SECTION

7

Ambulatory care

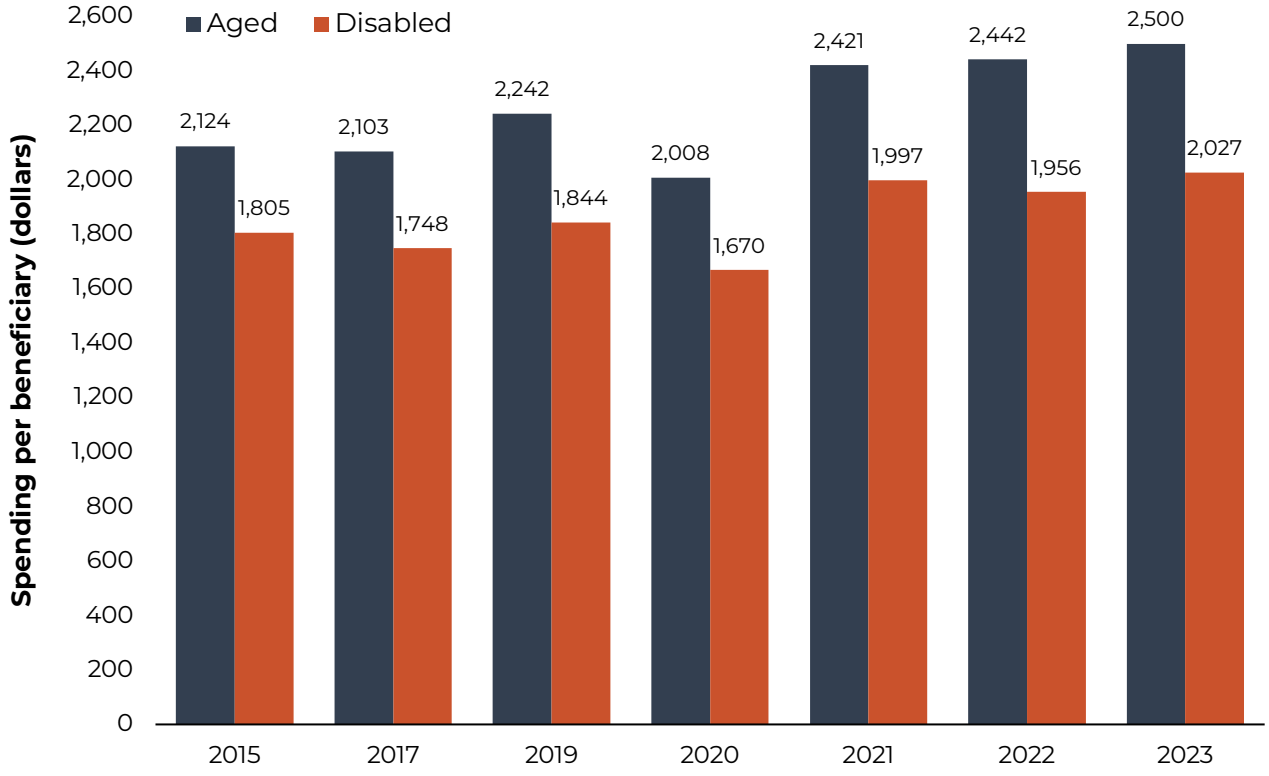
Physicians and other health professionals

Hospital outpatient services

Ambulatory surgical centers

Results of MedPAC's access-to-care survey

Chart 7-1 Medicare spending per FFS beneficiary on services in the physician fee schedule, 2015–2023



Note: FFS (fee-for-service). Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The "disabled" category excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the "aged" category. Dollar amounts are nominal figures, not adjusted for inflation.

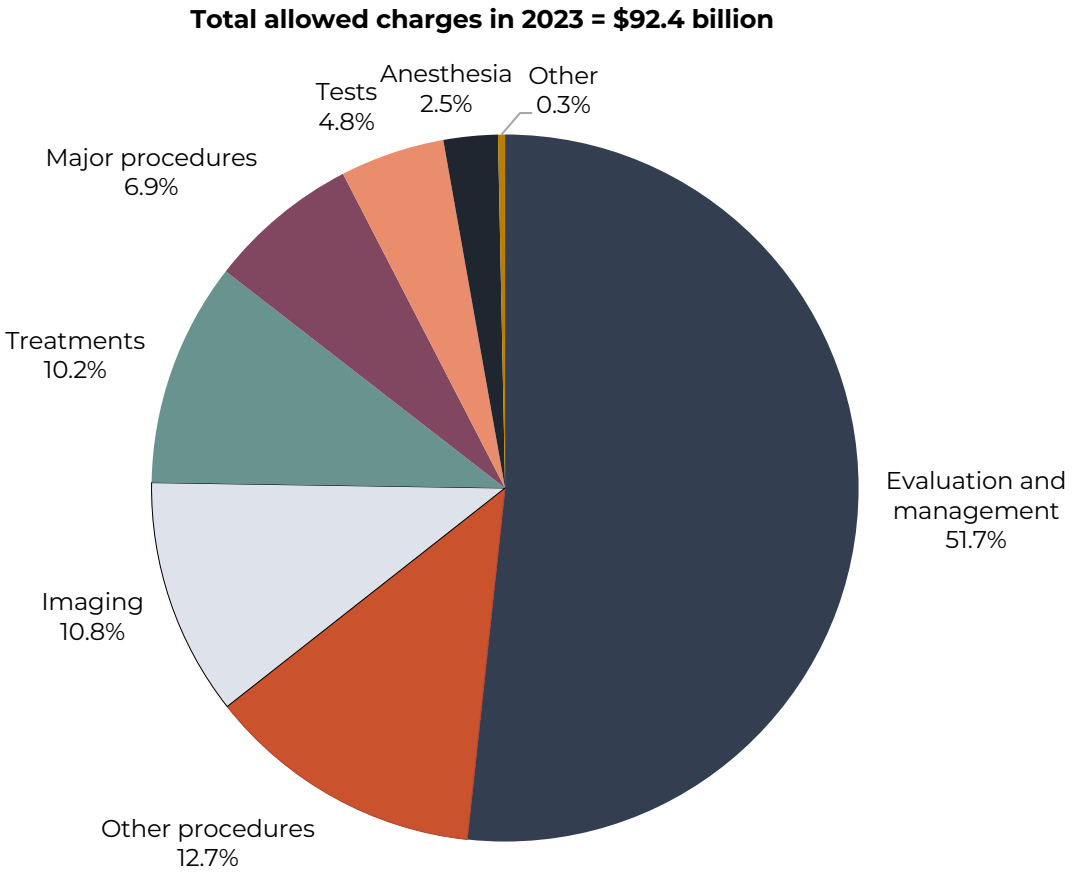
Source: The 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> The physician fee schedule includes a broad range of services, such as office visits, surgical procedures, and diagnostic and therapeutic services. Total fee schedule spending (excluding beneficiary cost sharing) was $70.9 billion in 2023 (data not shown).

> Spending per FFS beneficiary for fee schedule services remained largely stable between 2015 and 2017, then increased in 2019 (on a nominal basis). Spending per FFS beneficiary declined in 2020 due to the effects of the coronavirus pandemic, but spending rebounded in 2021. From 2021 to 2023, spending per beneficiary has continued to grow among aged beneficiaries and has been flat for those with disabilities.

> Per capita spending on fee schedule services for beneficiaries with disabilities (under age 65) is lower than that for aged beneficiaries (ages 65 and over). In 2023, for example, per capita spending for beneficiaries with disabilities was $2,027 compared with $2,500 for aged beneficiaries. Over the 2015 to 2023 period, spending per capita for aged beneficiaries grew at a faster rate (1.7 percent per year) than it did among beneficiaries with disabilities (1.2 percent per year).

Chart 7-2 Physician fee schedule allowed charges by type of service, 2023



Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries.

> In 2023, allowed charges for physician fee schedule services totaled $92.4 billion. "Allowed charges" includes both program spending and beneficiary cost-sharing liability. Allowed charges increased by 0.7 percent from 2022 on a nominal basis (data not shown). That slow growth rate is partly attributable to a 3.3 percent decline in the number of beneficiaries enrolled in fee-for-service Medicare as enrollment in Medicare Advantage continues to grow.

> In 2023, more than half of all allowed charges were for evaluation and management (E&M) services.

> Within the E&M category, about half of allowed charges were for office/outpatient visits (data not shown). The remaining allowed charges in the E&M category were for various types of services provided across a broad range of settings, including hospital inpatient departments, emergency departments, and nursing facilities (data not shown).

> The "treatments" category includes physical therapy, cancer treatments, and dialysis. The two procedure categories ("major" and "other") include various eye, cardiovascular, skin, and vascular procedures. The distinction between major procedures and other procedures is determined by the amount of the payment rate for each procedure and whether it is typically furnished in a facility setting.

Chart 7-3 Total number of encounters per FFS beneficiary was higher in 2023 compared with 2018, and the mix of clinicians furnishing them changed

	Encounters per beneficiary			Percent change in encounters per beneficiary	
Specialty category	2018	2022	2023	Average annual 2018–2022	2022–2023
Total (all clinicians)	21.8	22.3	23.2	0.5%	4.3%
Primary care physicians	4.0	3.1	3.1	–5.9	–0.1
Specialists	12.8	12.4	12.8	–0.6	2.7
APRNs/PAs	2.2	3.0	3.3	7.9	10.1
Other practitioners	3.3	3.7	4.0	3.1	8.6

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

Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> An "encounter" is a measure of beneficiary interaction with clinicians. For example, if a physician billed for an office visit and an X-ray on the same claim, we count that as one encounter.

> The overall number of encounters per FFS beneficiary grew by 0.5 percent annually, on average, over the 2018 to 2022 period. The growth rate over that period was impacted by the coronavirus pandemic, which sharply reduced encounters in 2020, but includes a rebound that occurred in 2021 and 2022.

> Encounters with specialist physicians accounted for the majority of all encounters. These encounters fell by an average of 0.6 percent per year between 2018 and 2022 but grew by 2.7 percent from 2022 to 2023.

> Encounters with APRNs and PAs grew rapidly from 2018 to 2023 (50 percent in total), and encounters with primary care physicians declined substantially (–22 percent). These changes continue a longer-term trend of declines in services billed by primary care physicians and rapid increases in the number of services billed by APRNs and PAs.

> The decline in encounters with primary care physicians occurred across a broad range of services, including evaluation and management services, tests, procedures, and imaging services (data not shown).

Chart 7-4 The number of clinicians billing Medicare's physician fee schedule increased, and the mix of clinicians changed, 2018–2023

	Number (in thousands)					Number per 1,000 FFS beneficiaries				
	Physicians					Physicians				
Year	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total
2018	139	462	237	174	1,012	4.2	13.9	7.1	5.2	30.4
2019	138	468	258	180	1,044	4.2	14.2	7.8	5.4	31.6
2020	135	468	268	172	1,043	4.2	14.5	8.3	5.3	32.3
2021	134	472	286	180	1,072	4.3	15.3	9.3	5.8	34.8
2022	133	477	308	184	1,102	4.5	16.1	10.4	6.2	37.2
2023	132	483	327	189	1,131	4.6	16.8	11.4	6.6	39.5

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialties" includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." "Other practitioners" includes clinicians such as physical therapists, psychologists, social workers, and podiatrists. The number of clinicians shown in this table includes only those with a caseload of more than 15 beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include beneficiaries enrolled in traditional Medicare Part B. Versions of this chart that were published before 2025 used beneficiary counts that included all beneficiaries enrolled in Part B, including both those in traditional FFS Medicare and Medicare Advantage. Numbers exclude nonperson providers such as clinical laboratories and independent diagnostic testing facilities. Components may not sum to totals due to rounding.

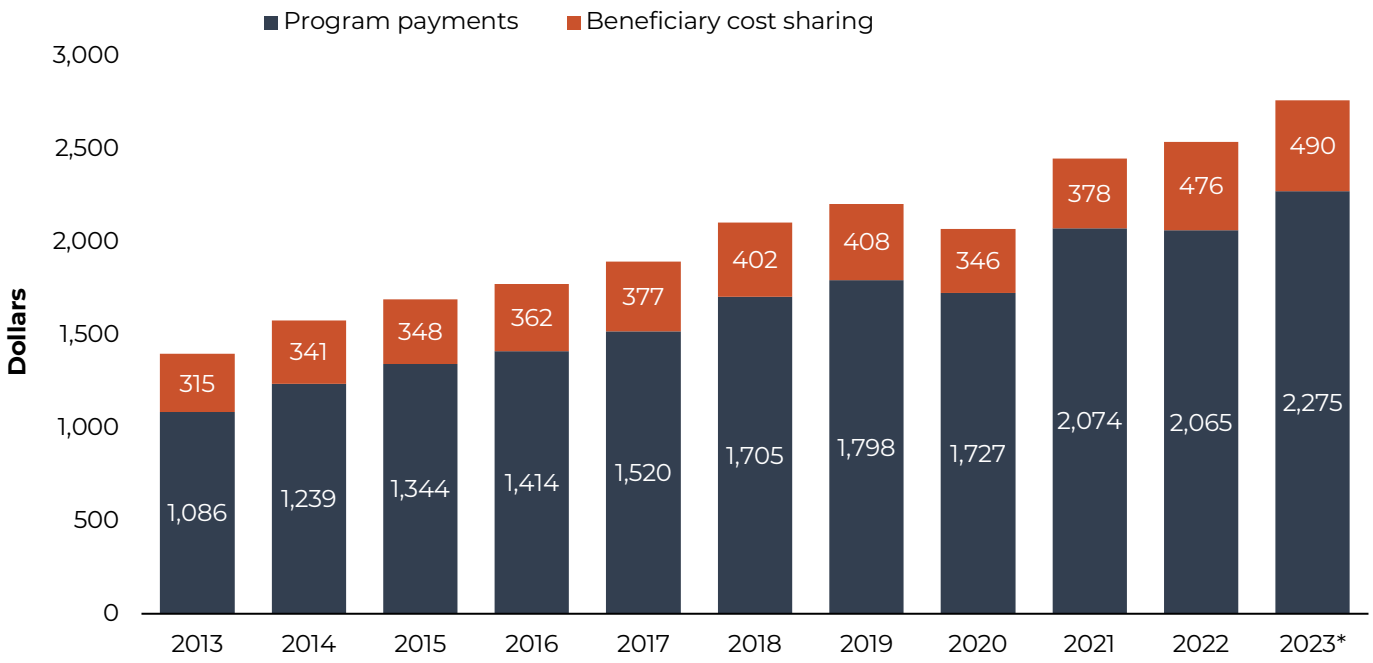
Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> From 2018 to 2023, the total number of clinicians billing the fee schedule grew in absolute terms and relative to the size of the FFS Medicare population.

> The total number of clinicians per 1,000 FFS beneficiaries increased from 30.4 to 39.5 over the 2018 to 2023 period, a total increase of 30 percent.

> Over the 2018 to 2023 period, the number of primary care physicians billing the fee schedule slowly declined—yielding a net loss of about 7,000 primary care physicians by 2023. However, on a per FFS beneficiary basis, the number of primary care physicians grew over the same period. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 237,000 to 327,000. The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased at a steady pace.

Chart 7-5 Spending per Part B FFS beneficiary on hospital outpatient services covered under the outpatient PPS increased, 2013–2023



Note: FFS (fee-for-service), PPS (prospective payment system). Spending amounts are for services covered by the Medicare outpatient PPS. They do not include services paid on separate fee schedules (such as ambulance services and durable medical equipment) or those paid on a cost basis (such as corneal tissue acquisition and flu vaccines) or payments for clinical laboratory services, except those packaged into payment bundles. Dollar amounts are nominal figures, not adjusted for inflation.
* Figures for 2023 are estimated.

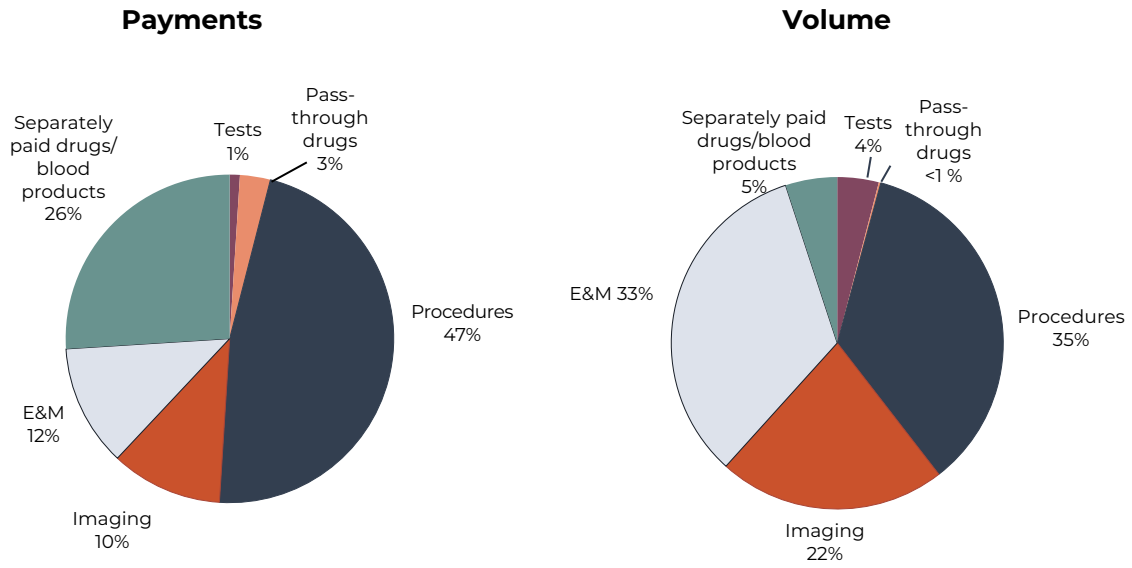
Source: CMS, Office of the Actuary.

> The Office of the Actuary estimates that spending per Part B FFS beneficiary under the outpatient PPS was $2,765 in 2023 ($2,275 in program spending, $490 in beneficiary cost sharing). We estimate that the outpatient PPS accounted for about 6.5 percent of total Medicare program spending in 2023 (data not shown).

> From 2013 to 2023, overall spending per Part B FFS beneficiary by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS increased by 97 percent, an average of 7.0 percent per year on a nominal basis. The Office of the Actuary projects continued growth in per capita total spending, averaging 8.0 percent per year from 2023 to 2025 (data not shown).

> Beneficiary cost sharing under the outpatient PPS includes the Part B deductible and coinsurance for each service. Under the outpatient PPS, beneficiary cost sharing was about 18 percent in 2023.

Chart 7-6 Procedures were the type of service with the highest payments and volume under the Medicare hospital outpatient PPS, 2023



Note: PPS (prospective payment system), E&M (evaluation and management). "Payments" includes both program spending and beneficiary cost-sharing liability. We grouped services into the following categories, according to the Berenson-Eggers Type of Service codes developed by CMS: E&M, procedures, imaging, and tests. "Pass-through drugs" and "separately paid drugs/blood products" are classified by their payment status indicator in the outpatient PPS.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2023.

> Hospitals provide many types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.

> Across services, payments are distributed differently from volume. For example, in 2023, procedures accounted for 47 percent of payments but only 35 percent of volume.

> Procedures (such as endoscopies, surgeries, and skin and musculoskeletal procedures) accounted for the greatest share of payments (47 percent) in 2023, followed by separately paid drugs and blood products (26 percent), E&M services (12 percent), and imaging services (10 percent).

Chart 7-7 Hospital outpatient services with the highest Medicare expenditures under the OPPS, 2023

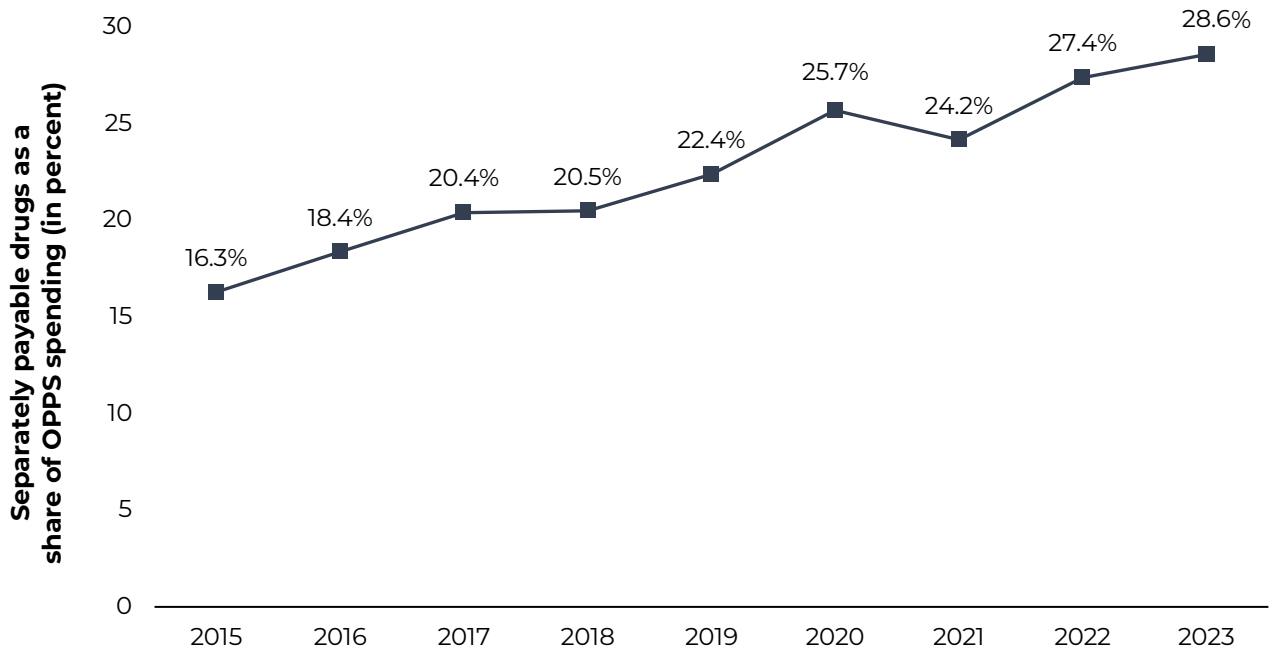
APC title	Share of Medicare expenditures	Volume (thousands)	Payment rate
Level 5 musculoskeletal procedures	8%	444	$13,048
All emergency visits	5	9,467	381
Clinic visits	4	27,486	121
Level 3 electrophysiologic procedures	3	97	23,481
Comprehensive observation services	3	863	2,439
Level 3 endovascular procedures	2	116	10,615
Level 4 musculoskeletal procedures	2	176	6,615
Level 3 drug administration	2	5,608	207
Level 3 radiation therapy	1	1,856	572
Level 1 laparoscopy and related procedures	1	176	5,212
Level 2 ICD and similar procedures	1	29	32,076
Level 4 imaging without contrast	1	1,768	503
Level 2 imaging with contrast	1	2,400	368
Level 1 endovascular procedures	1	293	2,958
Level 2 lower GI procedures	1	891	1,083
Level 2 imaging without contrast	1	7,585	107
Level 4 drug administration	1	2,340	333
Level 3 nuclear medicine and related services	1	593	1,327
Level 2 endovascular procedures	1	106	5,215
Level 4 nuclear medicine and related services	1	497	1,489
Level 3 pacemaker and similar procedures	1	69	10,329
Level 5 urology and related services	1	151	4,702
Level 3 imaging without contrast	1	2,925	234
Level 2 laparoscopy and related services	1	73	9,087
Level 1 intraocular procedures	1	301	2,159
Level 5 neurostimulator and related procedures	1	22	29,358
Level 1 imaging without contrast	1	6,797	87
Level 3 vascular procedures	1	189	2,979
Total	48		
Average for all APCs		604	$459

Note: OPPS (outpatient prospective payment system), APC (ambulatory payment classification), ICD (implantable cardioverter-defibrillator), GI (gastrointestinal). The payment rate for "all emergency visits" is a weighted average of payment rates for 10 emergency-visit APCs (not listed on this chart). In the last row, the average volume is the sum of the volume across all APCs divided by the number of APCs, and the average payment rate is a weighted average of the payment rates for all APCs, where the weights are the volume of services for each APC.

Source: MedPAC analysis of 100 percent analytic files of outpatient claims for 2023 and Addendum B from the 2023 final rule for the OPPS and the payment system for ambulatory surgical centers.

> Although the OPPS covers thousands of services, expenditures are concentrated in a few categories that have high volume, high payment rates, or both.

Chart 7-8 Separately payable drugs have increased as a share of total spending in the OPPS, 2015–2023



Note: OPPS (outpatient prospective payment system). "Separately payable drugs" refers to drugs that are new to the market and those that are established in the drug market but are deemed by CMS to qualify for separate payments because they are relatively expensive.

Source: MedPAC analysis of hospital outpatient standard analytic claims files from 2015 through 2023.

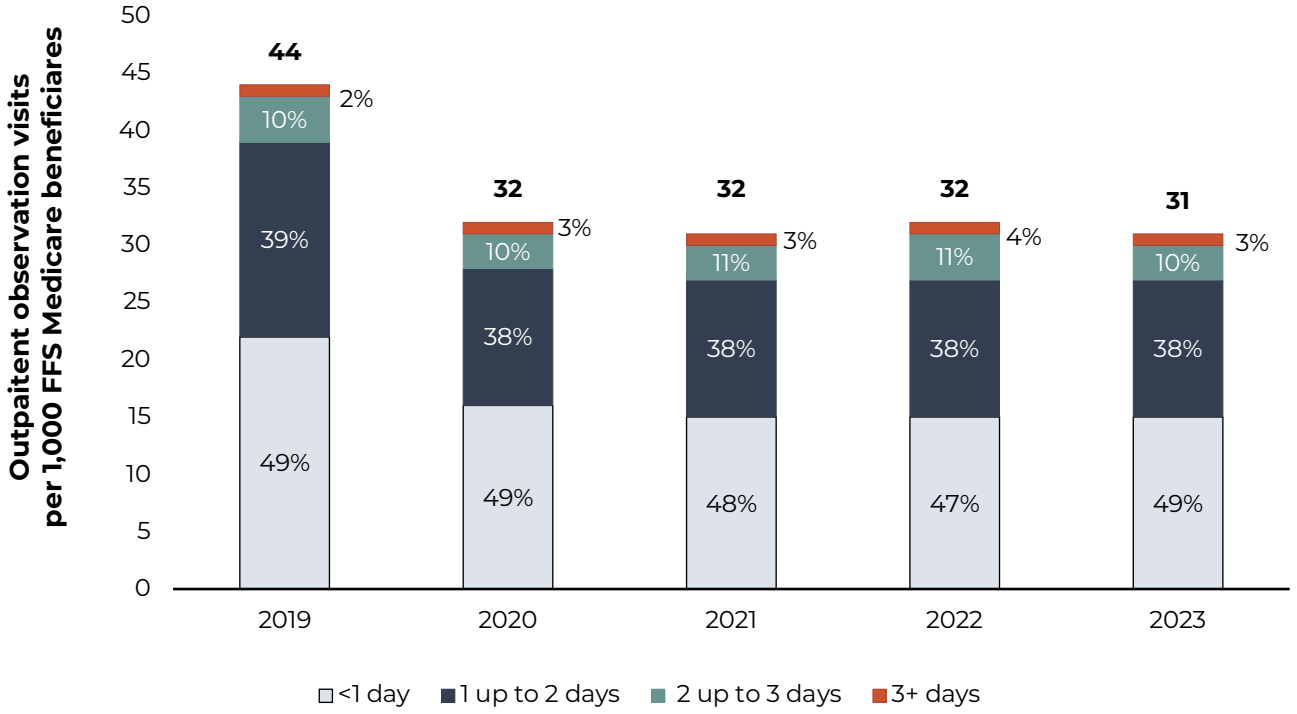
> Under the OPPS, most drugs are packaged, meaning their cost is reflected in the payment for the related services. However, drugs that are new to the market and established drugs that are relatively expensive are paid separately.

> Separately payable drugs have become an increasingly large share of OPPS spending, growing from 16.3 percent in 2015 to 28.6 percent in 2023.

> Except for 2021, the share of OPPS spending attributable to separately payable drugs increased each year from 2015 to 2022, though the increase was relatively small from 2017 to 2018. The small increase during that period was the result of a policy implemented by CMS that substantially decreased the payment rates for relatively expensive established drugs that hospitals obtained through the 340B Drug Pricing Program. Without that policy, we estimate that separately payable drugs would have been 22.7 percent of OPPS spending in 2018 and 24.8 percent in 2019.

> On September 28, 2022, the U.S. Supreme Court ruled that CMS's policy of paying reduced rates for the established drugs that are relatively expensive and are obtained through the 340B program was unlawful because the Secretary of Health and Human Services did not first conduct a survey of hospitals' acquisition costs. Consequently, for the remainder of 2022, CMS set the OPPS payment rates for these drugs at the standard OPPS payment rates and reprocessed the OPPS claims for 340B-acquired drugs from January 1, 2022, through September 27, 2022. This reprocessing of claims provided 340B hospitals with an additional $1.5 billion in OPPS payments for drugs in 2022, substantially increasing the share of total OPPS spending that was attributable to separately payable drugs that year.

Chart 7-9 Number of Medicare FFS outpatient observation visits per capita remained well below the 2019 level



Note: FFS (fee-for-service). "Observation visits" are separately payable visits under the outpatient prospective payment system. These visits last at least eight hours and do not result in an inpatient admission. Figures for FFS beneficiary enrollment are limited to those who resided in the U.S. and had Part B. Results differ from those published last year because of newer data and methodological updates, such as limiting beneficiary counts to beneficiaries residing in the U.S. Years are calendar years. Components do not sum to 100 percent due to rounding and component values that are not shown.

Source: MedPAC analysis of hospital outpatient claims and Common Medicare Environment files.

> Hospitals sometimes use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.

> In 2020, with the onset of the coronavirus pandemic, the number of observation visits per capita declined to 32 visits per 1,000 FFS Medicare beneficiaries (down from 44 visits per 1,000 beneficiaries in 2019). However, the distribution of the observation visits by length of stay remained relatively steady, with nearly half lasting less than one day, another nearly 40 percent lasting one up to two days, and about 13 percent lasting two or more days.

> The volume of observation visits per 1,000 FFS Medicare beneficiaries and the distribution of the length of those visits remained relatively steady from 2020 through 2023.

Chart 7-10 Number of Medicare-certified ASCs increased by 13 percent, 2017–2023

	2017	2018	2019	2020	2021	2022	2023
Medicare payments (billions of dollars)	$4.6	$4.9	$5.2	$4.9	$5.7	$6.1	$6.8
Percent growth in payments	7.4%	6.4%	7.3%	–6.4%	17.6%	5.8%	11.6%
New centers (during year)	215	231	239	186	264	223	252
Closed or merged centers (during year)	126	136	126	92	105	96	100
Net total number of centers (end of year)	5,559	5,654	5,767	5,861	6,020	6,147	6,299
Net percent growth in number of centers	1.6%	1.7%	2.0%	1.6%	2.7%	2.1%	2.5%
Volume per 1,000 FFS Part B beneficiaries	193	197	202	174	205	210	222
Share of all centers that are:							
Urban	93	93	93	93	93	93	93
Rural	7	7	7	7	7	7	7

Note: ASC (ambulatory surgical center), FFS (fee-for-service). "Medicare payments" includes program spending and beneficiary cost sharing for ASC facility services. Some figures differ from Chart 7-11 in our 2024 data book because CMS updated the Provider of Services file. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of Provider of Services file from CMS, 2024. Payment data are from MedPAC analysis of carrier standard analytic claims files.

> ASCs are distinct entities that furnish ambulatory surgical services that do not require an overnight stay in a hospital. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.

> Total Medicare payments per FFS Medicare beneficiary for ASC services increased by approximately 10 percent per year, on average, from 2017 through 2023 on a nominal basis (data not shown). From 2022 to 2023, total payments per FFS beneficiary rose 15 percent as the average complexity of services provided to FFS beneficiaries in ASCs increased and the number of services per FFS Medicare beneficiary increased (data not shown).

> The number of Medicare-certified ASCs grew at an average annual rate of 2.1 percent from 2017 through 2023. In this same period, an annual average of 230 new facilities entered the market, while an average of 112 closed or merged with other facilities.

Chart 7-11 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between $2.0 billion and $5.9 billion on these services

Measure	Broader version of measure			Narrower version of measure		
	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)
Imaging for nonspecific low back pain	13.9	9.9%	$269	3.8	3.5%	$74
PSA screening at age > 75 years	11.1	7.5	97	6.5	5.2	57
Spinal injection for low back pain	6.8	3.8	1,293	2.5	1.5	478
PTH testing in early CKD	6.7	4.0	125	5.6	3.4	104
Colon cancer screening for older adults	6.0	5.8	431	0.2	0.2	2
T3 level testing for patients with hypothyroidism	5.9	3.5	35	5.9	3.5	35
Carotid artery disease screening in asymptomatic adults	4.2	3.9	223	3.5	3.2	182
Preoperative chest radiography	3.4	3.1	49	0.8	0.7	11
Head imaging for uncomplicated headache	3.3	3.0	218	2.1	1.9	137
Stress testing for stable coronary disease	3.0	2.8	834	0.3	0.3	92
Cervical cancer screening at age > 65 years	2.0	1.9	40	1.7	1.7	35
Homocysteine testing in cardiovascular disease	1.1	0.9	9	0.2	0.1	1
Head imaging for syncope	1.0	1.0	68	0.6	0.6	40
Preoperative echocardiography	1.1	1.1	87	0.3	0.3	28
BMD testing at frequent intervals	0.6	0.6	13	0.4	0.4	9
Preoperative stress testing	0.6	0.6	171	0.2	0.2	52
CT for uncomplicated rhinosinusitis	0.6	0.6	44	0.3	0.3	18
Vitamin D testing in absence of hypercalcemia or decreased kidney function	0.5	0.4	8	0.5	0.4	8
Imaging for plantar fasciitis	0.5	0.4	10	0.2	0.2	4
Screening for carotid artery disease for syncope	0.5	0.4	24	0.3	0.3	15
PCI/stenting for stable coronary disease	0.3	0.3	1,174	0.04	0.04	181
Cancer screening for patients with CKD on dialysis	0.3	0.2	7	0.1	0.1	1
Hypercoagulability testing after DVT	0.2	0.2	6	0.1	0.1	2
Vertebroplasty/kyphoplasty for osteoporotic vertebral fractures	0.2	0.1	308	0.2	0.1	303
Arthroscopic surgery for knee osteoarthritis	0.2	0.2	136	0.02	0.02	21
Preoperative PFT	0.2	0.2	2	0.1	0.1	1
IVC filter to prevent pulmonary embolism	0.1	0.1	15	0.1	0.1	15
Renal artery angioplasty/stenting	0.1	0.1	134	0.01	0.01	31
EEG for headache	0.04	0.04	2	0.02	0.02	1
Carotid endarterectomy for asymptomatic patients	0.05	0.05	124	0.02	0.02	50
Pulmonary artery catheterization in ICU	0.01	0.01	0.2	0.02	0.005	0.2
Total	74.2	37.5	5,929	36.3	23.5	1,990

(Chart continued next page)

Chart 7-11 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between $2.0 billion and $5.9 billion on these services (continued)

Note: FFS (fee-for-service), PSA (prostate-specific antigen), PTH (parathyroid hormone), CKD (chronic kidney disease), BMD (bone mineral density), CT (computed tomography), PCI (percutaneous coronary intervention), DVT (deep vein thrombosis), PFT (pulmonary function test), IVC (inferior vena cava), EEG (electroencephalography), ICU (intensive care unit). Note that carotid endarterectomy now includes carotid stenting. "Count" refers to the number of unique services. Some totals do not equal the sum of their components due to rounding. The total for "share of beneficiaries affected" does not equal the column sum because some beneficiaries received services covered by multiple measures. "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2022. This method was developed by Schwartz et al. (2014) with updates to reflect changes to diagnosis and procedure coding over time. The broad and narrow versions of the measures for T3 level testing for patients with hypothyroidism and IVC filter to prevent pulmonary embolism are the same.

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

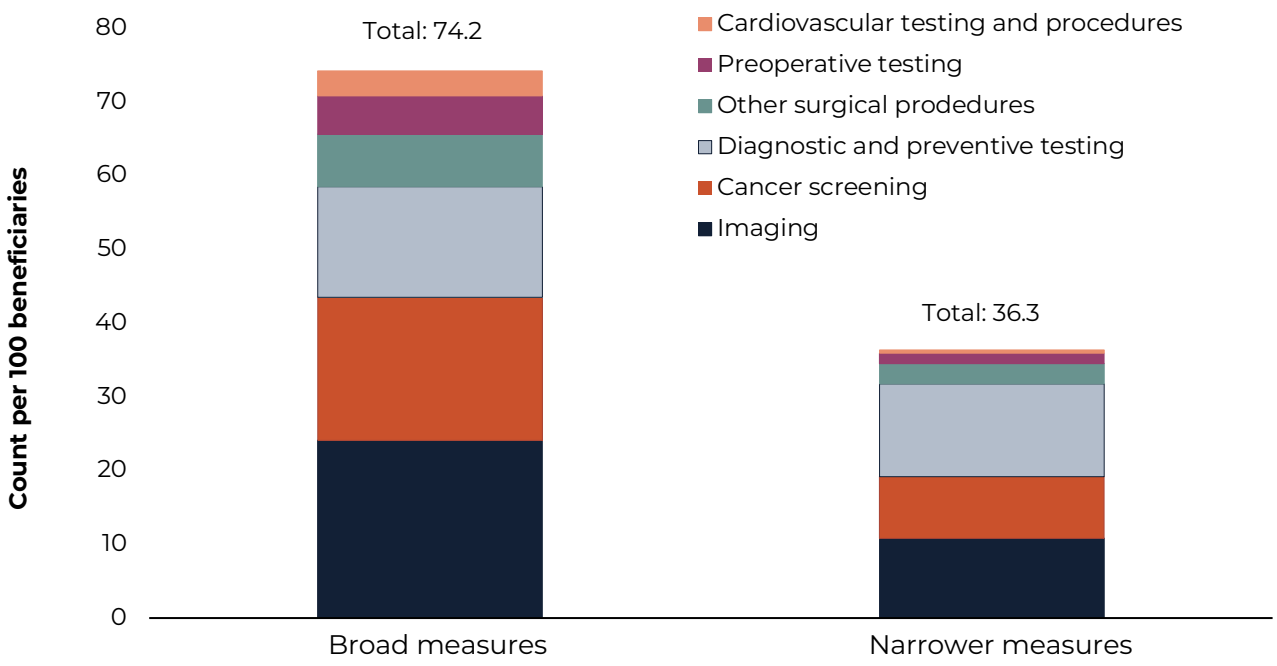
> Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.

> The 31 measures of low-value care in this chart were developed by a team of researchers. The measures are drawn from evidence-based lists—such as Choosing Wisely—and the medical literature. We applied these measures to 100 percent of Medicare claims data from 2023. These 31 measures do not represent all instances of low-value care; the actual number (and corresponding spending) may be much higher.

> The researchers developed two versions of each measure: a broader version (more sensitive, less specific) and a narrower version (less sensitive, more specific). Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure's specificity leads to less misclassification of appropriate use as inappropriate at the expense of potentially missing some instances of inappropriate use.

> Based on the broader versions of the measures, our analysis found about 74 instances of low-value care per 100 beneficiaries in 2023, with about 37 percent of beneficiaries receiving at least 1 low-value service that year. Medicare spending for these services was $5.9 billion. Based on the narrower versions of the measures, our analysis showed about 36 instances of low-value care per 100 beneficiaries, with 23 percent of beneficiaries receiving at least 1 low-value service. Medicare spending for these services totaled about $2.0 billion.

Chart 7-12 Imaging, cancer screening, and diagnostic and preventive testing accounted for most of the volume of low-value care in 2023



Note: "Count" refers to the number of unique services provided to fee-for-service Medicare beneficiaries.

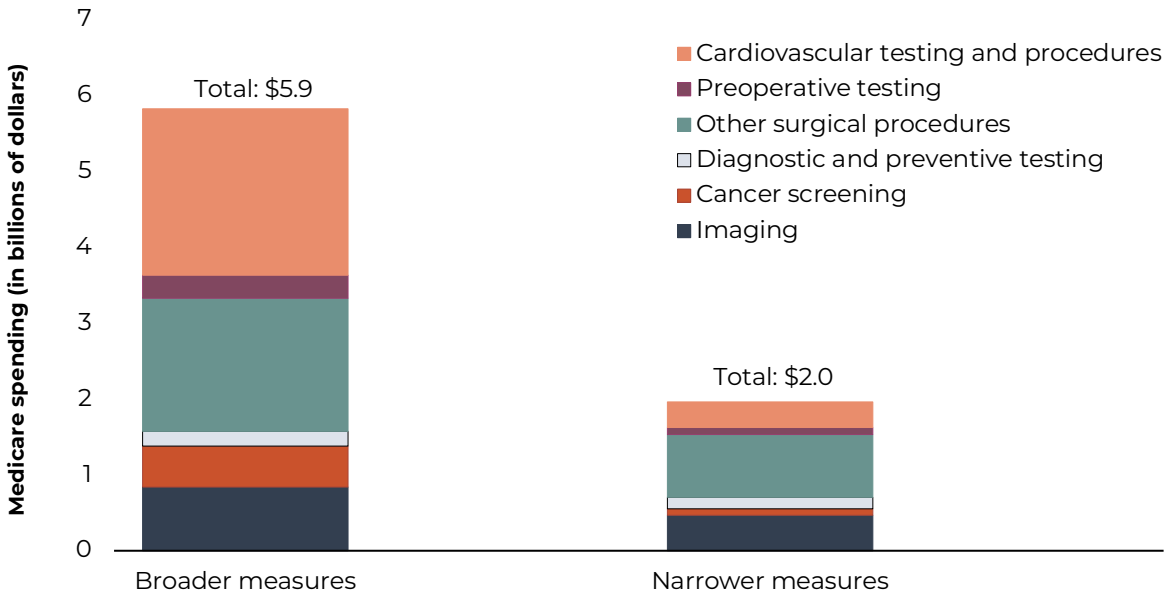
Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> We assigned each of the 31 measures of low-value care in Chart 7-11 to one of six clinical categories.

> Using the broader versions of the measures, imaging and cancer screening accounted for 59 percent of the volume of low-value care per 100 beneficiaries. The "imaging" category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults. The "cancer screening" category includes prostate-specific antigen testing for men ages 75 and older and colorectal cancer screening for older adults.

> Using the narrower versions of the measures, imaging and diagnostic and preventive testing accounted for 64 percent of the volume of low-value care per 100 beneficiaries.

Chart 7-13 Cardiovascular testing and procedures, other surgical procedures, and imaging accounted for most spending on low-value care in 2023



Note: "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2023. This method was developed by Schwartz et al. (2014).

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> Cardiovascular testing and procedures and "other surgical procedures" accounted for about 67 percent of total spending on low-value care using the broader measures. Other surgical procedures and imaging made up 59 percent of spending on low-value care using the narrower measures.

> The "cardiovascular testing and procedures" category includes stress testing for stable coronary disease and percutaneous coronary intervention with balloon angioplasty or stent placement for stable coronary disease. The "other surgical procedures" category includes spinal injection for low back pain and arthroscopic surgery for knee osteoarthritis. The "imaging" category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults.

> The spending estimates probably understate actual spending on low-value care because they do not include the cost of downstream services (e.g., follow-up tests and procedures) that may result from the initial low-value service. Also, we are not capturing all low-value care through these 31 measures.

Chart 7-14 In MedPAC's 2024 survey, Medicare beneficiaries were more likely to report being satisfied with their access to care than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Received health care in past year: "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%*	91%*
Providers that 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 (net)	97*	93*
Very satisfied	82*	66*
Somewhat satisfied	15*	26*
Dissatisfied (net)	3*	7*
Somewhat dissatisfied	2*	6*
Very dissatisfied	1*	2*
Providers with 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 (net)	88*	79*
Very satisfied	57*	40*
Somewhat satisfied	31*	39*
Dissatisfied (net)	12*	21*
Somewhat dissatisfied	8*	15*
Very dissatisfied	4*	6*

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> MedPAC surveys Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64 each year to compare these two groups' experiences accessing care in the prior 12 months.

> In our 2024 survey, higher shares of Medicare beneficiaries reported receiving any health care in the past year (95 percent) compared with privately insured individuals (91 percent).

> Among those who received health care in the past year:

>> Higher shares of Medicare beneficiaries were satisfied with their ability to find health care providers that accepted their insurance (97 percent) compared with privately insured people (93 percent).

>> Higher shares of Medicare beneficiaries were satisfied with their ability to find providers that had appointments when needed (88 percent) compared with privately insured people (79 percent).

Chart 7-15 In MedPAC's 2024 survey, Medicare beneficiaries reported slightly better access to primary care providers than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
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%*	91%*
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"		
For none of my primary care (I always see a doctor)	41*	34*
For any of my primary care (net)	57*	61*
For some of my primary care	37	38
For all or most of my primary care	19*	23*
Don't know	3*	5*
Tried to get a new primary care provider: "In the past 12 months, have you tried to get a new primary care provider?"		
Yes	11%*	16%*
Reason looked for new primary care provider: Among those who tried to get a new primary care provider, "Which of the following best describes the main reason you tried to get a new primary care provider in the last 12 months?" (Overall share)		
My provider retired or stopped practicing	45* (5)	37* (6)
I wanted to change providers	31 (3*)	31 (5*)
I recently moved, so I needed to find a primary care provider in my area	13 (1)	12 (2)
I changed my health plan and had to find a new provider who participated in the new plan	8* (1*)	15* (2*)
My primary care provider was no longer accepting [Medicare / my insurance]	3 (0*)	6 (1*)

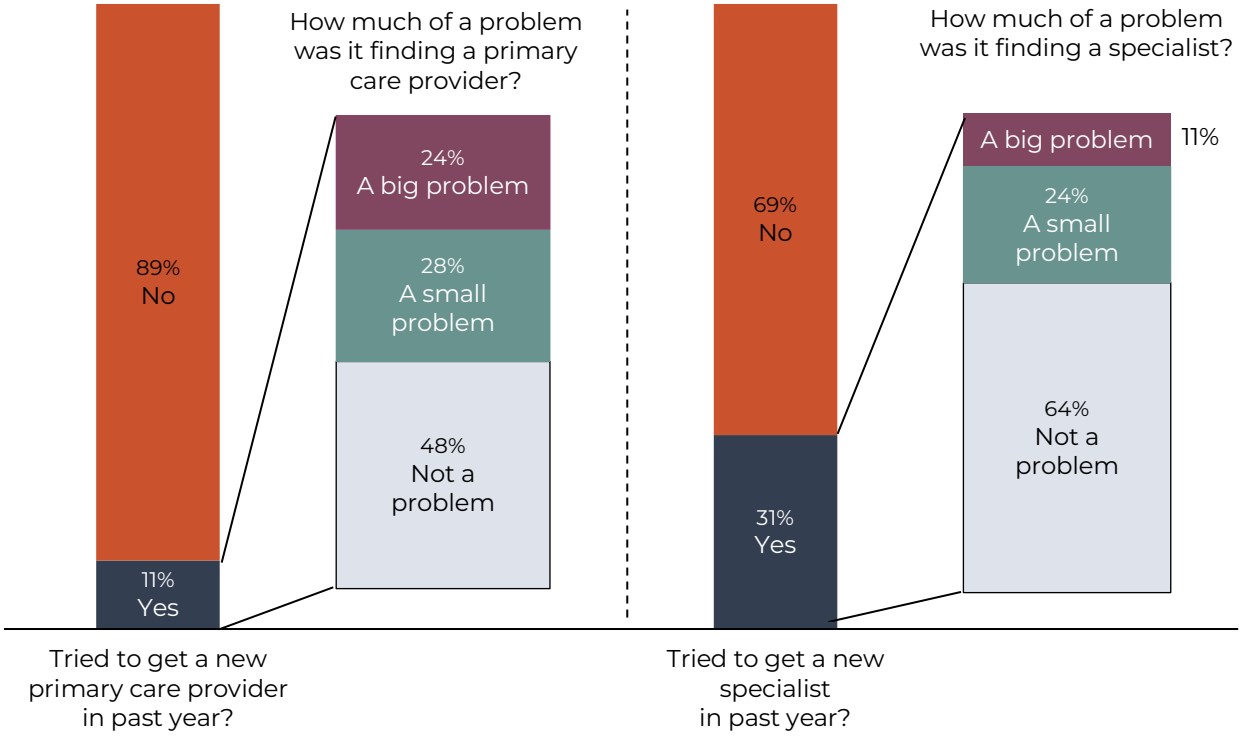
Note: NP (nurse practitioner), PA (physician assistant). We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "Overall share" refers to the share of all respondents with this insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> In our 2024 survey, higher shares of Medicare beneficiaries reported having a primary care provider (PCP) (96 percent) compared with privately insured people (91 percent). Lower shares of Medicare beneficiaries reported needing to find a new PCP in the past year compared with privately insured people (11 percent vs. 16 percent).

> Among those looking for a new PCP, only 3 percent of Medicare beneficiaries and 6 percent of privately insured people did so because their existing PCP no longer accepted their insurance (equivalent to nearly 0 percent and 1 percent, respectively, of these groups overall). A more common reason for looking for a new PCP was that a PCP had retired or stopped practicing, which was reported by 45 percent of Medicare beneficiaries looking for a new PCP and 37 percent of privately insured people in this situation (equivalent to 5 percent and 6 percent, respectively, of these groups overall).

Chart 7-16 Beneficiaries looking for a new clinician reported more problems finding a new primary care provider than a new specialist



Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> In our 2024 survey, among the 11 percent of Medicare beneficiaries who tried to get a new primary care provider in the past year, 52 percent reported problems finding one: 24 percent reported "a big problem" finding a new one, and another 28 percent reported "a small problem." These figures, combined, are equivalent to 5 percent of Medicare beneficiaries reporting problems finding a new primary care provider in the past year overall (data not shown).

> A larger share of patients look for a new specialist each year: In 2024, 31 percent of Medicare beneficiaries tried to get a new specialist in the past year. Among these beneficiaries, 36 percent reported problems finding a new specialist: 11 percent reported "a big problem," and 24 percent reported "a small problem" finding one. Combined, these figures are equivalent to 11 percent of Medicare beneficiaries reporting problems finding a new specialist overall (data not shown).

> Privately insured people reported more problems finding a new clinician than did Medicare beneficiaries, as we show in the next chart.

Chart 7-17 In our 2024 survey, Medicare beneficiaries reported fewer problems finding a new clinician than younger privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Get a new primary care provider: "In the past 12 months, have you tried to get a new primary care provider?"		
Yes	11%*	16%*
Problems finding a primary care provider: Among those who tried to get a new primary care provider, "How much of a problem was it finding a primary care provider who would treat you?" (Overall share)		
A problem (net)	52* (5*)	66* (10*)
A big problem	24* (2*)	31* (5*)
A small problem	28 (3*)	34 (5*)
Not a problem	48* (5)	34* (5)
Primary care providers not accepting your insurance: Among those who had a problem finding a new primary care provider, "Did anyone from a doctor's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	14* (1*)	27* (3*)
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"		
Yes	31	34
Problems finding a specialist: Among those who tried to get a new specialist, "How much of a problem was it finding a specialist who would treat you?" (Overall share)		
A problem (net)	36* (11*)	48* (16*)
A big problem	11* (3*)	18* (6*)
A small problem	24* (8*)	30* (10*)
Not a problem	64* (20*)	52* (17*)
Specialists not accepting your insurance: Among those who had a problem finding a new specialist, "Did anyone from a doctor's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	13* (1*)	27* (4*)
Get a new mental health professional: "Some specialists and other clinicians focus on mental health. In the past 12 months, have you tried to get a new mental health professional?"		
Yes	3*	8*
Problems finding a mental health professional: Among those who tried to get a mental health professional, "How much of a problem was it finding a mental health professional who would treat you?" (Overall share)		
A problem (net)	62 (2*)	74 (6*)
A big problem	37 (1*)	42 (3*)
A small problem	25 (1*)	32 (2*)
Not a problem	38 (1*)	26 (2*)
Mental health professionals not accepting your insurance: Among those who had a problem finding a new mental health professional, "Did anyone from a mental health professional's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	48 (1*)	45 (3*)

(Chart continued next page)

Chart 7-17 In our 2024 survey, Medicare beneficiaries reported fewer problems finding a new clinician than younger privately insured people (continued)

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "Overall share" refers to the share of all respondents with the respective insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> Our 2024 survey found that Medicare beneficiaries were less likely to report trying to get a new primary care provider (PCP) in the past year compared with privately insured people (11 percent vs. 16 percent). In contrast, there was not a statistically significant difference in the shares of respondents who tried to get a new specialist in the past year (31 percent vs. 34 percent)

> Among those looking for a new PCP, privately insured people were more likely than Medicare beneficiaries to report problems finding one. In 2024, 66 percent of the privately insured people who were looking for a new PCP reported problems (equivalent to 10 percent of all privately insured people), while 52 percent of the Medicare beneficiaries who were looking for a new PCP reported problems (equivalent to 5 percent of all Medicare beneficiaries). Privately insured people also reported more problems finding specialists than did Medicare beneficiaries (48 percent vs. 36 percent, equivalent to 16 percent of privately insured people and 11 percent of Medicare beneficiaries overall).

> Privately insured people were twice as likely as Medicare beneficiaries to encounter a PCP or a specialist who did not accept their insurance. For example, among those looking for a new PCP, 14 percent of Medicare beneficiaries and 27 percent of privately insured people encountered a doctor's office that did not accept their insurance (equivalent to 1 percent of Medicare beneficiaries and 3 percent of privately insured people overall). Similar shares reported this experience when looking for a new specialist.

> Very few people reported looking for a new mental health professional in the past year, but privately insured people were more likely than Medicare beneficiaries to report looking for this type of health care professional (8 percent vs. 3 percent). A majority of both groups reported problems finding this type of clinician: 62 percent of Medicare beneficiaries who were looking for a mental health professional and 74 percent of privately insured people who were looking reported problems finding one, equivalent to 2 percent and 6 percent, respectively, of these groups overall. Among those looking for a new mental health professional, about half of both groups encountered a mental health professional who did not accept their insurance.

Chart 7-18 In our 2024 survey, Medicare beneficiaries ages 65+ were less interested in using telehealth than privately insured people ages 50–64

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Had a telehealth visit: "In the past 12 months, have you had a [video / telephone] visit . . . with any type of health care provider?"		
Telehealth visit (video or telephone) (net)	33%	36%
Video visit	18*	26*
Telephone visit (audio only)	24*	20*
Satisfaction with telehealth visit: Among those who had a [video / telephone] visit, "How satisfied were you with the [video / telephone] visit(s) you had in the past 12 months?"		
Video visit(s)		
Satisfied (net)	92	90
Very satisfied	61	57
Somewhat satisfied	31	33
Dissatisfied (net)	8	10
Somewhat dissatisfied	4	7
Very dissatisfied	3	3
Telephone visit(s)		
Satisfied (net)	93	93
Very satisfied	62*	53*
Somewhat satisfied	31*	40*
Dissatisfied (net)	7	7
Somewhat dissatisfied	5	5
Very dissatisfied	2	2
Interest in using telehealth in the future: "Would you be interested in having the option to use [video / telephone] visits to see health care providers in the future?"		
Interested in at least one type of telehealth visit (net)	44*	61*
Interested in video visits	28*	46*
Interested in telephone visits	27*	36*

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. In our questions about having had any telehealth visits in the past 12 months (the first set of questions shown above), video visits were defined as "using a smartphone, computer, or tablet" and telephone visits were defined as "a phone call with audio but no video."
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

(Chart continued next page)

Chart 7-18 In our 2024 survey, Medicare beneficiaries ages 65+ were less interested in using telehealth than privately insured people ages 50–64 (continued)

> In our 2024 survey, about a third of Medicare beneficiaries and privately insured people reported having had some type of telehealth visit in the past year.

>> Medicare beneficiaries were somewhat more likely than privately insured people to have had an audio-only telephone visit (24 percent vs. 20 percent).

>> Meanwhile, privately insured people were somewhat more likely to have had a video visit than Medicare beneficiaries (26 percent vs. 18 percent).

> Across insurance groups and types of telehealth visits, 90 percent or more of telehealth users reported being satisfied with their visits.

> A little under half (44 percent) of all Medicare beneficiaries were interested in having the option to use telehealth in the future, while a higher share (61 percent) of privately insured people were interested in having access to telehealth.

>> 28 percent of Medicare beneficiaries were interested in having access to video visits.

>> 27 percent of Medicare beneficiaries were interested in having access to audio-only telephone visits.

> In analyses of Medicare beneficiary subgroups (not shown):

>> Telehealth visits were more commonly used by Medicare beneficiaries who lived in urban areas, had household incomes of at least $50,000, and were under the age of 75. These subgroups were also more interested in having access to telehealth in the future.

>> There were not statistically significant differences in the shares of White, Black, and Hispanic Medicare beneficiaries who used telehealth.

>> There were not statistically significant differences in the shares of different subgroups who were satisfied with their telehealth visits.

Chart 7-19 In our 2024 survey, Medicare beneficiaries were less likely to report long waits for appointments than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Long wait for 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?" (Overall share)		
For regular or routine care		
Never	51%* (48%*)	36%* (33%*)
Sometimes	37* (35*)	42* (40*)
Usually	9* (9*)	14* (13*)
Always	4* (4*)	8* (8*)
For an illness or injury		
Never	65* (54*)	54* (44*)
Sometimes	28* (24)	32* (26)
Usually	5* (4*)	9* (8*)
Always	2* (2*)	5* (4*)
Response to long wait: Among those who had to wait longer than they wanted for an appointment, "What did you do?" (Overall share)		
For regular or routine care		
Took the later appointment date	82 (38*)	80 (48*)
Went to a walk-in clinic	10 (5*)	12 (7*)
Decided not to schedule the appointment	5 (2*)	6 (3*)
Went to a hospital emergency room	3 (1)	2 (1)
For an illness or injury		
Took the later appointment date	60* (18*)	55* (20*)
Went to a walk-in clinic	22* (6*)	30* (11*)
Decided not to schedule the appointment	5* (1*)	8* (3*)
Went to a hospital emergency room	13* (4*)	7* (3*)

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. Instructions for the questions shown above read: "For the next few questions, please think about the number of days or weeks you had to wait to get a doctor's appointment. Do not include time spent on hold or in the waiting room" and "Please count video visits and phone visits as appointments." "Overall share" refers to the share of all respondents with the respective insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

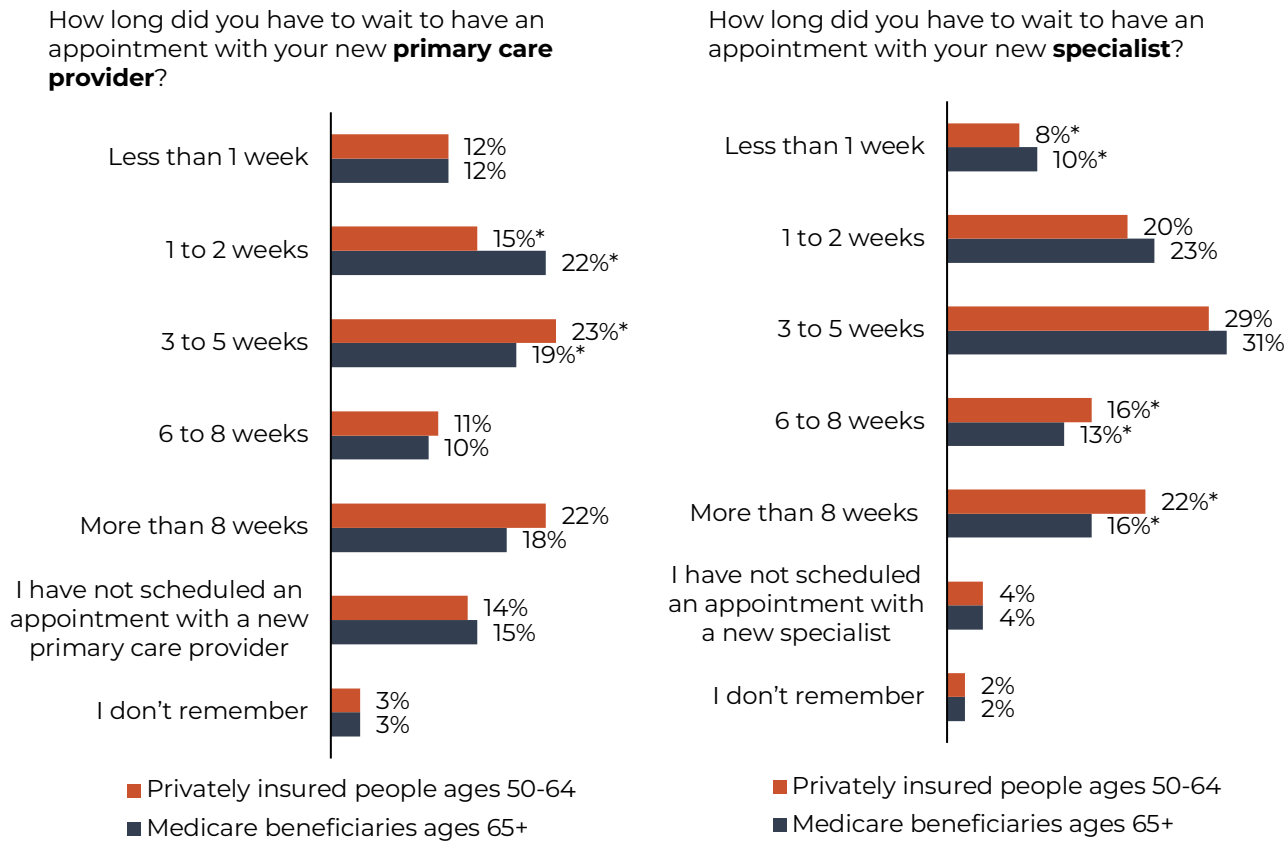
> In 2024, our survey found that Medicare beneficiaries were less likely than privately insured people to report having to wait longer than they wanted to get a doctor's appointment.

> Among those who needed appointments for routine care, about half (51 percent) of Medicare beneficiaries reported that they never had to wait longer than they wanted to get such an appointment, while only 36 percent of privately insured people reported never experiencing this problem.

> Among those who needed appointments for an illness or injury, about two-thirds (65 percent) of Medicare beneficiaries said they never had to wait longer than they wanted to get an appointment, compared with 54 percent of privately insured people.

Chart 7-20 In our 2024 survey, Medicare beneficiaries and privately insured people reported similar wait times for a first appointment with a new clinician

Among those who tried to get a new [primary care provider/specialist] in the past 12 months . . .



Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> Among Medicare beneficiaries who tried to get a new primary care provider (PCP) in the past year, about a third (34 percent) reported waiting two weeks or less for their first appointment. Similarly, among those trying to get a new specialist, a third (33 percent) waited two weeks or less for their first appointment.

> Wait times reported by Medicare beneficiaries were comparable with or, in some cases, better than those reported by privately insured people.

>> Medicare beneficiaries were more likely to be seen by a new PCP in one to two weeks and less likely to be seen in three to five weeks compared with privately insured people.

>> Medicare beneficiaries were more likely to be seen by a new specialist in less than one week and less likely to wait six weeks or more for an appointment.

Chart 7-21 In our 2024 survey, Medicare beneficiaries were less likely to report forgoing care than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Forgoing care: "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%*	27%*
Reason for forgoing care: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the **main reason** you did not see a doctor about this condition during the past 12 months?" (Overall share)		
I just put it off	27 (5*)	24 (6*)
I didn't think the problem was serious	28* (5)	18* (5)
I couldn't get an appointment soon enough	22 (4*)	21 (6*)
I thought it would cost too much	7* (1*)	23* (6*)
I couldn't find a doctor who would treat me	4 (1)	4 (1)
I put it off because I was worried about catching COVID-19	1 (0)	0 (0)
Other	11 (2)	10 (3)

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. Components do not sum to 100 percent due to rounding. "Overall share" refers to the share of all respondents with the respective insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> In our 2024 survey, 18 percent of Medicare beneficiaries and 27 percent of privately insured people reported forgoing care that they thought they should have gotten in the past year.

> About half of care-forgoers did so because they "didn't think the problem was serious" or "just put it off" (55 percent of Medicare beneficiaries and 42 percent of privately insured people reported one of these reasons).

> About one in five care-forgoers skipped care because they could not get an appointment soon enough: This reason accounted for 22 percent of Medicare care-forgoers (equivalent to 4 percent of all Medicare beneficiaries) and 21 percent of privately insured care-forgoers (equivalent to 6 percent of all privately insured people).

> Medicare beneficiaries were much less likely to forgo care due to concerns about cost compared with privately insured people: Only 7 percent of Medicare care-forgoers skipped care because they "thought it would cost too much" (equivalent to 1 percent of all Medicare beneficiaries), while 23 percent of privately insured care-forgoers skipped care for this reason (equivalent to 6 percent of all privately insured people).

Chart 7-22 In our 2024 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
Received health care in past year: "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	92%[ab]	96%[ab]	97%[ab]	84%[ab]	92%[ab]	93%[ab]
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"						
For all or most of my primary care	24[b]	16[ab]	15[ab]	28[b]	23[a]	21[ab]
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"						
Yes	26[b]	33[b]	39[b]	25[b]	32[b]	37[b]
Forgoing care: "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[ab]	18[a]	16[ab]	30[a]	29[a]	26[a]
Reason for forgoing care: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the **main reason** you did not see a doctor about this condition during the past 12 months?" (Overall share)						
I just put it off	24 (5)	35[a] (6)	27 (4[a])	21 (6)	21[a] (6)	26 (7[a])
I didn't think the problem was serious	26 (5)	29[a] (5)	28[a] (5)	18 (5)	17[a] (5)	19[a] (5)
I couldn't get an appointment soon enough	21 (4)	19 (3)	25 (4[a])	17 (5)	17 (5)	24 (6[a])
I thought it would cost too much	10[ab] (2[ab])	4[a] (1[a])	4[ab] (1[ab])	31[ab] (9[ab])	30[a] (8[a])	17[ab] (4[ab])
I couldn't find a doctor who would treat me	5 (1)	4 (1)	3 (0)	3 (1)	4 (1)	5 (1)
I put if off because I was worried about catching COVID-19	2 (0)	1 (0)	1 (0)	0 (0)	0 (0)	1 (0)
Other	11 (2)	7 (1[a])	13 (2)	10 (3)	12 (3[a])	9 (2)

Note: NP (nurse practitioner), PA (physician assistant). We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "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. "Overall share" refers to the share of all respondents with the respective insurance.

[a] Statistically significant difference between Medicare beneficiaries and private insurance people within the same income category (at the 95 percent confidence level).

[b] Statistically significant difference between lower-income respondents and middle- or higher-income respondents within the same insurance category (at the 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

(Chart continued next page)

Chart 7-22 In our 2024 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries (continued)

> In 2024, we found some differences in care patterns for lower-income Medicare beneficiaries (with household incomes below $50,000) and higher-income beneficiaries (with household incomes of $80,000 or more). For example:

>> Only 92 percent of lower-income beneficiaries reported receiving any health care in the past year, compared with 97 percent of higher-income beneficiaries.

>> Higher shares of lower-income beneficiaries reported forgoing care in the past year (20 percent) compared with higher-income beneficiaries (16 percent).

> Medicare beneficiaries were less likely than privately insured people to report cost as a barrier to care: Among lower-income privately insured respondents who had forgone care, 31 percent reported cost as the main reason they had done so (equivalent to 9 percent of lower-income privately insured people). By contrast, among lower-income Medicare beneficiaries who had forgone care, only 10 percent cited cost as the reason they had done so (equivalent to 2 percent of lower-income Medicare beneficiaries).

Chart 7-23 In our 2024 survey, White, Black, and Hispanic Medicare beneficiaries generally reported comparable experiences accessing care

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
Received 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]	94%	95%[a]	92%[ab]	89%	87%[ab]
Providers who accept their 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 (net)	97[a]	97	95	92[a]	95	95
Providers with 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 (net)	88[a]	92	89	79[a]	85	81
Long wait for 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 regular or routine care						
Usually or always	13[ab]	7[ab]	12	22[a]	17[a]	21
Sometimes or never	87[ab]	93[ab]	88	78[a]	83[a]	79
For an illness or injury						
Usually or always	7[a]	5	8	14[a]	10	16
Sometimes or never	93[a]	95	92	86[a]	90	84
Forgoing care: "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]	18	21	27[a]	23	32

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "White" refers to non-Hispanic White respondents, "Black" refers to non-Hispanic Black respondents, and "Hispanic" refers to Hispanic respondents of any race.

[a] Statistically significant difference between Medicare beneficiaries and private insurance people within the same race/ethnicity category (at the 95 percent confidence level).

[b] Statistically significant difference between White and Black or White and Hispanic within the same insurance category (at the 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024

> There were not statistically significant differences by race or ethnicity on most questions in our survey, including the shares of White and Black or Hispanic beneficiaries who:

>> had received health care in the past year,

>> were satisfied with their ability to find health care providers who accepted their insurance and had timely appointments available,

>> had to wait longer than they wanted to get an appointment for an illness or injury, or

>> reported forgoing care that they thought they should have gotten.

Chart 7-24 In our 2024 survey, rural Medicare beneficiaries were more likely to receive their primary care from a nonphysician than urban beneficiaries

	Medicare (ages 65 and older)		Private insurance (ages 50–64)	
Survey question	Urban	Rural	Urban	Rural
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"				
For none of my primary care (I always see a doctor)	43%[ab]	30%[b]	36%[ab]	27%[b]
For any of my primary care (net)	54[ab]	66[b]	59[ab]	69[b]
For some of my primary care	38	37	39[b]	33[b]
For all or most of my primary care	17[ab]	30[b]	20[ab]	36[b]
Don't know	2[a]	3	5[a]	4
Wait time for appointment with new PCP: Among those who tried to get a new primary care provider in the past 12 months, "How long did you have to wait to have an appointment with your new primary care provider?"				
I have not scheduled an appointment with a new primary care provider	16	10	15	10
Less than 1 week	12	12	12	14
1 to 2 weeks	19[ab]	34[b]	13[ab]	27[b]
3 to 5 weeks	19	19	24	18
6 to 8 weeks	11	6	11	12
More than 8 weeks (2 months)	20	13	23	14
I don't remember	3	5	2	5
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"				
Yes	33[b]	26[b]	35[b]	28[b]
Long wait for a routine appointment: Among those who needed an appointment for regular or routine care in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"(Overall share)				
Never	49[ab] (47[ab])	57[ab] (54[ab])	34[ab] (31[ab])	45[ab] (43[ab])
Sometimes	38[a] (36[a])	33 (32)	43[a] (40[a])	37 (35)
Usually	9[a] (9[a])	8 (8)	15[a] (14[a])	10 (10)
Always	4[a] (4[a])	3[a] (3[a])	8[a] (8[a])	7[a] (7[a])

Note: NP (nurse practitioner), PA (physician assistant), PCP (primary care provider). We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "Urban" respondents live 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 live outside of an MSA.

[a] Statistically significant difference between Medicare beneficiaries and privately insured people within the same area type (at the 95 percent confidence level).

[b] Statistically significant difference between urban and rural respondents within the same insurance category (at the 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

(Chart continued next page)

Chart 7-24 In our 2024 survey, rural Medicare beneficiaries were more likely to receive their primary care from a nonphysician than urban beneficiaries (continued)

> Our survey found a few differences between rural and urban beneficiaries' experiences accessing care. In particular:

>> More rural beneficiaries reported receiving all or most of their primary care from an NP or PA (30 percent) compared with urban beneficiaries (17 percent). This finding was also true among the privately insured.

>> More rural beneficiaries reported never having to wait longer than they wanted to get an appointment for regular or routine care (57 percent) compared with urban beneficiaries (49 percent) among those who needed this type of appointment. This finding was also true among the privately insured.

>> More rural beneficiaries reported waiting only one to two weeks for their first appointment with a new primary care provider (34 percent) compared with urban beneficiaries (19 percent). This finding was also true among the privately insured.

>> Fewer rural beneficiaries reported looking for a new specialist in the past year (26 percent) compared with urban beneficiaries (33 percent). This finding was also true among the privately insured.

> Among Medicare beneficiaries, there were no statistically significant differences between the shares of urban and rural residents who:

>> had received any health care in the past year;

>> were satisfied with their ability to find health care providers who accepted their insurance;

>> were satisfied with their ability to find health care providers who had appointments available when they needed them;

>> had a primary care provider;

>> tried to get a new primary care provider or a new mental health professional;

>> experienced a problem finding a new primary care provider, specialist, or mental health professional;

>> encountered a primary care or specialist practice that did not accept Medicare;

>> waited longer than they wanted to get an appointment for an illness or injury; and

>> reported forgoing care that they thought they should have gotten.