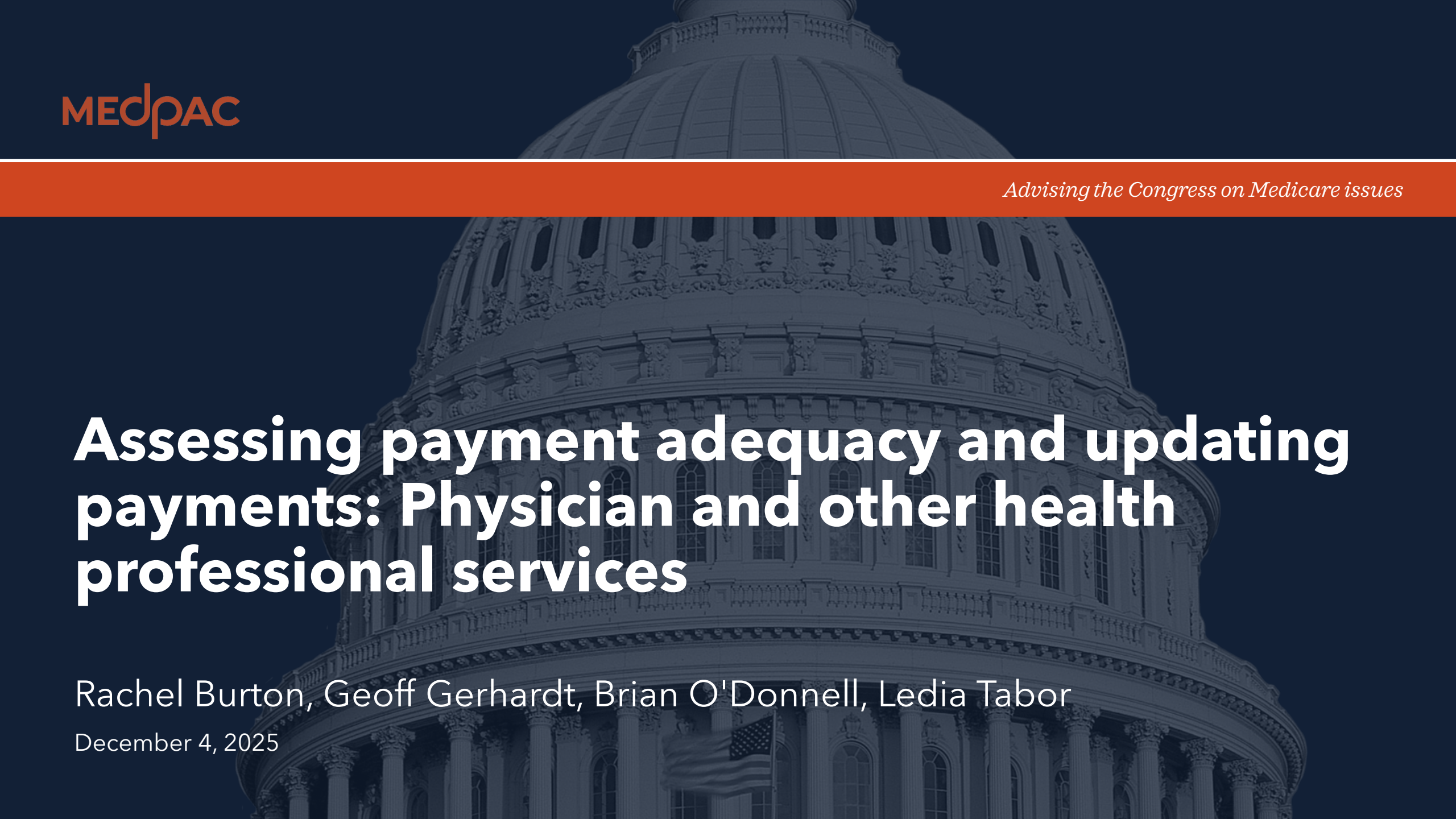
MEDPAC

Advising the Congress on Medicare issues



Assessing payment adequacy and updating payments: Physician and other health professional services

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Presentation roadmap

1. Overview of use and spending under Medicare's physician fee schedule
2. Beneficiaries' access to clinician care
3. Quality of clinician care
4. Clinicians' revenues and costs
5. Chair's draft recommendation
6. Discussion

Overview of use and spending under Medicare's physician fee schedule

Overview of use and spending under Medicare's physician fee schedule, 2024

Clinicians	1.4 million
Service units	1.1 billion
FFS patients	27.5 million
Payments from Medicare and FFS beneficiaries	$93.8 billion

Note: FFS (fee-for-service). Service units represent one individual service, such as an office visit, surgical procedure, or imaging scan.
Source: MedPAC analysis of Medicare claims data. Number of FFS patients who received a fee schedule service is an estimate based on total Part B FFS enrollment.

Payment adequacy framework: Physician and other health professional services

Beneficiaries' access to care

- Patient experiences in surveys and focus groups
- Share of clinicians accepting Medicare vs. private insurance
- Supply of clinicians
- Volume of clinician services

Quality of care

- Ambulatory care–sensitive hospital use
- Patient experience scores

Access to capital

- Not used to assess payment adequacy for physician and other health professional services due to data limitations

Clinicians' revenues and costs

- Spending per FFS Medicare beneficiary
- Growth in clinicians' input costs
- Clinicians' all-payer compensation
- Ratio of private insurance payment rates to FFS Medicare's payment rates

Update recommendation for physician fee schedule payment rates for 2027

Note: FFS (fee-for-service).

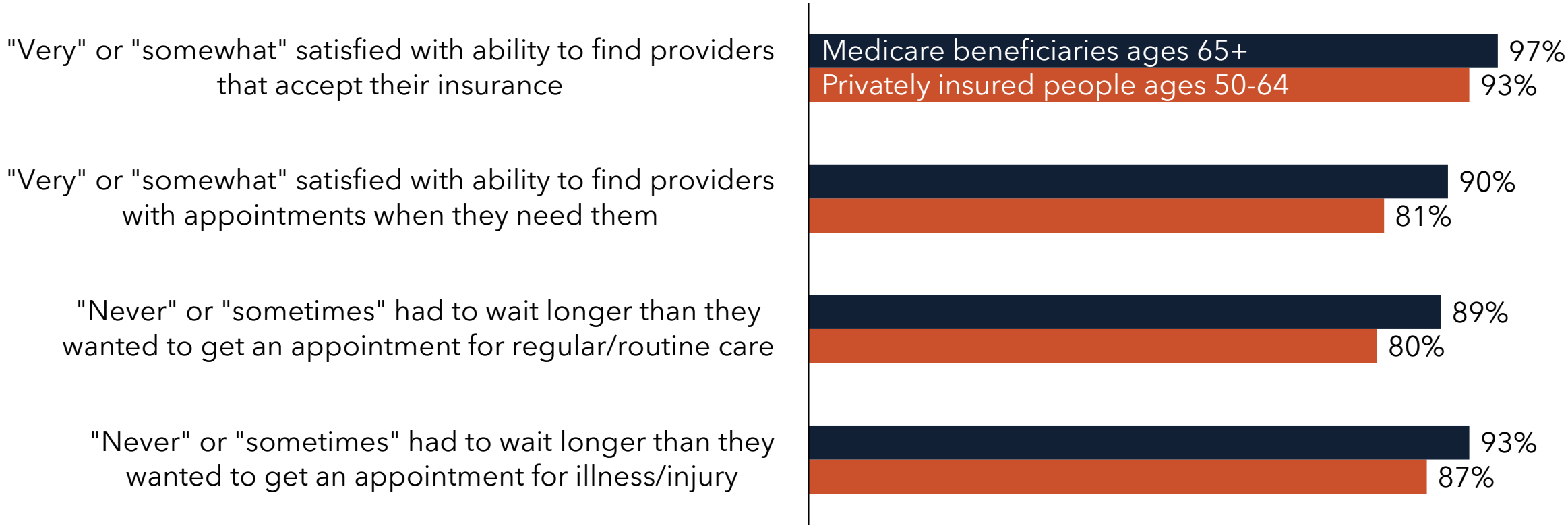
Access to care

One way MedPAC assesses access to care is through our annual patient survey (2003-2025)

- MedPAC's survey is much more recent than other national surveys
  - Results available within 1 month, instead of 2-3 years
- MedPAC currently contracts with Gallup to conduct our 10-minute survey of:
  - 5,000 Medicare beneficiaries ages 65+ (FFS and MA)
  - 5,000 privately insured people ages 50-64 (as a comparison group)
- Fielded July 18 – September 8, 2025, asking about past 12 months
- Gallup statisticians weight survey data to be nationally representative and identify results that are statistically significant

Note: FFS (fee-for-service), MA (Medicare Advantage). Gallup conducted the 2025 MedPAC access-to-care survey using the Gallup Panel, a national probability-based panel. A total of 9,867 completed surveys were collected, including from 4,788 Medicare beneficiaries aged 65+ and 5,079 privately insured adults aged 50–64. Data were collected via web and mail in English and via mail in Spanish. Data were weighted using base weights and post-stratification raking to National Health Interview Survey benchmarks using the following variables: age, gender, education, race, ethnicity, Census region.

In MedPAC's 2025 survey, Medicare beneficiaries generally reported better access to care than privately insured people



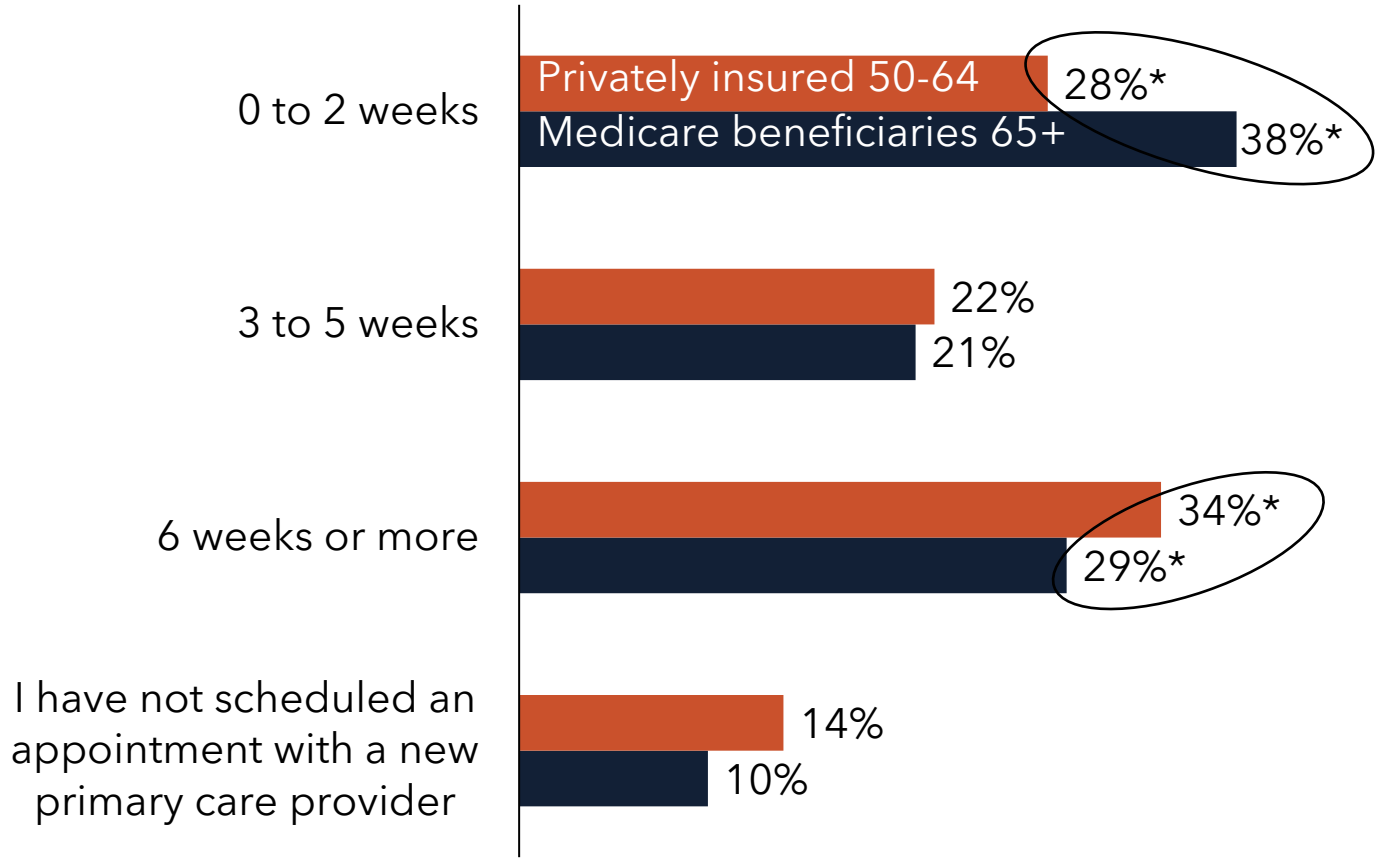
Note: For all results shown, there is a statistically significant difference between the shares of Medicare beneficiaries and privately insured people who reported a given experience (at a 95 percent confidence level). Satisfaction rates are among respondents who received any care in the past 12 months. Shares reporting how often they had to wait for appointments are among respondents who needed that type of appointment in the past 12 months. Our survey was completed by 4,788 Medicare beneficiaries ages 65 and over (including fee-for-service and Medicare Advantage enrollees) and 5,079 privately insured people ages 50 to 64; sample sizes for particular questions varied. Results are weighted to be nationally representative.

Source: MedPAC's 2025 access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

Medicare beneficiaries reported shorter waits for their first appointment with a new primary care provider

*Among those who looked for a **new primary care provider** in the past year…*

How long did you have to wait to have an appointment with your new primary care provider?



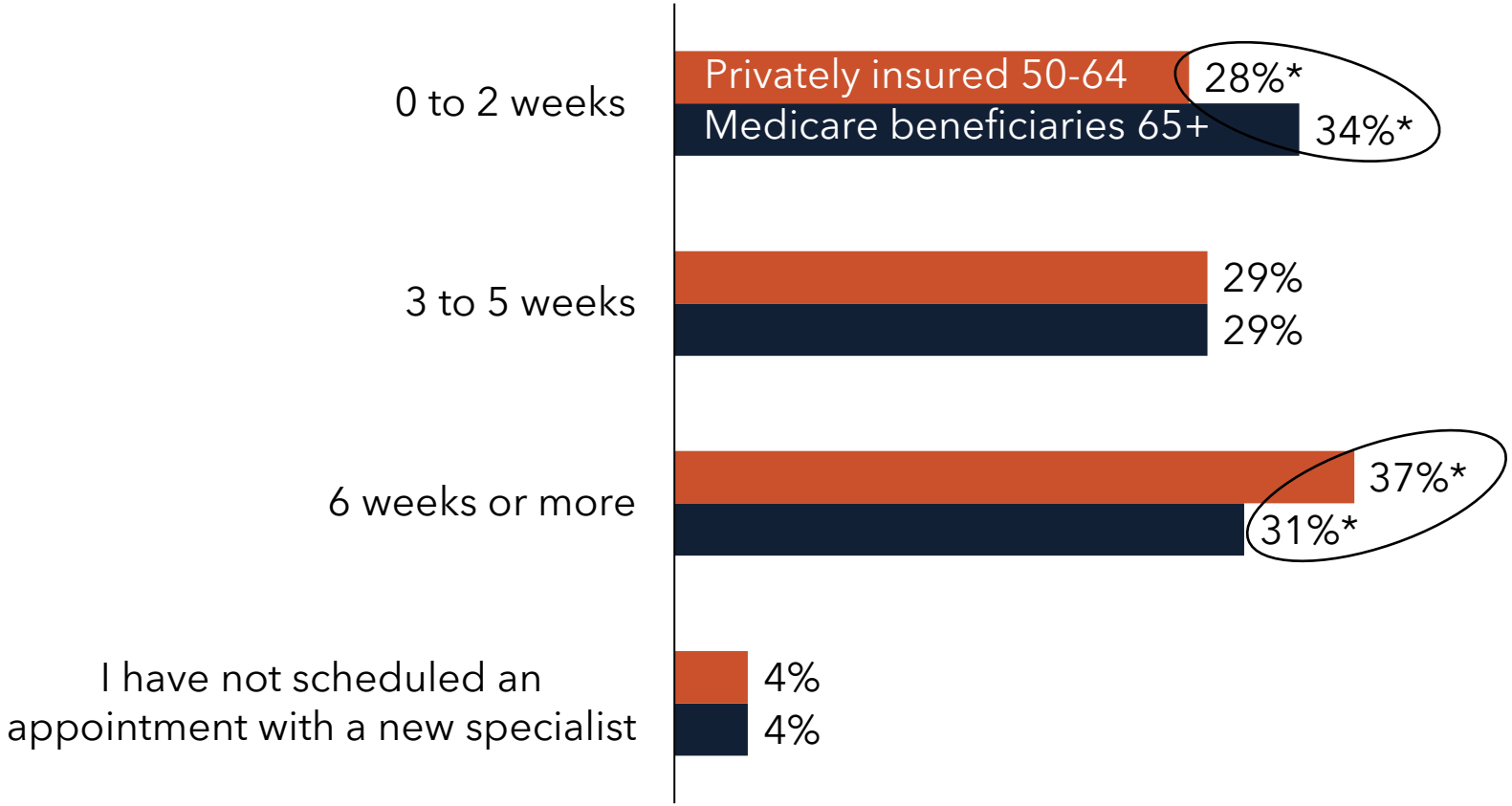
Note: *Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level). Question asked among the subset of respondents who looked for a new primary care provider in the past 12 months. Results weighted to be nationally representative.

Source: MedPAC's 2025 access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

Medicare beneficiaries also reported shorter waits for their first appointment with a new specialist

*Among those who looked for a **new specialist** in the past year…*

How long did you have to wait to have an appointment with your new specialist?



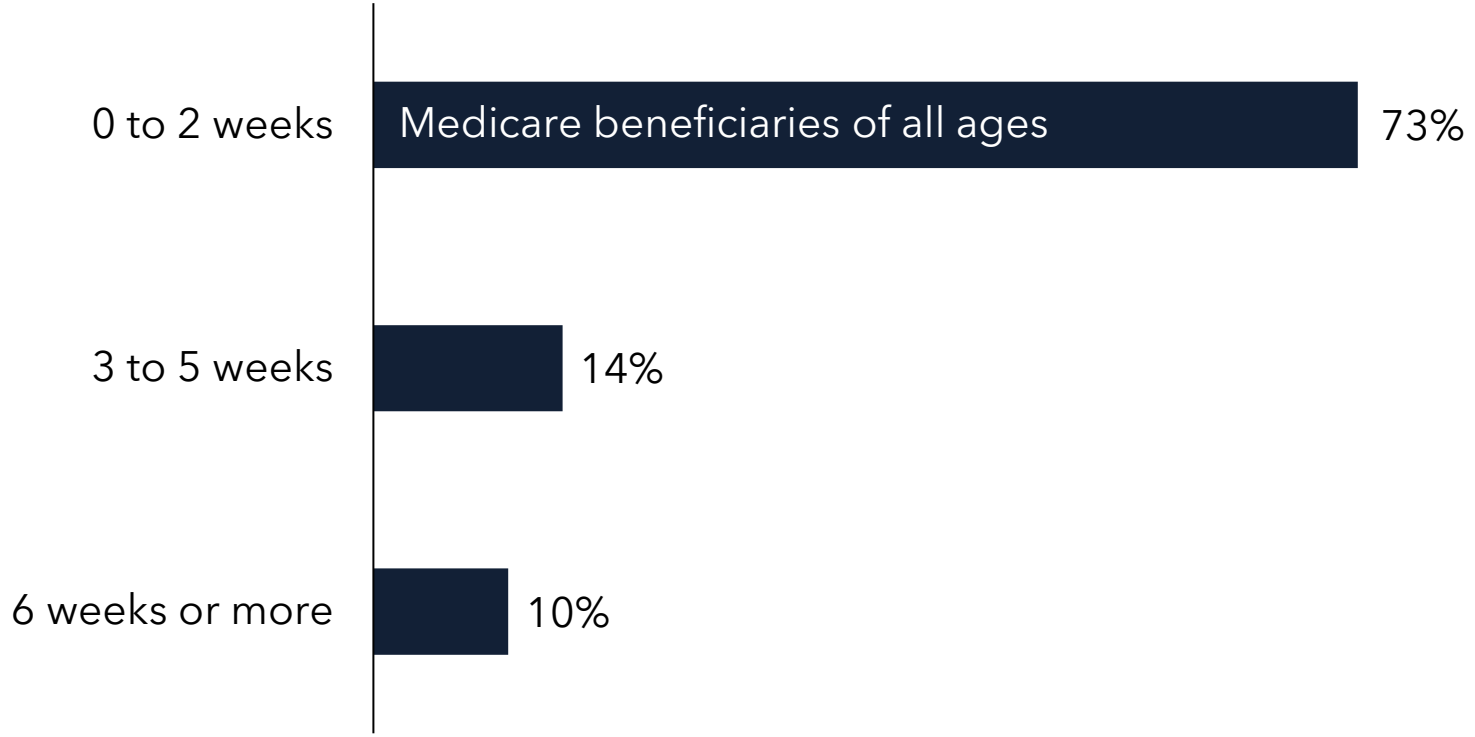
Note: *Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level). Question asked among the subset of respondents who looked for a new primary care provider in the past 12 months. Results weighted to be nationally representative.

Source: MedPAC's 2025 access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

In CMS's 2022 survey, 73% of Medicare beneficiaries waited 2 weeks or less for their last doctor's office visit

Among Medicare beneficiaries of all ages who recently had an office visit with a ***new or existing clinician****…*

How long did you have to wait for your appointment?



Note: CMS collected responses to this segment of their survey from 10,257 Medicare beneficiaries of all ages (including those under the age of 65). The graph reflects the experiences of beneficiaries who reported having a doctor's office visit that was scheduled after they contacted a doctor's office to set up an appointment; it does not include appointments scheduled after a provider reached out to a beneficiary to schedule a visit, visits scheduled at a prior visit, or standing appointments. Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries in 2022 (including those with fee-for-service Medicare and those enrolled in Medicare Advantage, since our analysis of this survey finds that these two groups report comparable wait times and MedPAC's survey groups together these two types of beneficiaries).

Source: MedPAC analysis of CMS's 2022 Medicare Current Beneficiary Survey.

The vast majority of physicians accept new Medicare patients

Among non-pediatric physicians accepting new patients in 2024…

95%

accept "all" or "some" new Medicare patients

- 85% accept "all" new Medicare patients
- 10% accept "some" new Medicare patients
- 3% only accept privately insured patients

- Higher Medicare acceptance rates among:
  - Hospital-owned practices
  - Specialists

Source: American Medical Association's 2024 Physician Practice Benchmark Survey.

Number of clinicians billing Medicare has increased, but the mix has changed

- From 2019 to 2024, the total number of clinicians billing the fee schedule grew by an average of 2.2% per year
- Changes varied by the type and specialty of clinician (2019–2024)
  - Rapid growth in APRNs and PAs
  - Growth in specialist physicians
  - Decline in primary care physicians
- Clinicians per FFS beneficiary increased for all types of clinicians
- Nearly all clinicians who billed under the fee schedule in 2024 accepted Medicare's payment rates as payment in full

Note: APRNs (advanced practice registered nurses), PAs (physician assistants).
Source: MedPAC analysis of Medicare claims data and annual report of the Boards of Trustees of the Medicare trust funds.

Quality of care

Quality of clinician care is difficult to assess

- Medicare does not collect much patient-reported outcomes (e.g., improving or maintaining physical and mental health) or clinical information (e.g., blood pressure, lab results) at the FFS beneficiary level
- CMS measures the performance of clinicians using MIPS
- MedPAC recommended eliminating MIPS in 2018 because it is fundamentally flawed:
  - Clinicians select a small set of quality and improvement activities measures to report from a catalog of several hundred different measures
  - Many clinicians are exempt from reporting

Note: FFS (fee-for-service), MIPS (Merit-based Incentive Payment System).
Source: Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

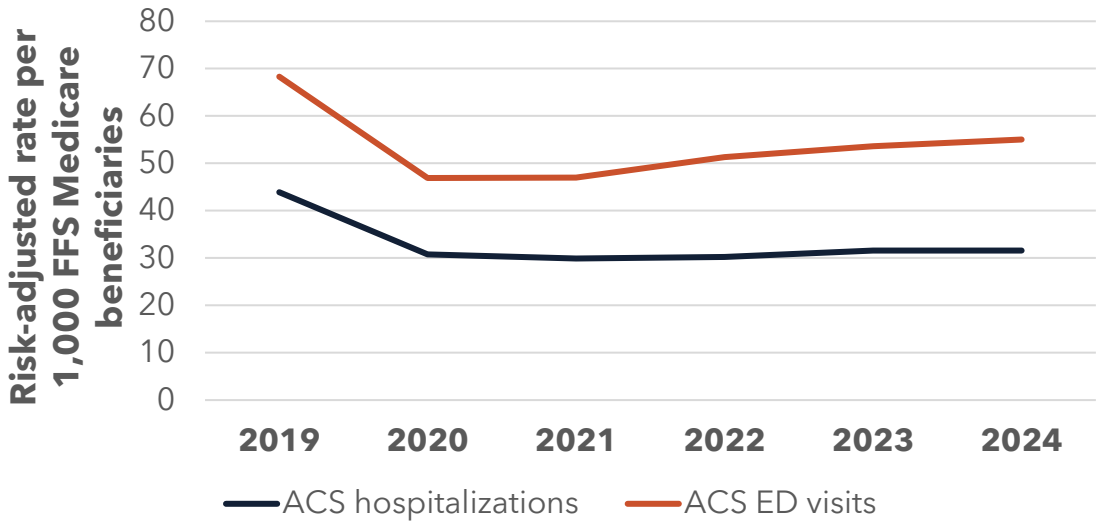
MedPAC assesses the quality of ambulatory care environment based on . . .

1. **Ambulatory care–sensitive hospitalizations and ED visits**
2. **Patient experience scores (FFS CAHPS)**

Note: ED (emergency department), FFS (fee-for-service).

Quality indicators we track remained relatively stable, 2024

- ACS hospital use remained relatively stable from 2023-2024 and below prepandemic levels



Note: ACS (ambulatory care sensitive), FFS (fee-for-service), ED (emergency department). 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.
Source: MedPAC analysis of 2019-2024 Medicare FFS claims data.

- CAHPS patient experience scores were relatively stable
  - Rating of FFS Medicare: 84/100
  - Rating of health care quality: 86/100

Note: CAHPS (Consumer Assessment of Health Providers and Systems).
Source: FFS CAHPS mean scores publicly reported by CMS.

Clinicians' revenues and costs

Aggregate payments per FFS beneficiary grew for most types of services

- Allowed charges (program payments + beneficiary cost sharing) for all fee schedule services per FFS beneficiary grew by 4.1% from 2023 to 2024
  - Higher than average annual growth rate from 2019 to 2023 (2.3%)
- Growth in allowed charges varied by type of service in 2024
  - Ranging from −0.3% for major procedures and anesthesia to 5.1% for E&M
  - 2024 growth rates for each type of service were higher than growth rates over 2019 to 2023 period

Note: FFS (fee-for-service), E&M (evaluation and management).
Source: MedPAC analysis of Medicare claims data, annual report of the Boards of Trustees of the Medicare trust funds.

New complexity add-on code contributed to E&M increase in spending and service units

- In 2024, on a per FFS beneficiary basis:
  - E&M service units increased by 10.9%
  - E&M allowed charges increased by 5.1%
- New complexity add-on code (G2211):
  - Can be billed with office/outpatient E&M visits when clinician is serving as focal point of patient's ongoing care or treating patient for complex health condition
  - 25 million service units
  - $400 million in allowed charges
- G2211 accounted for about half of E&M service unit increase and about one-fifth of increase in allowed charges

Note: FFS (fee-for-service), E&M (evaluation and management).
Source: MedPAC analysis of Medicare claims data.

Changes to fee schedule that may benefit primary care

- G2211 visit complexity add-on payment
- Increased payment rates for many E&M office/outpatient visits
- Care management codes
- Monthly per-beneficiary payments for advanced primary care management
  - Payments higher for patients with multiple medical conditions and QMB dual Medicare-Medicaid enrollment status
- –2.5% "efficiency adjustment" applied to work portion of valuation for non-time-based services (e.g., procedures and imaging)
  - Will increase payments for time-based services, such as E&M

Note: E&M (evaluation and management), QMB (Qualified Medicare Beneficiary).

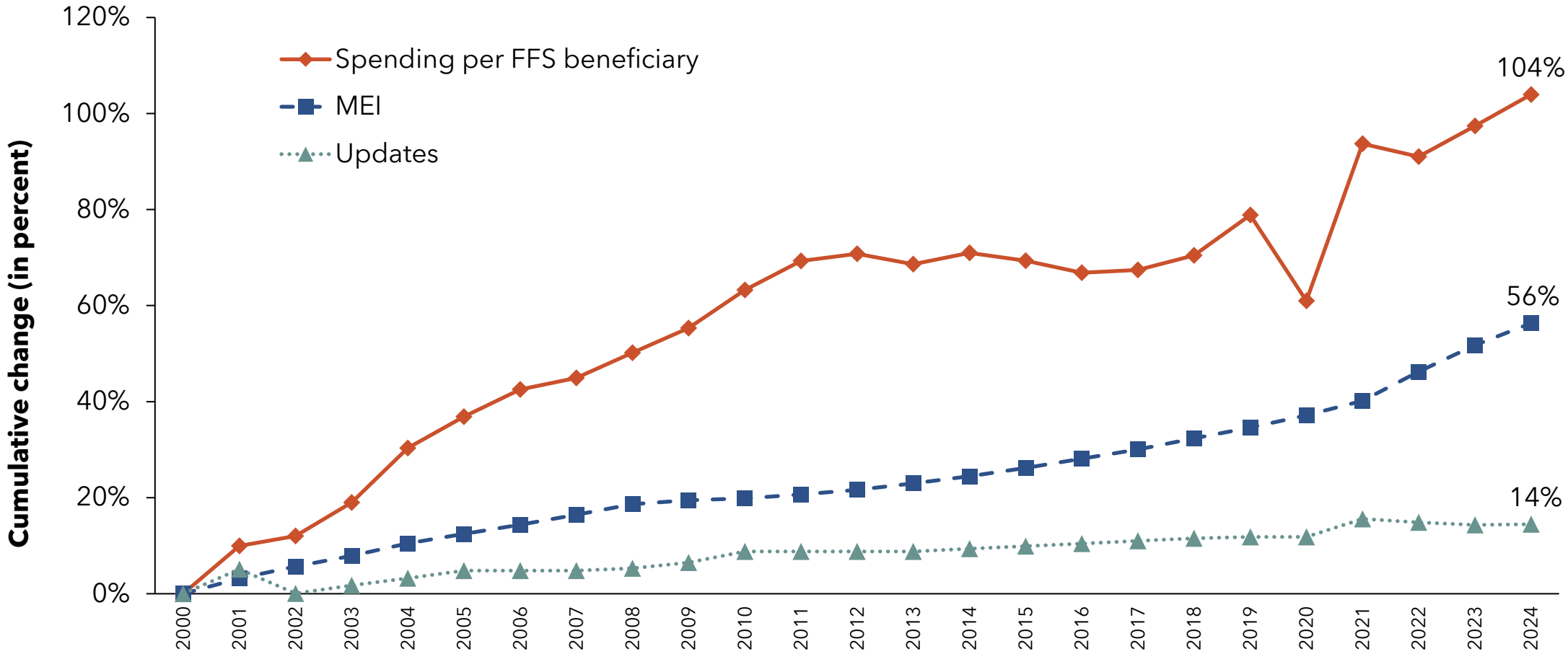
Growth in clinician input costs is moderating, but remains slightly elevated

- Medicare Economic Index (MEI) measures clinicians' input costs and is adjusted for economy-wide productivity
- MEI growth was 1% to 2% per year for several years before the coronavirus pandemic, increased through 2022, slowed through 2024, and is projected to moderate further

2022	2023	2024	2025	2026	2027
Actual MEI growth			**Projected MEI growth**		
4.3	3.8	3.0	2.6	2.3	2.1

Note: MEI growth projections are based on data from the second quarter of 2025. These figures are updated quarterly by CMS and are subject to change.
Source: CMS market basket update.

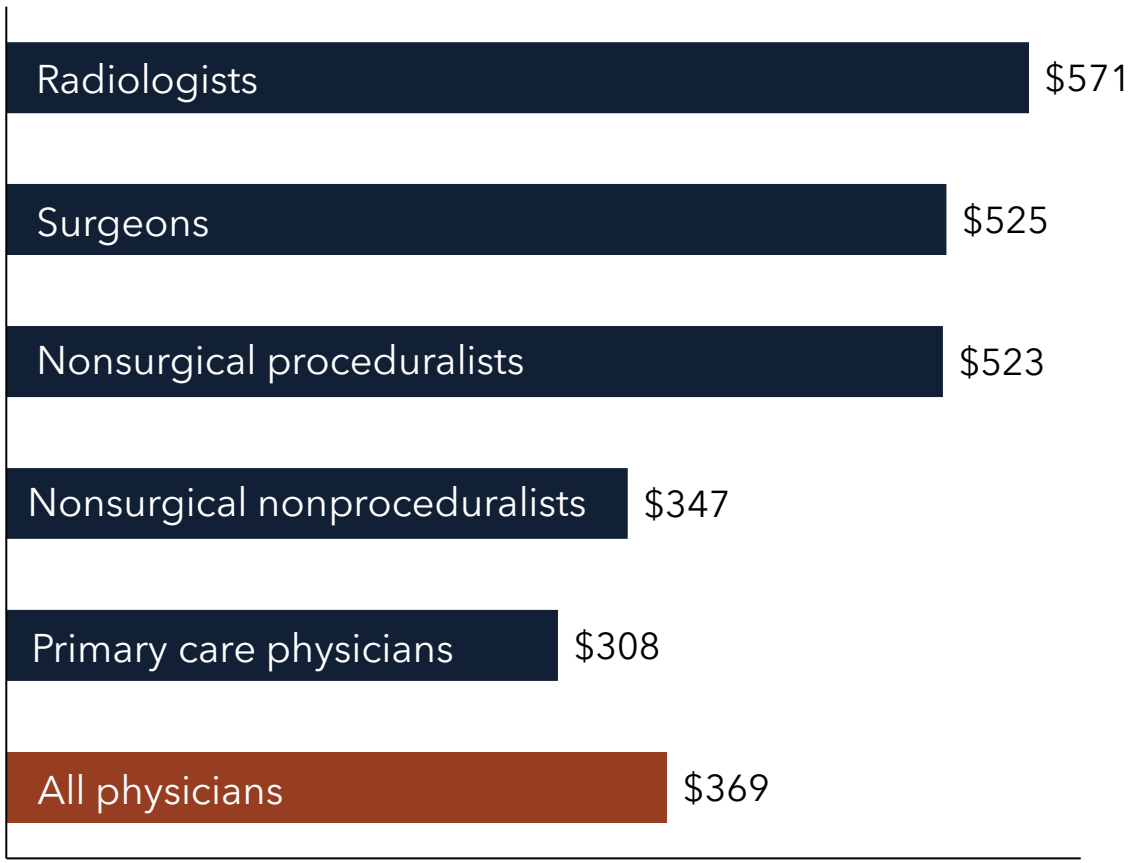
Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000–2024



Note: FFS (fee-for-service), MEI (Medicare Economic Index). MEI data are from the new version of the MEI (based on data from 2017) and include updated total-factor productivity data. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75% in 2021, 3.0% in 2022, 2.5% in 2023, and a weighted average of 1.25% and 2.93% for 2024 are included.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

In 2024, all-payer compensation grew 6% for physicians and 2% for NPs and PAs



Median annual compensation in 2024 (in thousands)

- All-payer compensation is an indirect measure of Medicare payment adequacy
- Median compensation in 2024:
  - Physicians: $369,000
  - Nurse practitioners (NPs): $129,000
  - Physician assistants (PAs): $133,000
- From 2019–2024, average annual increase was about 3.5%

Note: "Compensation" refers to median annual total cash compensation adjusted to reflect full-time work and does not include employer retirement contributions or payments for benefits. Dollar amounts rounded to nearest thousand.

Source: SullivanCotter's physician compensation and productivity survey; Bureau of Labor Statistics' occupational employment and wage statistics tables.

Private PPO payment rates remained higher than Medicare payment rates for clinician services in 2023

- We compare private insurance rates with Medicare rates because large differences could create an incentive for clinicians to focus on patients with private insurance
- Private PPO payment rates were 140% of FFS Medicare rates in 2023, up from 136% in 2022
- Despite lower rates, clinicians may accept Medicare for several reasons
  - Available capacity and desire to treat patients
  - FFS Medicare is a prompt payer
  - Private payers impose more administrative burdens (e.g., prior authorization)

Note: PPO (preferred provider organization), FFS (fee-for-service).
Source: MedPAC analysis of Medicare claims data and data on paid claims for PPO enrollees of a large national insurer.

Summary: Physician and other health professional services

Beneficiaries' access to care

- Beneficiaries' access to care generally better than privately insured
- Similar shares of clinicians accept patients with Medicare and private insurance
- Total number of clinicians increasing, mix changing
- Service units per FFS beneficiary increased by 7.4% in 2024

Positive

Quality of care

- Medicare does not collect much patient-reported outcomes or clinical information
- MIPS is fundamentally flawed
- Indicators we track remained relatively stable

Indeterminate

Clinicians' revenues and costs

- Allowed charges per FFS beneficiary increased 4.1% in 2024
- MEI growth moderating but still slightly elevated; MEI growth expected to slow to 2.1% in 2027
- Median compensation grew 6% for physicians and 2% for advanced practice providers in 2024
- Ratio of private insurance rates to Medicare rates increased slightly

Somewhat positive

Note: FFS (fee-for-service), MIPS (Merit-based Incentive Payment System), MEI (Medicare Economic Index).

Chair's draft recommendation

Chair's draft recommendation

For calendar year 2027, the Congress should increase payment rates for physician and other health professional services by 0.5 percentage points more than current law.

Impacts of chair's draft recommendation

- Chair's draft recommendation: increase payment rates by 0.5 percentage points more than current law
- Current law updates for 2027
  - A-APM clinicians: 0.75%
  - Other clinicians: 0.25%
- Combined effects of the chair's draft recommendation and current law for 2027
  - A-APM clinicians: 1.25% (0.75% + 0.5%)
  - Other clinicians: 0.75% (0.25% + 0.5%)

Note: A temporary 2.5% increase goes into effect in 2026; it will not be in effect in 2027 under current law.

Implications of chair's draft recommendation

Spending

- Increase spending relative to current law

Beneficiary and provider

- Should maintain clinicians' willingness to treat fee-for-service Medicare beneficiaries and maintain beneficiaries' access to care

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