring 14 hours per week, and 35 percent of physicians have dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2023a). In contrast, FFS Medicare generally requires no prior authorization for services and is known as a prompt payer since it is required to pay "clean" claims within 30 days and must pay providers interest on any late payments. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates.

The total number of clinician encounters per beneficiary grew from 2017 to 2022

We use the quantity of beneficiaries' encounters with clinicians as another measure of access to care. We use a claims-based definition of encounters.[13] Clinicians

TABLE 4–2

Total encounters per beneficiary were higher in 2022 compared with 2017, and the mix of clinicians furnishing them changed

	Encounters per FFS beneficiary			Percent change in encounters per FFS beneficiary	
Specialty category	2017	2021	2022	Average annual 2017–2021	2021–2022
Total (all clinicians)	21.5	21.6	22.3	0.1%	3.1%
Primary care physicians	3.7	3.1	3.1	–3.7	–0.3
Specialists	12.7	12.3	12.4	–0.8	1.3
APRNs/PAs	2.0	2.7	3.0	8.0	10.4
Other practitioners	3.2	3.5	3.7	2.3	6.7

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define an "encounter" as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician 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 beneficiaries and 2023 annual report of the Boards of Trustees of the Medicare trust funds.

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 98 percent of beneficiaries enrolled in FFS Medicare had at least one encounter in 2022.[14]

The total number of encounters per FFS Medicare beneficiary grew from 21.5 in 2017 to 22.3 in 2022 (Table 4-2). The average annual growth rate was 0.7 percent, although encounters for some types of services declined over the period (data not shown).

Change in the number of encounters per beneficiary varied by specialty and type of provider The number of encounters per beneficiary furnished by primary care and specialist physicians declined from 2017 to 2022, and the number of encounters per beneficiary provided by other types of clinicians increased (Table 4-2).[15] Encounters with APRNs and PAs grew the fastest. (The declines observed over the 2017 to 2021 period were largely due to the effects of the pandemic, when encounter volume fell sharply for almost all services. Data for 2022 indicate that encounters for most providers and types of services have begun increasing again.)

The 3.7 percent average annual decline in encounters per beneficiary with primary care physicians over the 2017 to 2021 period slowed in 2022, falling by just 0.3 percent that year. Encounters per beneficiary with specialists also fell over the 2017 to 2021 period, from 12.7 to 12.3, but grew by 1.3 percent in 2022. APRNs and PAs saw the largest increase in encounters, which grew by 10.4 percent in 2022. There was broad growth across different types of services in APRN and PA encounters: From 2021 to 2022, APRNs and PAs delivered 11.2 percent more E&M services, 13.1 percent more "other procedures," 10.6 percent more treatment services, 16.3 percent more imaging, and 11.2 percent more tests (data not shown). The exception was anesthesia, for which encounters with APRNs and PAs fell by 1.4 percent.

The number of encounters with APRNs and PAs has grown rapidly, but we are likely undercounting the number of fee schedule encounters provided by these

TABLE 4–3

Encounters per FFS beneficiary across service types, 2017–2022

	Encounters per FFS beneficiary			Change in encounters per FFS beneficiary	
Type of service	**2017**	**2021**	**2022**	**Average annual 2017–2021**	**2021–2022**
Total (all services)	21.5	21.6	22.3	0.1%	3.1%
Evaluation and management	12.8	12.7	13.0	–0.1	2.2
Major procedures	0.2	0.2	0.2	–0.7	2.2
Other procedures	2.3	2.3	2.3	–0.4	2.6
Treatments	2.4	2.7	2.9	2.6	7.9
Imaging	4.1	4.1	4.2	–0.5	2.9
Tests	2.0	1.9	2.0	–0.9	2.8
Anesthesia	0.5	0.5	0.5	0.0	–0.5

Note: FFS (fee-for-service). We define an "encounter" as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician 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 are 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 beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

clinicians due to "incident to" billing, under which Medicare allows services furnished by APRNs and PAs to be indirectly billed as "incident to" a physician visit, using the national provider identifier of a supervising physician if certain conditions are met. One study used Medicare claims data to estimate that in 2018, about 40 percent of office visits provided by APRNs and PAs were indirectly billed incident to a physician visit (Patel et al. 2022). 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 a more accurate count of the number of beneficiary encounters with different types of clinicians (Medicare Payment Advisory Commission 2019). These changes would also enable policymakers to better understand whether services provided by APRNs and PAs are disproportionately substituting for primary care services or specialty care services.

From 2017 to 2021, the number of encounters per beneficiary declined for almost all types of services—mostly as a result of decreases experienced during the pandemic (Table 4-3). Then, from 2021 to 2022, encounters for most types of service grew, with some differences across broad service categories. For example, the number of E&M encounters per beneficiary provided by all clinicians rose 2.2 percent, from 12.7 to 13.0. Over the same time period, anesthesia encounters fell by 0.5 percent, while encounters involving treatment (such as physical therapy, treatment for cancer, and dialysis) increased most rapidly (7.9 percent).

Quality of clinician care is difficult to assess

The quality of care provided by individual clinicians is difficult to assess for a few reasons. First, Medicare does not collect clinical information (e.g., blood pressure, lab results) or patient-reported outcomes

TABLE 4–4

Distribution of risk-adjusted rates of ambulatory care–sensitive hospitalizations and emergency department visits across hospital service areas, 2022

	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	21.1	30.0	40.9	1.9
Ambulatory care–sensitive ED visits	37.2	61.7	96.7	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 HSA with fewer than 1,000 FFS Medicare beneficiaries.

Source: MedPAC's analysis of of 2022 FFS Medicare claims data.

(e.g., improving or maintaining physical and mental health) at the FFS beneficiary level. Second, CMS measures the performance of clinicians using the Merit-based Incentive Payment System (MIPS), which, in March 2018, the Commission recommended eliminating because it is fundamentally flawed (Medicare Payment Advisory Commission 2018b). For example, MIPS allows clinicians to choose what measures to report from a catalog of hundreds of measures, which makes it harder to compare clinicians since only a few clinicians may report a certain measure. Also, many clinicians are exempt from reporting quality data for MIPS (e.g., if they see 200 or fewer Medicare beneficiaries or bill Medicare for $90,000 worth of services or less), so there is a sizable share of clinicians for whom CMS has no quality information. Third, for claims-based measures, Medicare's "incident to" policies obscure the ability to determine who actually performed a service because a substantial portion of services performed by APRNs and PAs appear in claims data to have been performed by physicians. As noted above, in June 2019, the Commission recommended requiring APRNs and PAs to bill the Medicare program directly.

We report on the quality of the ambulatory care environment for beneficiaries in FFS Medicare using outcome measures that assess ambulatory care–sensitive (ACS) hospitalizations and emergency department (ED) visits, as well as patient experience measures (using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)).[16] 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: ACS hospitalizations and ED visits

The Commission developed two claims-based outcome measures—ACS hospitalizations and 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 entails hospital use that could have been prevented with timely, appropriate, high-quality care. For example, 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.

Consistent with previous years, in 2022, 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).[17] This variation signals opportunities to improve the quality of ambulatory care (Table 4-4). The HSA at the 90th percentile of ACS hospitalizations had a rate that was almost twice 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 indicates opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can indicate best practices for ambulatory care systems.

The median risk-adjusted ACS hospitalization and ED visit rates per HSA were relatively consistent from 2021 to 2022 (data not shown). However, the risk-adjusted rates went down (improved) substantially in 2021 and 2022 compared with 2019. For example, in 2019 the median ACS ED visit rate per HSA was 98.6 per 1,000 FFS beneficiaries compared with a median rate of 61.7 per 1,000 FFS beneficiaries in 2022 (Medicare Payment Advisory Commission 2021). Overall, ED visits for services unrelated to COVID-19 have declined 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 2021 to 2022 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 ACS ED visit). It is difficult to untangle whether and how much of the decline in ACS ED visits is due to these and other changes in ED use or because of improved quality of care.

Disparities in rates of risk-adjusted ACS hospitalizations and ED visits for FFS beneficiaries with different social risks We have found disparities in rates of ACS hospitalizations and ED visits across different groups of Medicare beneficiaries, which could indicate differential access to high-quality ambulatory care (Medicare Payment Advisory Commission 2023b). For example, beneficiaries receiving the Part D low-income subsidy (a proxy for low income) had rates of ACS hospitalization that were 1.3 times higher than those of other beneficiaries. Black beneficiaries had a rate of ACS ED visits that was 2.1 times higher than that of Asian/Pacific Islander beneficiaries. Outcomes for low-income beneficiaries were worse across race/ethnicity categories. However, even within income categories, differences across the race/ethnicity groups persisted. For example, among non-LIS beneficiaries, Black beneficiaries had a rate of ACS hospitalizations that was 1.8 times higher (worse) than that of Asian/Pacific Islander beneficiaries.

Patient experience scores

The Agency for Healthcare Research and Quality's CAHPS surveys generate standardized and validated measures of patient experience. 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 and how often it happened, from the patient's perspective. 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 to measure beneficiaries' experience of care with Medicare and their FFS providers.

Between 2021 and 2022, FFS CAHPS measure scores were relatively stable. The 2022 FFS CAHPS measure score for "getting needed care and seeing specialists" was 80 (score on a scale of 0 to 100) and the score for "getting appointments and care quickly" was 75; both measures have been trending downward over the past five years (Table 4-5, p. 104). The score for "rating of health plan (FFS Medicare)" was 83, which has been stable over the past five years. The "rating of health care quality" score returned to the prepandemic score of 85. In 2022, 77 percent of surveyed beneficiaries reported receiving an annual flu vaccine, a measure that has improved over the years.

Clinicians' revenues and compensation have increased, but inflation has been higher than usual

Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services. Instead, we rely on indirect measures of how Medicare payments compare with costs of providing services. We find that Medicare payment rate updates have grown more slowly than clinicians' input cost growth, especially in the last few

TABLE 4–5

Medicare FFS CAHPS® performance scores, 2018–2022

CAHPS composite measure	2018	2019*	2020	2021	2022	Score change, 2018–2022
Getting needed care and seeing specialists	83%	–	83%	81%	80%	–3
Getting appointments and care quickly	77	–	78	75	75	–2
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	85	–	85	85	85	0
Rating of health plan (FFS Medicare)	83	–	84	83	83	0
Rating of health care quality	85	–	86	87	85	0
Annual flu vaccine	74	–	77	77	77	3

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 also converts to a linear mean score on a 0 to 100 scale. The question in row 6 is a yes/no response.
*CMS halted collection of the 2019 beneficiary experience survey at the start of the coronavirus pandemic in 2020.

Source: FFS CAHPS mean scores provided by CMS.

years, but increases in the volume and intensity of services furnished by clinicians have resulted in higher physician fee schedule spending per FFS beneficiary. Physicians' all-payer compensation has increased at rates similar to the general rate of inflation, which may be partially due to growth in private insurance payment rates as well as to growth in the volume and intensity of services clinicians have furnished per Medicare beneficiary over time.

Medicare's conversion factor has not grown in recent years, but payment rates for E&M visits have increased substantially

Payment rates are updated each year by updating the fee schedule's conversion factor.[18] (All other things equal, increasing the conversion factor by 1 percent results in a 1 percent increase to payment rates.) In most years, the update to the conversion factor reflects two factors: (1) a percentage specified in statute (which may be zero) and (2) if necessary, a budget-neutrality adjustment. The budget-neutrality adjustment is a percentage arrived at by CMS to ensure that any changes it has made to the relative values of particular billing codes in the fee schedule do not, in and of themselves, increase or decrease total physician fee schedule spending.

The statutory update to the conversion factor is currently specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (shown in the "Update" rows of Table 4-6). MACRA specified that clinicians' payment rates were to be updated by 0 percent from 2020 to 2025. Starting in 2026, payment rates will increase by 0.75 percent per year for clinicians in advanced alternative payment models (A–APMs) and by 0.25 percent per year for all other clinicians.[19] (Examples of A–APMs include accountable care organization models that require providers to take on some financial risk.)

In 2021, CMS increased the payment rates for office and outpatient E&M visits, upon the recommendation of the AMA/Specialty Society Relative Value Scale

TABLE 4–6

Physician fee schedule payment rate updates, adjustments, and bonuses under current law

	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 +1.8%)	(–9% to +1.9%)	(–9% to +2.3%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)
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), N/A (not applicable), MIPS (Merit-based Incentive Payment System). "One time" adjustments apply in a given year only and are not included in subsequent years' payment rates. A–APM bonuses and MIPS adjustments are based on clinicians' A–APM participation and quality measure performance from two years prior. The annual change to the conversion factor (a fixed dollar amount) for Medicare's physician fee schedule is based on (1) the updates specified in law (e.g., 0 percent plus a one-time increase of 1.25 percent in 2024); (2) expiration of one-time increases (e.g., the one-time increase of 2.5 percent in 2023); (3) CMS's budget-neutrality adjustment (e.g., –2.2 percent in 2024), which ensures that changes to the relative values of particular billing codes in the fee schedule do not change total physician fee schedule spending by more than $20 million (not shown); and (4) the –2 percent sequester (which applies for one year at a time and is not built into subsequent years' payment rates).
*Includes $500 million of additional MIPS adjustments per year for "exceptional" performance through 2024. The maximum positive MIPS adjustments shown for 2021–2023 are the highest adjustments actually made in those years, while the maximum adjustments for 2024 and onward are theoretical maximums specified in law. In 2024, the maximum MIPS adjustment is up to +9% plus $500 million for exceptional performance (not shown).

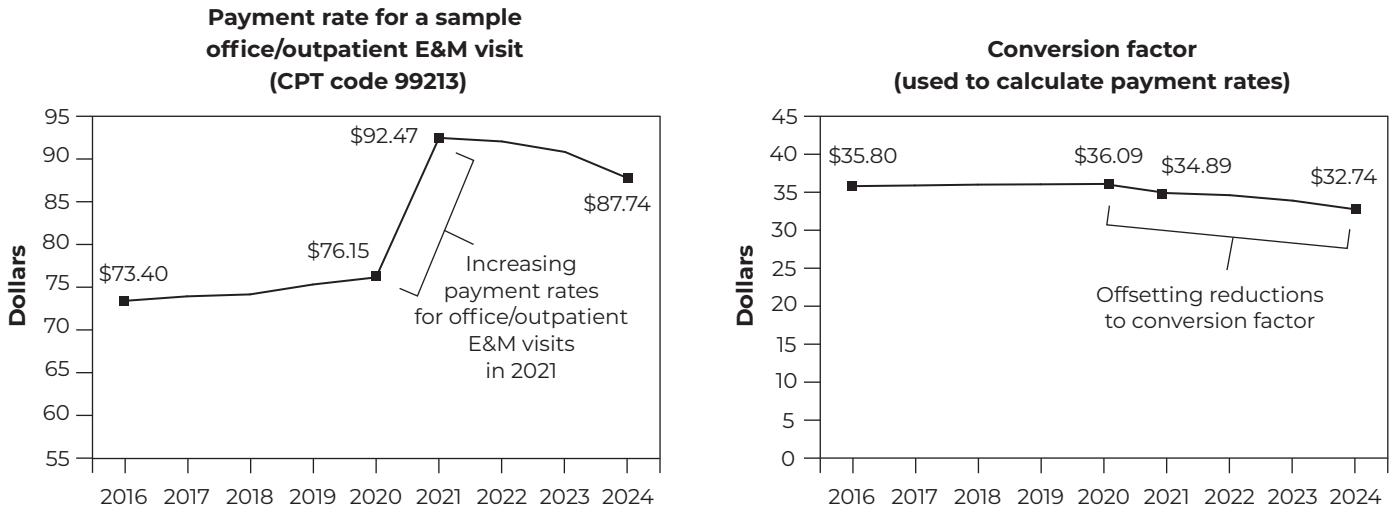
Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015; the Coronavirus Aid, Relief, and Economic Security Act; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes; the Protecting Medicare and American Farmers from Sequester Cuts Act; and the Consolidated Appropriations Act, 2023; also CMS's final rules for the physician fee schedule for the payment years shown.

Update Committee (the RUC). Increasing the payment rates for these billing codes required an offsetting –6.8 percent budget-neutrality adjustment to the fee schedule's conversion factor. To avoid a reduction of this size to the conversion factor (and, thus, to payment rates) in 2021, the Congress subsequently passed laws that provided a series of one-year-only increases to the conversion factor that decline in size from 2021 through 2024 (shown in the "Payment increase (one time)" row of Table 4-6). These increases effectively phase in the 6.8 percent reduction to the conversion factor over time. As a result, payment rates for office and outpatient E&M visits (which are provided by a wide variety of clinicians) have increased substantially (shown at left in Figure 4-1, p. 106), while the conversion factor has declined (shown at right in Figure 4-1, p. 106).

In 2024, part of the 3.4 percent decline in the conversion factor that year (captured at right in Figure 4-1, p. 106) is also offsetting the cost of a new add-on

FIGURE 4–1

Increases to payment rates for office/outpatient E&M visits required offsetting decreases to the conversion factor



Note: E&M (evaluation and management), CPT (Current Procedural Terminology). The "office/outpatient E&M visit" code set refers to CPT codes 99202–99205 (new patients) and 99211–99215 (established patients). CPT code 99213 refers to a visit involving a low level of medical decision-making; if time is used for code selection, 20–29 minutes are spent on the date of the encounter. Payment rates shown for 99213 are nonfacility national payment rates. The right graph captures a budget-neutrality adjustment made to the conversion factor in 2024 to account for the cost of a new add-on code (G2211).

Source: Centers for Medicare & Medicaid Services. 2023. "Search the physician fee schedule" (interactive billing code payment rate look-up website), https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

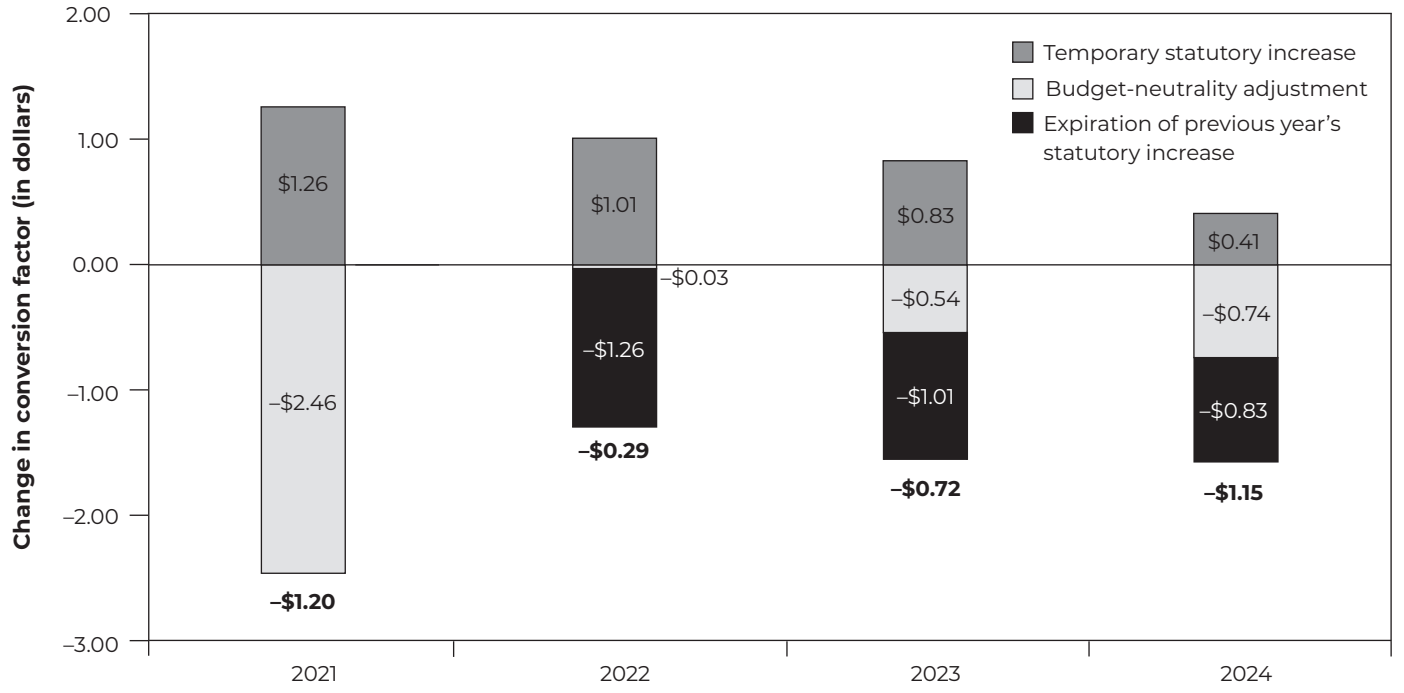
code that will add another $16 to the payment rate for office/outpatient E&M visits provided by clinicians who have an ongoing relationship with a patient (which will be in addition to the payment amount shown at left in Figure 4-1). This add-on code is expected to be used by primary care clinicians and by specialists treating a patient's serious or complex medical condition (Centers for Medicare & Medicaid Services 2023b).[20]

Figure 4-2 shows net annual changes in the conversion factor resulting from budget-neutrality adjustments and temporary one-year statutory increases over the 2021 to 2024 period. In 2021, CMS's required budget-neutrality adjustment of –$2.46 was partially offset by $1.26 resulting from the Congress's temporary statutory increase of 3.75 percent, for a net change in the conversion factor of –$1.20. In 2022, a net change in the conversion factor of –$0.29 was due to the combined effects of the expiration of the 2021 temporary increase (–$1.26), a small budget-neutrality adjustment ($0.03), and the Congress's temporary statutory increase of 3 percent ($1.01). For 2023, a net change in the conversion factor of $0.72 resulted from the combined effects of the expiration of the 2022 temporary increase (–$1.01), a budget-neutrality adjustment of –$0.54, and the Congress's temporary statutory increase of 2.5 percent ($0.83). If the current-law statutory update and budget-neutrality adjustment scheduled for 2024 are in effect, the conversion factor will be reduced by $1.15 and will be $3.35 less than what it was in 2020 (latter data not shown).

Allowed charges per beneficiary grew at about the same rate from 2021 to 2022 as during previous years

Despite the recent reduction in the conversion factor, the total payments that clinicians received per FFS beneficiary grew from 2021 to 2022, in part because clinicians continued to increase the volume and/or intensity of services they deliver. We measure the total

FIGURE 4–2 **Recent declines in the conversion factor are the result of several countervailing effects**



Note: Changes shown for 2024 are based on information published in the final physician fee schedule rule for that payment year. Components may not sum to totals due to rounding.

Source: Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2022, Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2020.

payments a clinician receives using allowed charges (which include Medicare payments and beneficiary cost sharing) for services furnished to FFS beneficiaries that are paid under the physician fee schedule.[21]

We also present changes in units of service per beneficiary. For most types of service, a unit of service represents one individual service, such as an office visit, surgical procedure, or imaging scan. A difference between a change in allowed charges and a change in units of service means that a factor other than volume is affecting the amount of allowed charges being generated. For example, if providers substitute high-resolution computed tomography (CT) scans for regular CT scans, the allowed charges for imaging services would increase at a higher rate than would units of service for imaging. However, there are other reasons that changes in allowed charges can diverge from changes in service units. For example, increases in allowed charges may be attributable to increases in Medicare's payment rates for certain services. Also, decreases in allowed charges could be related to the movement of services from freestanding offices to the outpatient hospital setting where fee schedule payments are lower.

As measured by units of service per beneficiary, the volume of clinician services grew somewhat more quickly over the 2021 to 2022 period (4.0 percent) than it did during the prepandemic years covering 2017 to 2019 (2.4 percent) (Table 4-7, p. 108).[22] Volume growth during both periods of time varied by type of service, but growth rates were higher in 2022 than during the 2017 to 2019 period, except for major procedures and anesthesia.

TABLE 4–7 **Growth in allowed charges per FFS beneficiary varied by type of service, 2017–2022**

Type of service	Change in units of service per FFS beneficiary		Change in allowed charges per FFS beneficiary		Share of 2022 allowed charges
	Annual average 2017–2019	2021–2022	Annual average 2017–2019	2021–2022	
All services	**2.4%**	**4.0%**	**2.9%**	**2.8%**	**100.0%**
Evaluation and management	1.2	2.4	2.3	2.2	51.6
Imaging	1.8	3.0	2.7	3.0	10.8
Major procedures	1.8	0.1	3.6	–0.2	7.2
Other procedures	2.0	3.2	3.7	2.5	12.8
Treatments	6.7	10.0	5.7	5.7	10.0
Tests	1.9	2.7	1.9	6.8	4.7
Anesthesia	1.7	0.8	1.9	0.7	2.5

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. Components may not sum to total allowed charges due to rounding

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

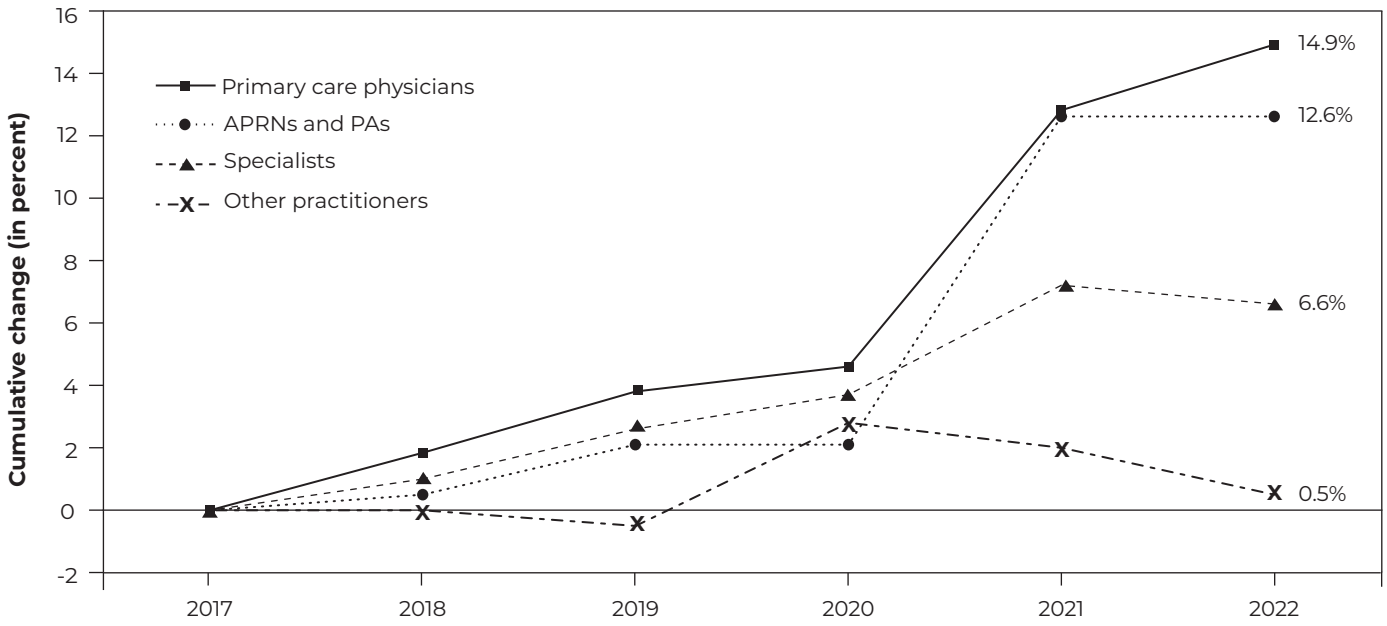
From 2021 to 2022, across all services, allowed charges per beneficiary rose by 2.8 percent. Among broad service categories, growth rates were 2.2 percent for E&M services, 3.0 percent for imaging services, 2.5 percent for other procedures (i.e., procedures that are not considered major procedures), 5.7 percent for treatments, 6.8 percent for tests, and 0.7 percent for anesthesia. Allowed charges per beneficiary for major procedures fell by 0.2 percent. For most categories, growth in allowed charges from 2021 to 2022 was similar to the rate of growth in the years immediately prior to the pandemic. The exceptions were major procedures, other procedures, and anesthesia, which grew more slowly from 2021 to 2022 than over the 2017 to 2019 period. Most of the slowdown occurred among cardiac and vascular surgical procedures, which have experienced lower annual volume growth than they did prior to the pandemic.

Over the entire 2017 to 2022 period, treatments had the highest rate of growth in allowed charges among the broad service categories. The treatments category includes services such as administration of dialysis and cancer treatments, physical therapy, and spinal manipulation. Increases in physical, occupational, and speech therapy services were the primary drivers of growth: Spending per beneficiary on these types of treatments rose by 13.4 percent from 2021 to 2022 and grew by more than 50 percent over the 2017 to 2022 period (data not shown). The increase in allowed charges in the treatment category is mirrored by increases in service units for these types of services. The growth in volume and spending may be related to provisions in the Bipartisan Budget Act of 2018 that made changes to the application of Medicare's outpatient therapy caps and the process of getting exemptions from those caps.

Increases or decreases in allowed charges can result from changes in volume, changes in payment rates for individual services, changes in the intensity of certain services (e.g., furnishing a higher-intensity E&M visit rather than a lower-paying, less intensive E&M visit), 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

FIGURE 4–3

Cumulative change in allowed charges per unit of service from 2017 to 2022



Note: APRN (advanced practice registered nurse), PA (physician assistant).

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

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. Figure 4-3 shows cumulative changes in allowed charges per unit of service from 2017 to 2022 by type of provider. Among primary care physicians, spending per unit of service was 14.9 percent higher in 2022 than it was in 2017. Over this period, cumulative growth in spending per unit increased by 12.6 percent among APRNs and PAs, by 6.6 percent for all specialist physicians, and by 0.5 percent for other practitioners.

Among primary care physicians, specialists, and APRNs and PAs, the largest single-year increase in spending per unit of service occurred in 2021. This growth was largely driven by increases in Medicare payment rates for office/outpatient E&M visits (see, for example, Figure 4-1, p. 106). Among primary care physicians and APRNs and PAs, a large portion of fee schedule revenue comes from E&M services. The degree to which specialists bill for E&M services varies across types of specialties, but in aggregate the increase in E&M payment rates was enough to cause a substantial increase in spending per unit of service during 2021, despite a decrease in the fee schedule's conversion factor. Other practitioners (which include physical therapists, podiatrists, and optometrists) generally do not bill for E&M services, so they were not as affected by the increase in E&M rates.

Average payment rates of private insurance preferred provider organizations remained higher than Medicare payment rates for clinician services

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 coverage. 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 U.S.[23] In 2022, the average PPO payment rate for clinician services was 136 percent of FFS Medicare's average payment rate, up from 134 percent in 2021. The growing difference between Medicare and private-payer rates resumes a long-standing trend after the difference lessened in 2021, which was likely due to a substantial increase in Medicare payment rates for E&M office/outpatient visits in that year (a rate increase that appears not to have been immediately matched by private plans).[24]

The ratio in 2022, as in prior years, varied by type of service. For example, private insurance rates were 104 percent of Medicare rates for care management/coordination E&M visits but 195 percent of Medicare rates for CT scans.

The gap between private insurance rates and Medicare rates has grown over the last decade as Medicare rates have increased more modestly than private insurance rates: 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 FFS Medicare program.

The growth in private insurance rates probably results from 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, according to an AMA survey, from 2012 to 2022, the share of physicians who were either directly employed by a hospital or were part of a practice with hospital ownership increased from about 29 percent to 41 percent (Kane 2023).

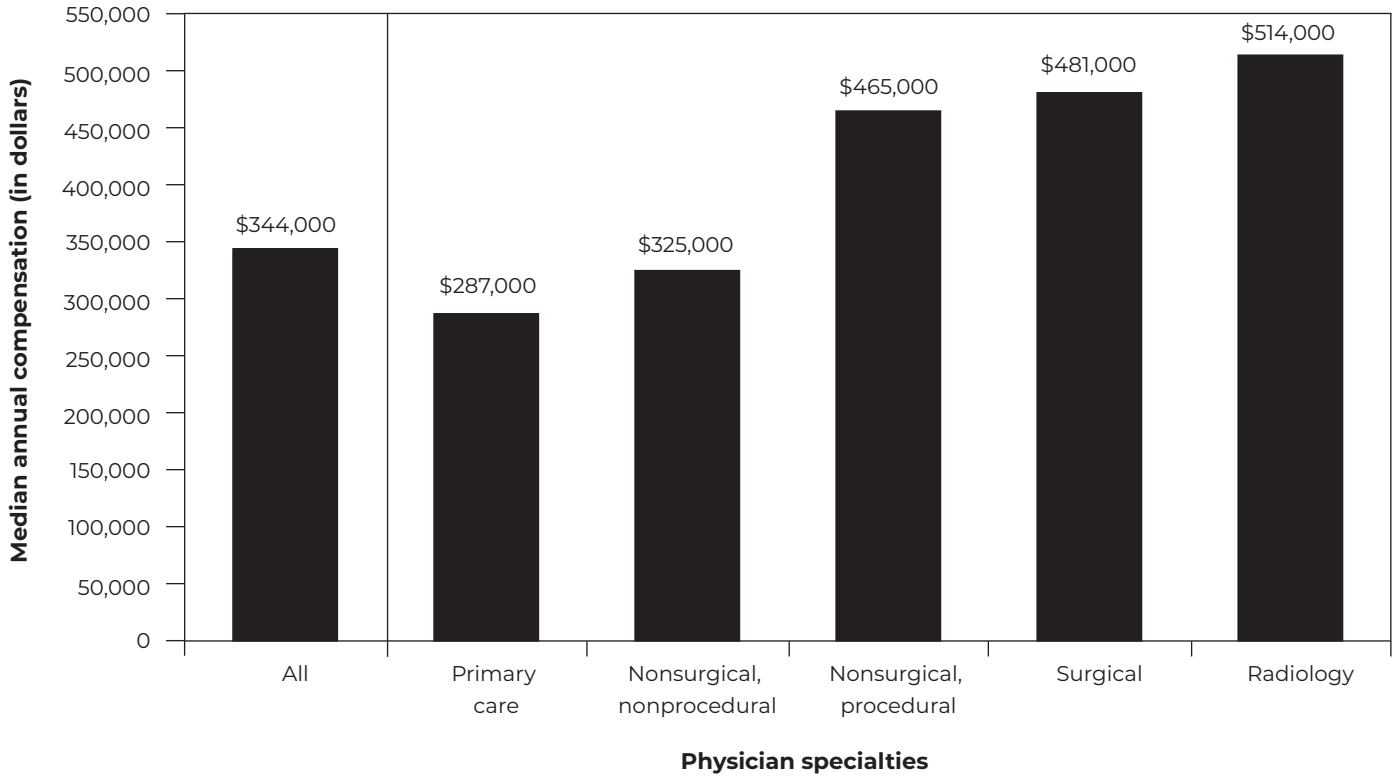
Studies show that private insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation (Capps et al. 2018, Clemens and Gottlieb 2017, Neprash et al. 2015). Similarly, the Commission has found that independent practices with larger market shares and hospital-owned practices have received higher private insurance rates for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). The AMA survey found that the top reason physicians gave for selling their practice to a hospital was to enhance their ability to negotiate higher payment rates with payers (cited by 80 percent of physicians working in practices acquired by hospitals); other commonly cited reasons were to improve access to costly resources and get help complying with payers' regulatory and administrative requirements (cited by about 70 percent of respondents in these practices) (Kane 2023).

Compensation and productivity data indicate that clinicians who work in hospital-owned practices do not necessarily earn higher compensation, but they do tend to see fewer patients and bill for fewer services than clinicians in physician-owned practices (Medical Group Management Association 2023, Medical Group Management Association 2022, Whaley et al. 2021). A recent Medscape survey of employed physicians found that the most appealing aspects of working as an employed physician were not having to run a small business and having stable income, while the top drawbacks were loss of autonomy, more workplace rules, and potentially less income (McKenna 2022).

The AMA survey found that, as of 2022, 47 percent of physicians worked in a physician-owned practice, 31 percent worked in a hospital-owned practice, 10 percent worked as an employee or contractor in a hospital setting, 4.5 percent worked for a practice owned by a private equity group, and the remainder worked in various other arrangements. (Some insurers also increasingly employ clinicians. UnitedHealth Group's Optum Health is now reported to be the largest employer of clinicians in the U.S., with 130,000 employed or aligned clinicians (Emerson 2023, UnitedHealth Group 2023).) The AMA survey also found that 44 percent of physicians reported an ownership stake in their practice in 2022—down from 53 percent in 2012. The share of physicians with an ownership stake may decline further in the coming years since a decreasing share of younger physicians report ownership interests, and female physicians (whose share of the physician workforce has been increasing) are also less likely to report ownership interests (Kane 2023).

FIGURE 4–4

Compensation for primary care physicians is much lower than for most specialists, 2022



Note: Figure includes all physicians who reported their 2022 annual compensation in the survey (*n* = 106,376). All numbers are rounded to the nearest thousand. "Compensation" refers to median total cash compensation adjusted to reflect full-time work and does not include employer retirement contributions or payments for benefits. The primary care group includes family medicine, internal medicine, and general pediatrics. The nonsurgical, nonprocedural group includes psychiatry, emergency medicine, hospital medicine, endocrinology and metabolism, nephrology and hypertension, neurology, physical medicine and rehabilitation, rheumatology, and other internal medicine/pediatrics. The nonsurgical, procedural group includes cardiology, dermatology, gastroenterology, pulmonology, and hematology/oncology. The surgical group includes general surgery, orthopedic surgery, cardiovascular and cardiothoracic surgery, neurological surgery, ophthalmology, otolaryngology, urology, obstetrics/gynecology, and other surgical specialties. Certain nonsurgical, nonprocedural specialties (endocrinologists, rheumatologists, psychiatrists) had lower median compensation than primary care physicians.

Source: SullivanCotter's Physician Compensation and Productivity Survey, 2023.

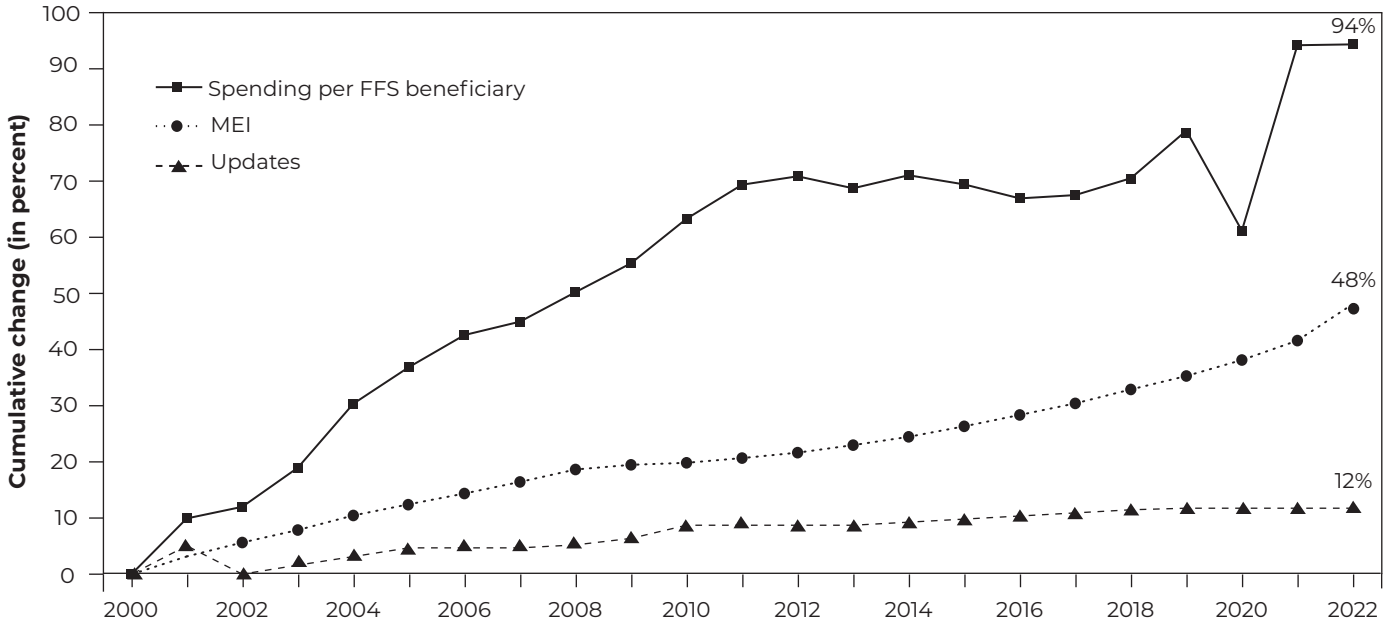
Median compensation grew by 9 percent for physicians and by 5 percent for advanced practice providers from 2021 to 2022

Since the Commission lacks data that would allow us to calculate clinicians' all-payer profit margins from delivering services, we use clinician compensation data as a rough proxy for profitability. Relatively high clinician compensation levels indicate that total revenues are greater than costs. These compensation levels also give some assurance that providing clinician services is profitable and that there is an incentive for individuals to pursue careers as clinicians. We note, however, that Medicare constitutes only a portion of the revenue most clinicians receive, since clinicians usually accept a variety of types of insurance—making clinician compensation an indirect measure of Medicare's payment adequacy.

After relatively modest rates of growth during the pandemic, clinician compensation appears to have strongly rebounded from 2021 to 2022. According to SullivanCotter's latest clinician compensation and

FIGURE 4–5

Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000–2022



Note: FFS (fee-for-service), MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. MEI data are from the new version of the MEI (based on data from 2017). Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows increases to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments, advanced alternative payment model participation bonuses, and payment increases of 3.75 percent in 2021 and 3.0 percent in 2022 because they are one-time payments not built into subsequent years' payment rates.

Source: MedPAC analysis of Medicare regulations and Trustees' reports.

productivity surveys, from 2021 to 2022, median compensation grew by 9 percent for physicians—a little faster than inflation, which grew by 8 percent according to the consumer price index for all urban consumers (CPI–U) (Bureau of Labor Statistics 2023b). Over this same period, median compensation grew by 5 percent for advanced practice providers (e.g., NPs, PAs).[25,26] By 2022, median compensation was $344,000 for physicians and $131,000 for advanced practice providers.[27] As we show in Figure 4-4 (p. 111), physician compensation varied substantially by specialty in 2022, with primary care physicians earning a median compensation of $287,000 while radiologists earned a median of $514,000.

The high growth rate in physician compensation from 2021 to 2022 was observed across most specialty categories, including nonsurgical, nonprocedural specialties (which saw growth of 10 percent) as well as nonsurgical, procedural specialties; surgical specialties; and primary care specialties (which all saw growth of 9 percent). Compensation grew less for radiology (6 percent) and pathology (5 percent).

There was similar consistency in the growth rate of advanced practice provider compensation across specialties. Among these types of clinicians, those practicing in nonsurgical, nonprocedural specialties; nonsurgical, procedural specialties; and surgical specialties all saw 5 percent growth in median compensation from 2021 to 2022. Clinicians and those practicing in primary care specialties and radiology saw 4 percent growth.

Over a four-year period (from 2018 to 2022), median compensation grew at lower rates. For physicians, median compensation grew by an average of 3.4 percent per year—more slowly than CPI–U inflation, which grew by an average of 3.9 percent per year over this period (Bureau of Labor Statistics 2023b). For advanced practice providers, median compensation grew by an annual average of 4.0 percent over this period.[28]

Growth in input costs accelerated in recent years but is projected to moderate in 2025

We report the growth in clinicians' input costs because it helps us understand the extent to which Medicare payment rate updates and clinician revenues are keeping pace with the costs associated with running a practice. 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).[29]

MEI growth was 1 percent to 2 percent per year for several years before the coronavirus pandemic and was 2.1 percent in 2020.[30] MEI growth then increased to 2.5 percent in 2021 and 4.6 percent in 2022. However, MEI growth is projected to moderate in the coming years—to 4.1 percent in 2023, 3.1 percent in 2024, and 2.6 percent in 2025.[31]

Over the longer term, cumulative MEI growth has far exceeded updates to physician fee schedule payment rates. For example, from 2000 to 2022, the MEI increased cumulatively by 48 percent compared with 12 percent for fee schedule updates. However, the volume and intensity of clinician services delivered each year has increased, which has resulted in fee schedule spending per FFS beneficiary growing by 94 percent over the same time period (Figure 4-5). This contrast suggests that growth in volume and intensity has helped offset the gap between MEI growth and annual updates.

Unlike the changes in fee schedule updates and MEI growth (which represent price changes), the growth in fee schedule spending per FFS beneficiary represents the combined effects of changes in price, volume, and intensity. Because increases in volume and intensity generally increase costs (e.g., furnishing an additional service may require clinicians to purchase additional supplies), the growth in fee schedule spending per FFS beneficiary should not be interpreted as profit growth.[32] Nonetheless, the substantial growth in fee schedule spending per FFS beneficiary suggests that simply comparing changes in fee schedule updates to MEI growth is insufficient to capture changes over time in clinicians' ability to provide services to Medicare beneficiaries.

How should Medicare fee schedule payments change in 2025?

Under current law, payment rates are expected to decline in 2025, due to the expiration of a 1.25 percent pay increase in 2024 that applies for one year only and a 0 percent update specified in current law for 2025. Although most of our payment adequacy indicators are positive, expected cost increases in 2025 could be difficult for clinicians to absorb.

In addition, as discussed in our March 2023 report to the Congress, the Commission is concerned that 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. Since these lower payments could put clinicians who furnish care to low-income beneficiaries at greater financial risk and reduce access to care for these beneficiaries, Medicare should provide additional support to clinicians who serve this population.

RECOMMENDATION 4

The Congress should:

- **for calendar year 2025, update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50 percent of the projected increase in the Medicare Economic Index; and**
- **enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.**

The Commission's March 2023 recommendation to support clinicians when they care for low-income Medicare beneficiaries

In our March 2023 report to the Congress, the Commission recommended instituting a new Medicare safety-net (MSN) add-on payment for clinicians who treat low-income beneficiaries (Medicare Payment Advisory Commission 2023c). Specifically, the Commission recommended that the Congress enact an add-on payment under the physician fee schedule for services provided to Medicare beneficiaries who are dually enrolled in Medicaid and Medicare and to beneficiaries who receive the Part D low-income subsidy (LIS) (as proxies for low income).[33] The add-on payments would equal the allowed charge amounts for physician fee schedule services furnished to these beneficiaries multiplied by 15 percent when provided by primary care clinicians and 5 percent for all other clinicians. The MSN add-on could be made as lump-sum payments to clinicians, rather than applied to individual claims, and should not be subject to beneficiary cost sharing.

The Commission contends that Medicare should provide additional financial support to clinicians who care for low-income beneficiaries because treating these beneficiaries can generate less revenue, even though the costs required to treat them are likely the same as for other beneficiaries, if not higher.

The revenue for treating beneficiaries with low incomes is often lower than the revenue clinicians collect for treating other beneficiaries because clinicians are prohibited from collecting cost-sharing amounts (either the annual Part B deductible or 20 percent coinsurance) from most beneficiaries who are dually enrolled in Medicaid and Medicare. In addition, state Medicaid programs are allowed to pay less than the full Medicare cost-sharing amount if paying the full amount would lead a provider to receive more than the state's Medicaid payment rate for the service.[34] One study found that 42 states limited Medicaid payments of Medicare cost sharing when Medicaid's fee schedule amount was lower than Medicare's rate (Roberts et al. 2020).

We estimate that in 2019, providers did not collect about $3.6 billion in revenue due to these policies. 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

(continued next page)

RATIONALE 4

Overall, access to clinician services for Medicare beneficiaries appears to be comparable with, or better than, that of privately insured individuals, though quality of care is difficult to assess. Physician fee schedule spending per beneficiary dropped sharply in 2020 due to the pandemic, but spending since then has largely recovered and is now growing at rates close to prepandemic levels. Clinicians' all-payer compensation grew rapidly in 2022, but clinicians' input costs grew faster in 2022 than in previous years. While projected to moderate by 2025, input cost growth is projected to remain slightly above the low levels experienced for several years prior to 2021.

Current law calls for payment rates to decline from 2024 to 2025 because of the expiration of a 1.25 percent pay increase that applies only to 2024 payments. The Commission is concerned that such payment levels may make it difficult for clinicians to absorb recent and continued cost increases. Then again, aggregate payments appear adequate on the basis of many of our indicators. Therefore, given these mixed findings, the

The Commission's March 2023 recommendation to support clinicians when they care for low-income Medicare beneficiaries (cont.)

these low-income beneficiaries, and it would thus reduce the financial risk involved in treating these patients.

Some clinicians treat a disproportionate share of low-income beneficiaries. 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 beneficiaries receiving Part D's LIS. Across all primary care physicians, 28 percent of total allowed charges were associated with LIS beneficiaries. The share of allowed charges associated with LIS beneficiaries was slightly lower for non–primary care physicians (25 percent), but higher for nurse practitioners (41 percent). While the Commission recognizes that all clinicians who furnish care to beneficiaries with lower income are at risk of lower revenue, we support providing a higher add-on rate for services furnished by primary care clinicians (including practitioners such as nurse practitioners and physician assistants) because even though they typically serve as a beneficiary's primary point of contact with the health care system, primary care clinicians generally receive less total compensation than specialists and thus have a greater need for safety-net payments.

Using 2019 data, we estimate that a 15 percent safety-net add-on payment for primary care clinicians and a 5 percent add-on for other clinicians would have increased the average clinician's fee schedule revenue by 1.7 percent. The increase for each clinician would vary by their specialty and share of services furnished to low-income beneficiaries: Safety-net payments would increase total fee schedule revenue for primary care clinicians by 4.4 percent and non–primary care clinicians by 1.2 percent. Because Medicare does not have an existing program to provide financial support to clinicians when they furnish care to beneficiaries with low incomes, and because 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 Commission emphasizes that MSN add-on payments should not be extended to Medicare Advantage (MA) plans or included in MA benchmarks because many LIS beneficiaries are already enrolled in plans designed for dual enrollees, and plans can operate their own initiatives to support clinicians who serve low-income beneficiaries. ■

Commission recommends that the Congress raise the physician fee schedule base payment rate in 2025 by half of the projected increase in the MEI.

The MEI is currently projected to grow by 2.6 percent in 2025, so this recommendation would yield an estimated increase in payment rates of 1.3 percent (50 percent × 2.6 percent = 1.3 percent) above current law. These MEI growth figures are projections, are subject to uncertainty, and could be larger or smaller than actual MEI growth.

In addition to the recommendation for an across-the-board increase to the base payment rate, the Commission contends that, for reasons set forth in last year's physician update chapter, it is important to provide additional financial support to clinicians when they furnish care to low-income beneficiaries (see text box on the Commission's 2023 recommendation) (Medicare Payment Advisory Commission 2023c). Our recommendation would therefore also call for the Congress to enact add-on payments to clinicians for physician fee schedule services furnished to low-income Medicare beneficiaries. These new add-on payments should be consistent with the clinician safety-net recommendation in our March 2023 report.

We estimate that the recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by 1.7 percent. The increase for each clinician would vary depending on their specialty—with primary care clinicians receiving higher add-on payments than other clinicians—and depending on the share of services they furnish to low-income beneficiaries. On average, safety-net payments would increase Medicare fee schedule revenue for primary care clinicians by 4.4 percent and for other clinicians by 1.2 percent.

We estimate that the combination of our half-of-MEI payment update and our safety-net add-on payments would increase the average clinician's Medicare fee schedule revenue by 3 percent, with revenue increasing by an average of 5.7 percent for primary care clinicians and by an average of 2.5 percent for other clinicians.

IMPLICATIONS 4

Spending

- This recommendation would increase program spending relative to current law by $2 billion to $5 billion in 2025 and by $10 billion to $25 billion over five years.

Beneficiaries and providers

- We expect that this recommendation will help ensure FFS Medicare beneficiaries' access to care by maintaining clinicians' willingness and ability to treat them. This recommendation may increase clinicians' willingness and ability to treat beneficiaries with low incomes. ■

APPENDIX 4–A

Key findings from the Commission's 2023 access-to-care survey

TABLE 4A–1

Medicare beneficiaries reported access to care that is comparable with, or better than, that of privately insured people, 2022 and 2023

	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
Survey question	**2022**	**2023**	**2022**	**2023**
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	55%[ab]	49%[a]	40%[a]	37%[a]
Sometimes	32[ab]	39	40[a]	40
Usually	8[a]	9[a]	12[ab]	14[a]
Always	4[a]	4[a]	8[a]	8[a]
For illness or injury				
Never	67[a]	65[a]	58[a]	55[a]
Sometimes	26	27[a]	29	30[a]
Usually	4[a]	6[a]	8[a]	10[a]
Always	3[a]	2[a]	5[a]	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?"				
Yes	18[a]	20[a]	24[a]	27[a]
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[a]	14	15[a]
Specialist	26[b]	32	29[b]	33
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?"				
Primary care provider				
No problem	46	45[a]	38	32[a]
Share of total insurance group	*5*	*5*	*5*	*5*
Small problem	32	32	33	35
Share of total insurance group	*4*	*4[a]*	*5*	*5[a]*
Big problem	22	23[a]	29	33[a]
Share of total insurance group	*2[a]*	*3[a]*	*4[a]*	*5[a]*
Specialist				
No problem	68[a]	64[a]	59[a]	54[a]
Share of total insurance group	*18*	*20*	*17*	*18*
Small problem	22	23	26	28
Share of total insurance group	*6*	*7[a]*	*7*	*9[a]*
Big problem	10[a]	13[a]	15[a]	18[a]
Share of total insurance group	*3[ab]*	*4[a]*	*4[ab]*	*6[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." Survey sample sizes are approximately 4,000 Medicare beneficiaries and 4,000 privately insured people in 2022 and approximately 5,000 of each group in 2023; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Due to a recent change in MedPAC's survey methods, results from 2022 onward (shown above) may not be directly comparable with prior years (which are not shown but are available in prior years' chapters).
[a]Statistically significant difference between Medicare beneficiaries and the privately insured in a given year (at a 95 percent confidence level).
[b]Statistically significant difference between 2022 and 2023 within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's access-to-care surveys conducted in the summers of 2022 and 2023.

TABLE 4A–2

Lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries in 2023

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
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	53%[a]	46%[b]	44%[ab]	44%[a]	42%	34%[ab]
Sometimes	35	43[b]	41[b]	37	37	42
Usually	8[a]	7[a]	11[ab]	11[a]	14[a]	16[ab]
Always	4[a]	4[a]	4[a]	8[a]	7[a]	9[a]
For illness or injury						
Never	66[a]	67[a]	63[a]	57[a]	56[a]	54[a]
Sometimes	27	25	27	29	29	31
Usually	5	6[a]	7	8	10[a]	10
Always	2[a]	3	2[a]	6[a]	5	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?"						
Yes	23[a]	17[ab]	17[ab]	28[a]	31[a]	25[a]
Received any health care: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	91[a]	97[ab]	97[ab]	82[a]	90[ab]	93[ab]
Availability of providers who accept your insurance: Among those who received health care in the past 12 months, "How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?"						
Satisfied ("very" or "somewhat")	96[a]	96[a]	96[a]	88[a]	91[a]	92[ab]
Availability of timely appointments: Among those who received health care in the past 12 months, "How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?"						
Satisfied ("very" or "somewhat")	89[a]	87[a]	86[a]	76[a]	77[a]	77[a]
Have a primary care provider: "A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?"						
Yes	96[a]	96[a]	97[a]	89[a]	92[a]	93[ab]
See specialists: "How many different specialists, if any, have you seen in the past 12 months?"						
0	31[a]	20[ab]	13[ab]	45[a]	36[ab]	32[ab]
1	26	24[a]	23[a]	24	30[a]	29[a]
2+	44[a]	55[ab]	64[ab]	31[a]	34[a]	39[ab]

Note: "Lower income" refers to respondents with household incomes of less than $50,000 per year, "middle income" refers to respondents with household incomes between $50,000 and $79,999, and "higher income" refers to respondents with household incomes of $80,000 or more. 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 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage.
[a]Statistically significant difference between Medicare beneficiaries and the privately insured within the same income category (at a 95 percent confidence level).
[b]Statistically significant difference between lower-income respondents and middle- or higher-income respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC's access-to-care survey conducted in summer 2023.

TABLE 4A–3

Few statistically significant differences in White, Black, and Hispanic Medicare beneficiaries' survey responses in 2023

	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
Survey question	**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	49%[a]	56%	49%[a]	37%[a]	52%[b]	30%[a]
Sometimes	39	36	36	40	35	44
Usually	9[a]	5	10	15[a]	8[b]	14
Always	4[a]	2	5[a]	8[a]	5	12[a]
For illness or injury						
Never	66[a]	70	57	55[a]	68[b]	47
Sometimes	26[a]	24	33	31[a]	23	33
Usually	6[a]	4	8	10[a]	5	12
Always	2[a]	1	2[a]	5[a]	3	8[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?"						
Yes	19[a]	18	23	26[a]	19	33
Received any health care: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	95[a]	92[b]	86[b]	91[a]	92	85[b]
Availability of providers who accept your insurance: Among those who received health care in the past 12 months, "How satisfied or dissatisfied have you been with your ability to find health care providers that accept Medicare/your insurance?"						
Satisfied ("very" or "somewhat")	96[a]	94	96[a]	91[a]	93	87[ab]
Availability of timely appointments: Among those who received health care in the past 12 months, "How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?"						
Satisfied ("very" or "somewhat")	87[a]	89	87[a]	76[a]	83[b]	74[a]
Have a primary care provider: "A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?"						
Yes	96[a]	97	96[a]	92[a]	94	89[a]
See specialists: "How many different specialists, if any, have you seen in the past 12 months?"						
0	20[a]	33[b]	37[b]	34[a]	42[b]	37
1	25	23	28	28	27	35
2+	55[a]	44[ab]	35[b]	39[a]	31[a]	28[b]

Note: "White" refers to non-Hispanic White respondents, "Black" refers to non-Hispanic Black respondents, and "Hispanic" refers to Hispanic respondents of any race. 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 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Questions about looking for a new provider and problems finding a new provider are no longer shown in this table due to small cell sizes.
[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 between White and Black or Hispanic respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC's access-to-care survey conducted in summer 2023.

TABLE 4A–4

Few statistically significant differences between urban and rural Medicare beneficiaries' survey responses in 2023

	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
Survey question	**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	47%[ab]	56%[ab]	36%[ab]	45%[ab]
Sometimes	40	34	40	38
Usually	9[a]	7	15[a]	11
Always	4[a]	3	9[a]	7
For illness or injury				
Never	65[a]	66	54[a]	60
Sometimes	27[a]	27	31[a]	29
Usually	6[a]	5	10[a]	7
Always	2[a]	2	5[a]	4
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?"				
Yes	20[a]	20	27[a]	27
Looking for a new provider: "In the past 12 months, have you tried to get a new…?" (Share answering "Yes")				
Primary care provider	12[a]	12	16[ab]	10[b]
Specialist	34[b]	23[b]	34[b]	27[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?"				
Primary care provider				
No problem	45[a]	44	33[a]	28
Share of total geographic group with this insurance	*5*	*5*	*5*	*3*
Small problem	33	27	35	38
Share of total geographic group with this insurance	*4*	*3*	*5*	*4*
Big problem	22[a]	30	32[a]	34
Share of total geographic group with this insurance	*3[a]*	*3*	*5[a]*	*3*
Specialist				
No problem	66[a]	55	54[a]	50
Share of total geographic group with this insurance	*22[ab]*	*12[b]*	*18[a]*	*13*
Small problem	21[ab]	33[b]	28[a]	27
Share of total geographic group with this insurance	*7[a]*	*7*	*10[a]*	*7*
Big problem	13	12	18	22
Share of total geographic group with this insurance	*4*	*3*	*6*	*6*

Note: "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. 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 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage.
[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 between urban and rural respondents within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's access-to-care survey conducted in the summer of 2023.

Endnotes

1 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf.

2 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.

3 Our survey is fielded among a sample drawn from the Gallup Panel. The Gallup Panel is a probability-based panel generated via random-digit-dial or address-based sampling. Approximately 8 percent of people invited to join the Gallup Panel do so. When they join, they specify which language they would like to receive surveys in and through what mode they would like to receive surveys. Our survey was fielded via web or mail and in English or Spanish, depending on panelists' preferences. We paid most respondents a $5 incentive to complete the survey. We oversampled Black and Hispanic respondents. Among eligible individuals invited to complete our survey, 50 percent completed it. Questions asked of all Medicare beneficiaries ages 65 and over (n = 4,991) have a margin of error of +/− 1.7 percentage points at the 95 percent confidence level, and questions asked of all privately insured people ages 50 to 64 (n = 5,527) have a margin of error of +/− 1.9 percent.

4 We annually conduct focus groups with beneficiaries and clinicians 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 summer 2023, we conducted four focus groups with Medicare beneficiaries in each of three urban markets. Two of the groups in each market were composed of beneficiaries dually eligible for Medicare and Medicaid. 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.

5 By design, some of the questions in the Commission's survey ask for respondents' subjective assessments of the degree to which their care needs were met, rather than for data that may be difficult to recall. For example, respondents use their own judgment when determining whether they are able to schedule timely appointments. Subjective responses can be useful measures for tracking beneficiary experience and perceptions, particularly over time.

6 Compared with beneficiaries with higher incomes, those with lower incomes are less likely to have had access to employer-sponsored health insurance prior to joining Medicare (Bureau of Labor Statistics 2023a). Instead, lower-income beneficiaries are more likely to have been uninsured prior to joining Medicare or covered through Medicaid or a Marketplace plan, both of which often have narrower provider networks than employer-sponsored insurance (Graves et al. 2020, Kaiser Family Foundation 2022, Schappert and Santo 2023). As a result, lower-income beneficiaries may have previously had fewer options when searching for a clinician who could see them promptly and thus may be more accustomed to long waits for appointments.

7 Multiple-race individuals are included in our definition of "Hispanic" this year; last year, such individuals were inadvertently excluded from our "Hispanic" group.

8 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 2022, about 19 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.

9 We used the number of total Part B beneficiaries, including those in FFS Medicare and MA, 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.

10 The decline in clinicians per beneficiary during the pandemic largely reflects clinicians who temporarily or permanently stopped furnishing care and a reduction in the number of beneficiaries seeking care, which resulted in fewer clinicians meeting the threshold of treating more than 15 beneficiaries.

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

12 Clinicians who opted out of Medicare were concentrated in the specialties of behavioral health (43 percent), oral health (27 percent), and primary care (12 percent) (Centers for Medicare & Medicaid Services 2023c).

13 Specifically, we define an "encounter" as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service.

14 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 2023 Medicare Trustees' report.

15 Practitioners can submit claims under more than one specialty. For those practitioners, we use the specialty associated with the plurality of allowed charges billed to the physician fee schedule.

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

17 The roughly 3,400 Dartmouth-defined HSAs are a collection of ZIP codes whose residents are hospitalized chiefly in that area's hospitals.

18 Payment rates for a service can also change because of adjustments to the relative value units for that service.

19 MACRA also specified two types of additional payments for clinicians: (1) an annual bonus for clinicians with a sufficient share of patients or payments in A–APMs and, (2) for clinicians not participating in A–APMs, payment adjustments through the Merit-based Incentive Payment System (MIPS), which can be positive or negative depending on a clinician's performance on measures of quality, cost, participation in clinical improvement activities, and use of health information technology such as an electronic health records. Beginning in 2026, the A–APM bonus will no longer be available, but MIPS payment adjustments will continue for clinicians not participating in A–APMs. In 2023, about 227,000 clinicians (roughly 17 percent of participating providers) received MACRA's A–APM participation bonus (Centers for Medicare & Medicaid Services 2023a). Another 600,000 clinicians received a positive MIPS adjustment, worth up to 2.34 percent (slightly higher than in past years) (Centers for Medicare & Medicaid Services 2023d). About 23,000 clinicians received a negative MIPS adjustment to their payment rates, up to −9 percent (Centers for Medicare & Medicaid Services 2023d). Another 74,000 clinicians received a neutral (0 percent) MIPS adjustment because their MIPS score was the same as the MIPS performance threshold. We estimate that over 460,000 clinicians were ineligible for A–APM bonuses or MIPS adjustments (e.g., because they saw a low volume of Medicare beneficiaries).

20 The right graph of Figure 4-1 (p. 106) captures a budget-neutrality adjustment made to the conversion factor in 2024 to account for the cost of the new add-on code (G2211). The left graph of Figure 4-1 does not show the add-on code (G2211), which adds $16.05 to the payment rate for certain visits with new or established patients when a clinician serves as the continuing focal point for all needed health care services and/or provides ongoing care related to a patient's single, serious condition or a complex condition.

21 Allowed charges are a function of the physician fee schedule's relative value units and conversion factor plus other payment adjustments, such as those determined by geographic practice cost indexes.

22 We are excluding data from 2020 and 2021 because volume (and allowed charges) declined sharply in 2020 due to delayed or forgone care during the pandemic and then increased almost as sharply in 2021. Given the anomalous nature of those two years, we do not believe they are representative of long-term trends in practice patterns.

23 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. Data do not include Medicare Advantage claims.

24 We conclude that the narrowing of the overall difference between Medicare and private-payer rates from 2020 to 2021 was likely due to E&M payment changes because, over that period, the ratio of Medicare to private-payer rates for E&M office/outpatient visits fell from 127 percent to 114 percent.

25 The SullivanCotter compensation data are limited in that a majority of the provider organizations that contributed compensation data for this survey are affiliated with a hospital or health system.

26 The growth rates reported in this statement were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2021 and 2022.

27 The dollar amounts reported in this statement were calculated using all staff clinicians in SullivanCotter's 2022 sample.

28 Average annual growth rates from 2018 to 2022 were calculated using consistent cohorts of staff physicians and staff advanced practice providers who were in SullivanCotter's samples in 2018, 2019, and 2022.

29 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 physicians' expense

data from 2006. However, CMS recently updated the MEI's cost categories and cost weights using data on physician offices from 2017 gathered from the Census Bureau's Services Annual Survey, along with data from other sources (Centers for Medicare & Medicaid Services 2022).

30 MEI growth data included in this chapter differ from those published in physician fee schedule rules because of methodological differences. MEI growth data included in this chapter reflect the MEI growth that occurred or is projected to occur in a given year. In contrast, MEI growth data in fee schedule rules reflect the most recently available actual historical data at the time of publication. For example, the 2024 MEI growth figure published in the fee schedule final rule uses data from the second quarter of 2023. Thus, the MEI measures published in fee schedule rules represent lagged measures of input cost growth.

31 MEI growth projections in this chapter are as of the third quarter of 2023 and are subject to change.

32 We do not calculate profit margins for clinicians (as we do for other types of providers who bill Medicare) because clinicians do not submit cost reports to CMS.

33 The Commission's definition of low-income Medicare beneficiaries includes all beneficiaries who receive full or partial Medicaid benefits and beneficiaries who do not qualify for Medicaid benefits in their states but receive the Part D low-income subsidy (LIS) 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 nearly all Medicare beneficiaries who receive full or partial Medicaid benefits are also automatically eligible to receive the LIS. About 19 percent of Medicare FFS beneficiaries with Part B coverage are LIS beneficiaries, but they account for roughly 25 percent of all allowed charges billed under the physician fee schedule.

34 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.

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