CHAPTER 4

Physician and other health professional services

RECOMMENDATION

4 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.

COMMISSIONER VOTES: YES 15 • NO 2 • NOT VOTING 0 • ABSENT 0

CHAPTER 4

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Chapter summary

In 2024, traditional fee-for-service (FFS) Medicare's physician fee schedule (PFS) paid for about 9,000 types of medical services provided by clinicians across a variety of care settings. These services included office visits, surgical procedures, imaging, and tests delivered in physician offices, hospitals, skilled nursing facilities, 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 chiropractors, physical therapists, psychologists, and other types of health professionals. The Medicare program and its beneficiaries paid $93.8 billion in 2024 for fee schedule services billed by about 1.5 million clinicians, accounting for just over 15 percent of spending in FFS Medicare. Spending on clinician services by FFS Medicare and its beneficiaries was $1.4 billion higher in 2024 than in 2023, representing a 1.5 percent increase in total spending. This increase is largely attributable to 4.1 percent growth in spending per FFS beneficiary, which was partially offset by a 2.5 percent decrease in the number of beneficiaries enrolled in FFS Medicare.

Assessment of payment adequacy

Based on our assessment of the latest available data, the Commission's indicators of the adequacy of clinician payments have remained positive

In this chapter

or improved since last year, although input cost inflation remains slightly elevated.

Beneficiaries' access to care—In the Commission's 2025 survey, Medicare beneficiaries reported access to clinician services that was generally better than that of privately insured people. Our findings are consistent with findings of other national surveys, which have found that people ages 65 and older (almost all of whom have Medicare coverage) report better access to care than younger adults; Medicare beneficiaries of any age are also more likely than privately insured people to rate their insurance coverage positively.

Other surveys indicate that the share of clinicians accepting Medicare is comparable with the share accepting private insurance, despite private health insurers' higher payment rates. And almost all clinicians who bill Medicare accept PFS amounts as payment in full and do not seek to increase total payments for fee schedule services by balance-billing beneficiaries up to a limiting charge as "nonparticipating" providers. In addition, very few clinicians forgo all Medicare payments by electing to "opt out" of the program; these clinicians may collect the full amount they charge to patients.

The supply of most types of clinicians billing Medicare's PFS has been growing in recent years, although the composition of the clinician workforce continues to change. Over the last several years, the number of primary care physicians billing the fee schedule has slowly declined, the number of specialists has steadily increased, and the number of APRNs and PAs has climbed rapidly. The number of clinicians per FFS beneficiary has grown, partially because of a decline in the number of FFS beneficiaries.

Interest in becoming a clinician remains high. Over the last 40 years, the number of applicants to U.S. medical schools has grown, exceeding population growth, and applicants to medical school continue to far exceed first-year enrollment. The number of APRNs and PAs has grown rapidly, suggesting robust interest in becoming these types of clinicians.

The number of clinician services furnished per FFS beneficiary has increased over time, with faster growth from 2023 to 2024 (7.1 percent) compared with the average annual growth rate from 2019 to 2023 (2.3 percent). Growth varied by type of service. From 2023 to 2024, the number of evaluation and management (E&M) services per FFS beneficiary increased by 10.9 percent, while treatments and nonmajor procedures increased by 7.6 percent and 3.6

percent, respectively. Imaging, tests, major procedures, and anesthesia saw somewhat smaller growth of 3.3 percent, 3.2 percent, 3.1 percent, and 1.7 percent, respectively.

Quality of care—The quality of clinician care is difficult to assess, but the indicators we track suggest it has remained relatively stable. In 2024, risk-adjusted rates of ambulatory care-sensitive hospitalizations and emergency department visits remained below (that is, better than) prepandemic levels and continued to vary across health care markets. Between 2023 and 2024, 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 or to their full panel of patients. Instead, we rely on indirect measures of clinicians' payments and costs for providing services.

PFS spending per FFS beneficiary grew for most types of services in 2024, despite payment rates for many types of services declining from 2023 to 2024. Among broad service categories, growth rates were 5.1 percent for E&M services, 4.0 percent for imaging, 2.2 percent for other (i.e., nonmajor) procedures, 4.9 percent for treatments, and 3.7 percent for tests. Spending per FFS beneficiary on major procedures and anesthesia each declined by 0.3 percent. Changes in spending are driven by changes in volume, mix of services (including billing for new codes designed to support care management), and changes in payment rates, which include a 2 percent across-the-board payment-rate reduction because of a required budget-neutrality adjustment.

Growth in clinicians' input costs as measured by the Medicare Economic Index (MEI) has moderated from recent highs during the coronavirus pandemic and is expected to moderate further in the coming years. Currently, MEI growth is projected to be 2.7 percent in 2025 and 2.2 percent in 2026. Although past updates have not kept pace with the growth in clinicians' input costs, the volume and intensity of clinician services per FFS beneficiary have increased substantially over time, which has resulted in markedly higher PFS spending. As part of a broader review of access to care and fee schedule updates in our June 2025 report to the Congress, the Commission concluded that, to date, below-MEI updates have not impeded access.

Since the Commission lacks data that would allow us to determine whether providers' revenues are greater than their costs and whether delivering clinician

services is therefore profitable, we examine clinician compensation levels as a rough proxy for all-payer profitability. Clinician compensation levels suggest that providing clinician services is profitable. From 2023 to 2024, median physician compensation increased 6 percent (to $369,000)—twice as fast as inflation (3 percent)—according to SullivanCotter compensation data. Meanwhile, median compensation for nonphysician practitioners increased more slowly than inflation—by 2.5 percent for physician assistants (to $133,000) and by 2.3 percent for nurse practitioners (to $129,000), according to the U.S. Bureau of Labor Statistics. We note that clinician compensation is only an indirect measure of Medicare's payment adequacy since Medicare payments constitute only a portion of the revenue most clinicians receive, and many employed physicians' compensation may not be directly tied to fee schedule payments.

To gain further insight into clinicians' revenues and incomes and to assess clinicians' incentives to treat Medicare beneficiaries versus patients with other types of insurance, we compare Medicare payment rates with private-insurance rates. In 2024, preferred provider organizations' payment rates for clinician services were, on average, 147 percent of FFS Medicare's payment rates—up from 140 percent in 2023. A 2024 survey by the American Medical Association suggests 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 to help comply with payers' regulatory and administrative requirements). Despite the growing divergence between Medicare and private insurers' payment rates, Medicare beneficiaries continue to have similar (or better) access to care relative to the privately insured, and the volume of care beneficiaries receive continues to increase, which indicate that clinicians continue to have an incentive to treat Medicare beneficiaries.

How should payment rates change in 2027?

In 2027, current law calls for PFS payment rates to decline by 1.7 percent for qualifying clinicians in advanced alternative payment models (A-APMs) (e.g., accountable care organization models that involve some financial risk) and to decline by 2.2 percent for all other clinicians, relative to 2026 payment rates. These declines reflect the net effects of two statutory provisions: (1) the expiration of a one-year increase of 2.5 percent that applies in 2026 only, and (2) positive updates of 0.75 percent and 0.25 percent for qualifying clinicians in A-APMs and all other clinicians, respectively, in 2027 pursuant to the Medicare and CHIP Reauthorization Act of 2015 (MACRA).

Based on our indicators, current payments to clinicians appear to be adequate to ensure access to care. However, going forward, clinicians are projected to face moderate rates of input cost growth. While evidence suggests that full MEI updates have not been necessary to maintain access to care, ongoing cost increases that substantially exceed payment updates could be difficult for clinicians to absorb.

Given these concerns, for calendar year 2027, the Commission recommends that the Congress increase current-law updates to Medicare payment rates for physician and other health professional services by 0.5 percentage points more than current law. After the expiration of 2026's temporary 2.5 percent update, this recommendation would increase payment rates in 2027 by a total of 1.25 percent for qualifying clinicians participating in A-APMs and by a total of 0.75 percent for other clinicians. After accounting for the expiration of the temporary 2.5 percent increase at the end of 2026, net payment rates for 2027 would be 1.2 percent and 1.7 percent lower, respectively, than in 2026. These net reductions would be smaller than what would otherwise occur under current law. The Commission's recommendation would be a permanent update that would be built into subsequent years' payment rates, not a temporary update (like the 2.5 percent update that applies in 2026 only). The Commission maintains that this recommendation balances the need to provide adequate payments to clinicians with the need to limit growth in beneficiaries' cost sharing and premiums and maintain financial pressure on clinicians to constrain their costs. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Physicians and other health professionals who provide services to FFS beneficiaries are paid according to Medicare's physician fee schedule (PFS). In 2024, the PFS paid for about 9,000 types of medical services for FFS beneficiaries, including office visits, surgical procedures, imaging, and tests.[1] Just under 1.5 million clinicians—including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), chiropractors, physical therapists, psychologists, and other types of health professionals—billed the Medicare PFS for services in 2024, about 4.1 percent more than the previous year.

Background

To determine payment rates under the PFS, CMS establishes relative values for each service furnished by physicians and other health professionals. Services' relative values are multiplied by a conversion factor, which is a fixed dollar amount, to produce a total payment amount for each service.[2] Starting in 2026, payment rates will be updated by two conversion factors—one that applies to services furnished by qualifying participants in advanced alternative payment models (A–APMs) ($33.57 in 2026) and a second, lower rate for services furnished by nonqualifying providers ($33.40). When fee schedule services are delivered in certain facilities, such as hospitals or ambulatory surgical centers, CMS makes an additional payment through a separate facility payment system to pay for nonpractitioner costs such as nursing staff, medical supplies, equipment, and rooms. In such instances, the PFS payment rate is reduced, but it is normally more than offset by the additional fee Medicare pays through the applicable facility payment system (discussed in separate chapters of this report), resulting in higher program spending than if the service were delivered in a nonfacility setting.

In 2024, PFS spending constituted just over 15 percent of spending in FFS Medicare (Boards of Trustees 2025).[3] That year, the FFS Medicare program and its beneficiaries paid $93.8 billion for PFS services, up 1.5 percent (or $1.4 billion) since 2023. This increase is largely due to the 2.5 percent decrease in the number of beneficiaries enrolled in FFS Medicare and 4.1 percent growth in spending per FFS beneficiary.

In 2024, just under 1.5 million clinicians—including physicians, APRNs, PAs, chiropractors, physical therapists, psychologists, and other types of health professionals—billed the Medicare PFS for services. The total number of clinicians billing the fee schedule in 2024 was about 5 percent higher than the previous year.

Are FFS Medicare payments adequate in 2026?

To examine the adequacy of Medicare's FFS payments for clinician services, we analyze beneficiaries' access to care, the quality of their care, and clinicians' revenues and costs. Overall, our indicators of payment adequacy are positive or improved since last year, although input cost inflation remains slightly elevated.

Medicare beneficiaries generally report better access to care than the privately insured

Although directly measuring access to care is challenging, most of our indicators suggest that FFS Medicare beneficiaries have relatively good access to care. In the Commission's 2025 survey, Medicare beneficiaries reported access to care that was generally better than that of privately insured people. The share of clinicians accepting Medicare is also high and comparable with the share accepting private insurance.

Almost all clinicians who treat FFS Medicare beneficiaries accept the PFS's payment rates as payment in full, although they have the option, if they are a "nonparticipating" provider, to balance bill beneficiaries for higher amounts. If they elect to "opt out" of the program, clinicians treating FFS Medicare beneficiaries can also choose to forgo all FFS Medicare payments and may collect the full amount they charge patients. Very few clinicians choose to opt out of the program, and the number of clinicians choosing to do so has remained stable over time.

The overall number of clinicians billing FFS Medicare has grown in recent years. The composition of the clinician workforce billing the fee schedule continues to change, with the number of primary care physicians slowly

declining over time (although there was modest growth in 2024), the number of specialists growing steadily, and the number of APRNs and PAs growing rapidly.

Most beneficiaries report 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 survey of Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64. Our annual survey is completed by about 10,000 patients, and responses are weighted to produce nationally representative results that are available to us within one month of fielding—making it a more up-to-date data source for assessing beneficiaries' access to care than CMS's Medicare Current Beneficiary Survey.[4] The Commission's survey includes both beneficiaries in FFS Medicare and those enrolled in Medicare Advantage (MA) plans, because in our focus groups we have found that many beneficiaries have difficulty accurately identifying the type of Medicare coverage they have in a questionnaire format. We consider this combined group to be representative of the experiences of FFS beneficiaries because FFS beneficiaries and MA enrollees tend to report comparable experiences accessing care in our analyses of CMS's survey (which is a much longer survey that is merged with administrative data and completed by nearly three times as many Medicare beneficiaries as our survey). For example, our analysis of CMS's 2023 survey found no statistically significant differences in the shares of FFS and MA beneficiaries who: saw their usual care provider in the past year, said their usual care provider usually or always spent enough time with them, were satisfied with the ease with which they could get to a doctor from where they live, reported having trouble getting health care in the past year, and reported foregoing care that they thought they should have gotten.

Consistent with our 2024 survey, our 2025 survey found that Medicare beneficiaries reported access to care that was generally better than that of privately insured people. (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.) (See Table 4-A1, p. 141, in this chapter's appendix for some of our key survey findings for Medicare beneficiaries versus privately insured people.)

We also draw on findings from local focus groups that we conduct to ask beneficiaries and clinicians about their experiences with health care.[5] We held separate groups with beneficiaries enrolled in traditional FFS Medicare and those enrolled in MA plans and, where relevant, we highlight similarities or differences in experiences.

Relatively high satisfaction with overall access to care Our 2025 survey found that the vast majority of Medicare beneficiaries ages 65 and over (94 percent) and privately insured people ages 50 to 64 (92 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 (97 percent) compared with privately insured people (93 percent). A higher share of Medicare beneficiaries was also satisfied with their ability to find health care providers that had appointments when they needed them (90 percent) compared with privately insured people (81 percent). In our focus groups, Medicare beneficiaries in both FFS Medicare and MA plans reported high satisfaction with their insurance coverage, with most participants rating their coverage as "excellent" or "good" (NORC at the University of Chicago 2025).

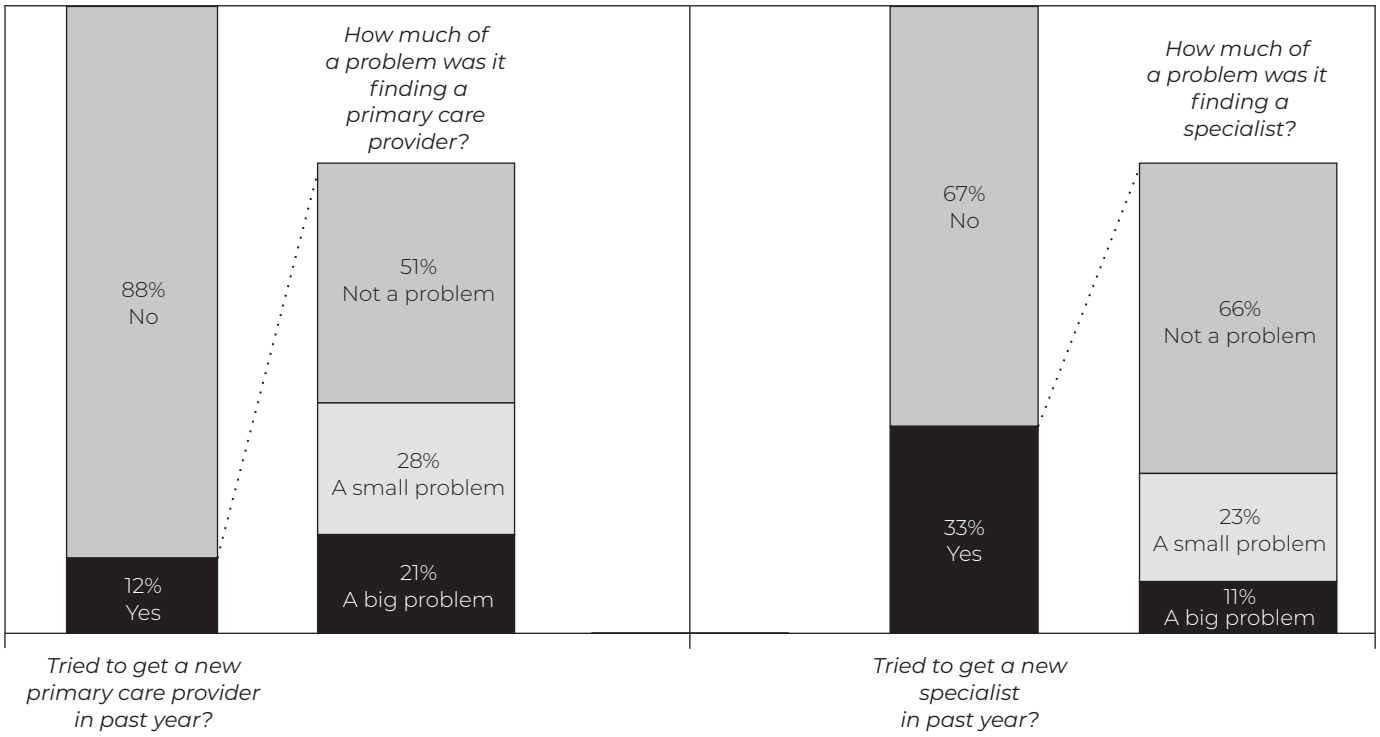
Nearly all Medicare beneficiaries reported having a primary care provider In our 2025 survey, 96 percent of Medicare beneficiaries reported having a primary care provider (PCP) compared with 92 percent of privately insured people. This finding is consistent with what we gathered from our focus groups, in which all beneficiaries we spoke with reported having a regular source of primary care.

Our survey found that Medicare beneficiaries were less likely to report receiving all or most of their primary care from a nurse practitioner (NP) or PA (19 percent) compared with privately insured people (24 percent). In our focus groups, some beneficiaries reported that they go to practices that employ a mix of clinician types and said that they alternate their appointments among different clinicians or see whoever is available.

Medicare beneficiaries reported having fewer problems finding a new clinician than the privately insured In our 2025 survey, 12 percent of Medicare beneficiaries and 14 percent of privately insured people reported

FIGURE 4–1

Medicare beneficiaries had slightly more problems finding a new primary care provider than a new specialist, 2025



Note: We received completed surveys from 4,788 Medicare beneficiaries ages 65 and over and 5,079 privately insured individuals ages 50 to 64. Sample sizes for individual questions varied. MedPAC's survey of Medicare beneficiaries included beneficiaries with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans because our analysis of the Medicare Current Beneficiary Survey found that these two groups of beneficiaries reported comparable experiences accessing care. Survey data are weighted to produce nationally representative results. In our survey, 12 percent of Medicare beneficiaries reported that they tried to get a new primary care provider in the past year; about one-third reported that they tried to get a new specialist.

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

looking for a new PCP. Among those respondents, 21 percent of Medicare respondents (equivalent to 2 percent of all Medicare beneficiaries) reported experiencing a "a big problem" finding a new one compared with 28 percent of privately insured respondents (equivalent to 4 percent of all privately insured people). Survey respondents most commonly looked for a new PCP because their old PCP had retired or stopped practicing.

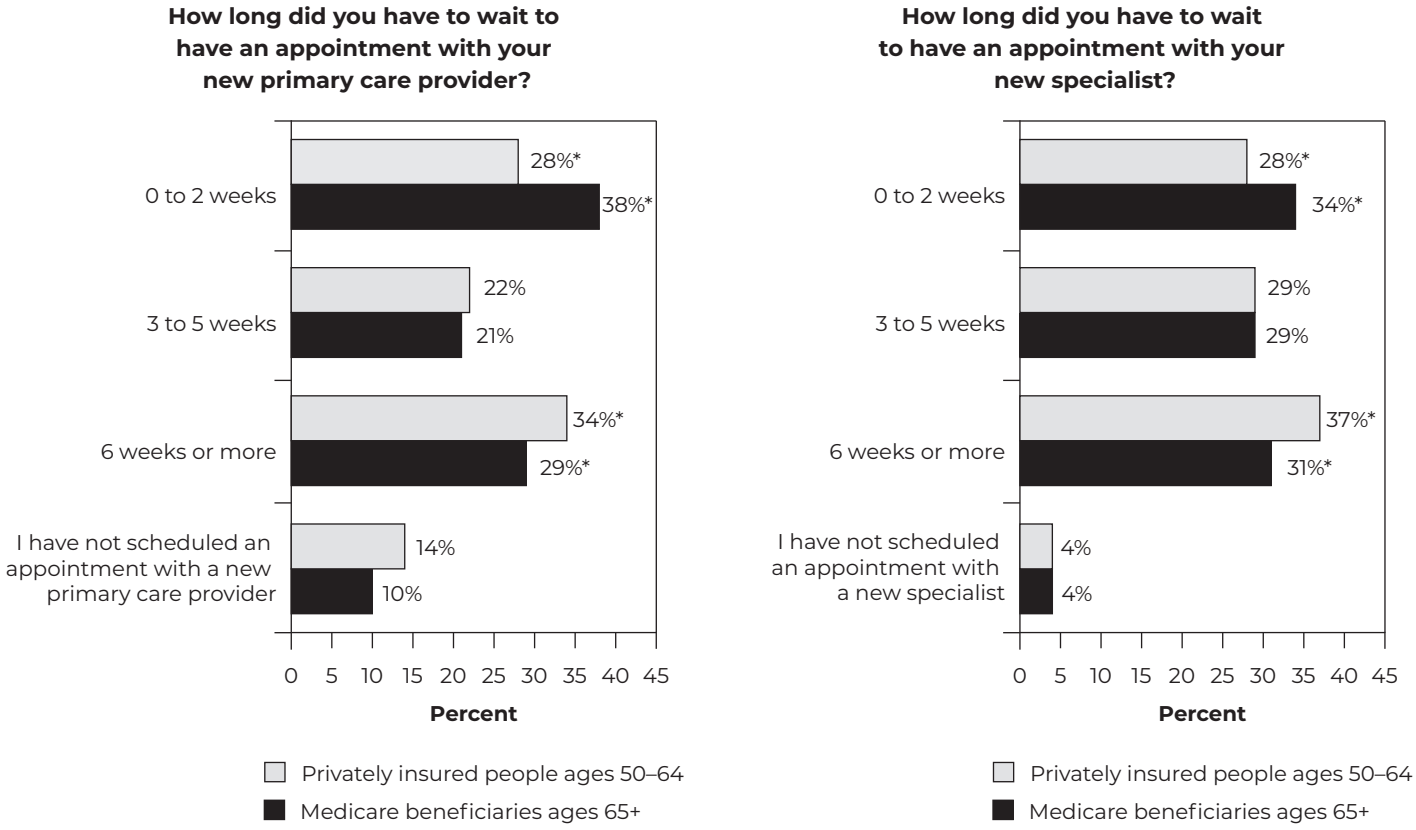
A third of our survey respondents looked for a new specialist in the past 12 months, and among those looking, 11 percent of Medicare respondents (equivalent to 4 percent of all Medicare beneficiaries) reported experiencing "a big problem" finding a new one compared with 17 percent of privately insured respondents (equivalent to 5 percent of all privately insured people).

Among survey respondents looking for a new clinician, a higher share of beneficiaries reported a problem finding a new PCP than a new specialist. This finding is true both for Medicare beneficiaries (shown in Figure 4-1) and the privately insured (not shown). (As discussed below, the number of primary care physicians treating more than 15 FFS Medicare beneficiaries has declined over time (see Table 4-1, p. 115).)

FIGURE 4–2

Medicare beneficiaries were more likely than privately insured people to get an appointment with a new clinician within two weeks, 2025

Among survey respondents who tried to get a new primary care provider/specialist in the past 12 months . . .



Note: We received completed surveys from 4,788 Medicare beneficiaries and 5,079 privately insured individuals. Sample sizes for individual questions varied. Medicare beneficiaries surveyed included beneficiaries with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans. Survey data are weighted to produce nationally representative results. Percentages do not sum to 100 percent because the response option "I don't remember" is not included above.
* Statistically significant difference between Medicare beneficiaries and privately insured people (at a 95 percent confidence level).

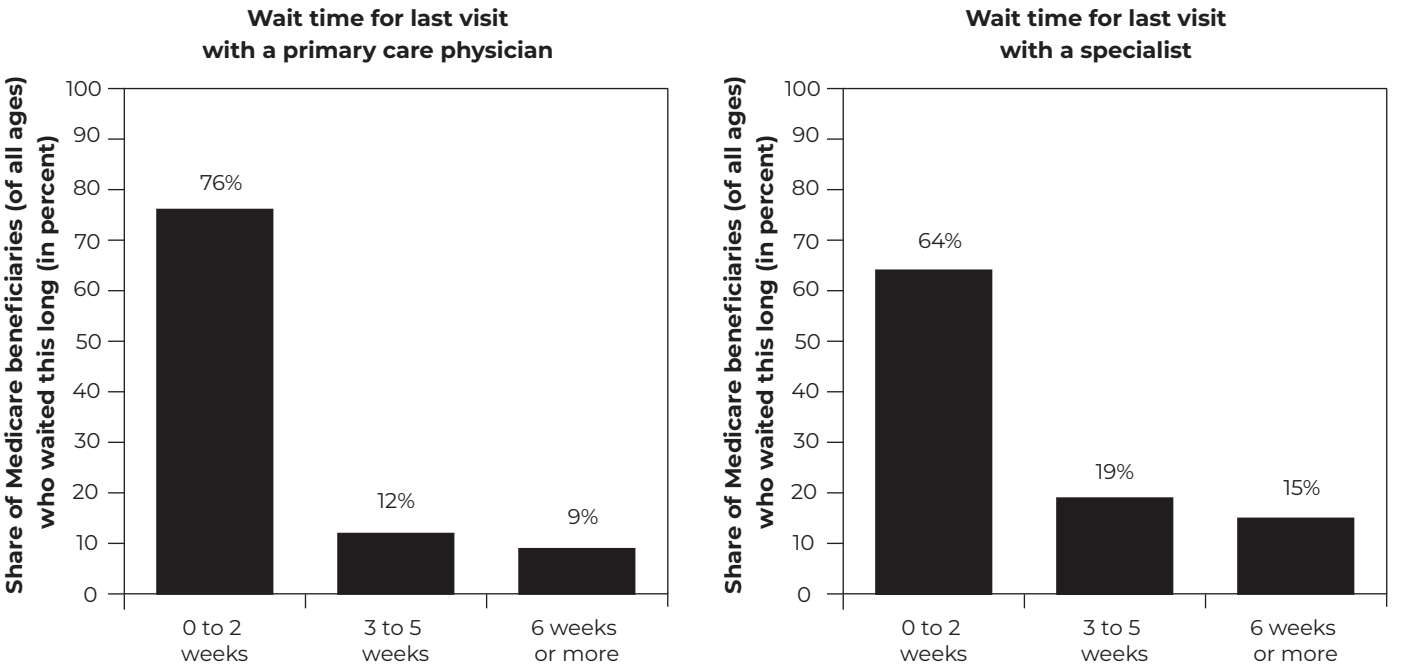
Source: MedPAC's 2025 access-to-care survey, fielded by Gallup from July 18 to September 8, 2025.

Medicare beneficiaries reported shorter waits for appointments than the privately insured Our 2025 survey found that among respondents looking for a new PCP, a higher share of Medicare beneficiaries reported being able to get their first appointment with a new PCP within two weeks or less compared with privately insured people (38 percent vs. 28 percent) (Figure 4-2). This was also true for respondents looking for a new specialist (34 percent vs. 28 percent). One possible reason Medicare beneficiaries reported shorter wait times for new appointments could be 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 who work full time.

Our survey also found that among those who tried to get a new clinician in the past 12 months, 10 percent of Medicare beneficiaries and 14 percent of privately insured people had yet to secure an appointment with a

FIGURE 4–3

Most Medicare beneficiaries waited two weeks or less for their last doctors' office visit (with either a new or existing clinician), 2023



Note: Bar chart 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. CMS collected responses to this segment of their survey from 11,350 Medicare beneficiaries of all ages (including those under the age of 65). Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries in 2023 (including those with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans).

Source: MedPAC analysis of CMS's 2023 Medicare Current Beneficiary Survey.

new PCP (not a statistically significant difference), and 4 percent of both Medicare beneficiaries and privately insured people had yet to secure an appointment with a new specialist (Figure 4-2).

Once Medicare beneficiaries establish a care relationship with a new clinician, subsequent appointments appear to be easier to schedule, according to CMS's Medicare Current Beneficiary Survey, which is a larger survey fielded among beneficiaries of all ages (including beneficiaries under age 65). CMS's survey asks about wait times for the most recent doctor's office visit that a beneficiary scheduled, and groups together appointments scheduled with new and existing clinicians. The survey finds that most beneficiaries were seen within two weeks, with 76 percent of beneficiaries reporting waiting two weeks or less for their last visit with a primary care physician and 64 percent waiting two weeks or less for their last visit with a specialist (Figure 4-3). This difference may reflect primary care providers squeezing in existing patients for same- or next-day appointments when patients have an urgent health issue, since a core tenet of primary care is providing "first-contact" care to patients when they have a health issue (Starfield et al. 2005).

In our focus groups, beneficiaries also reported longer wait times for specialty care than primary care. Beneficiaries reported that the first visit can take months to a year to happen, but a few mentioned being able to see the specialist right away

if their primary care provider facilitated the referral. Many beneficiaries reported that wait times as a new patient tended to be much longer than as an established patient.

For routine care, beneficiaries in our focus groups reported no major issues with seeing their clinicians, with wait times ranging from a few days to a month. For more urgent care, beneficiaries described using a variety of resources to be seen in a timely manner, such as using a patient portal to contact their clinician.

Beneficiaries reported problems finding a new mental health professional, but access is improving In our 2025 survey, only a small share of people reported trying to get a new mental health professional in the past 12 months—3 percent of Medicare beneficiaries and 7 percent of privately insured people. Among those looking for a new mental health professional, 29 percent of Medicare beneficiaries and 36 percent of privately insured people reported "a big problem" finding one (not a statistically significant difference, given how few people looked for this type of clinician). (These shares are equivalent to 1 percent of Medicare beneficiaries and 3 percent of privately insured people overall.) The shares of respondents who reported problems finding a mental health professional has declined since we first started asking this question in 2023, which coincides with Medicare covering additional types of mental health services and mental health professionals in recent years.

Patients reported sometimes forgoing care but not necessarily due to difficulty accessing it In our 2025 survey, a smaller share of Medicare beneficiaries reported forgoing care that they thought they should have received in the past 12 months (17 percent) compared with privately insured people (27 percent). The most common reasons Medicare beneficiaries cited for not obtaining this care were that they did not think the problem was serious or they just put it off (cited by about half of those reporting forgoing care). Medicare beneficiaries were much less likely to report forgoing care because they thought it would cost too much (6 percent of those reporting forgoing care) compared with privately insured individuals (20 percent of those reporting forgoing care). Among people who reported forgoing care, comparable shares of Medicare beneficiaries and privately insured people reported doing so because they could not get an appointment soon enough (23 percent of Medicare beneficiaries who reported forgoing care and 21 percent of privately insured people who reported forgoing care).

Other surveys also find that Medicare beneficiaries have relatively good access to care Our 2025 survey's overall finding that Medicare beneficiaries reported access to care that was generally 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 having a problem with their health insurance, and less likely to report issues affording medical bills (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, data from the Medical Expenditure Panel Survey (MEPS) and the National Health Interview Survey (NHIS) have been combined to find that around age 65, when most people gain eligibility for Medicare, there are fewer reports of being unable to get necessary care and of being unable to get necessary care specifically due to cost (Jacobs 2021). Another analysis of MEPS found that enrollment in Medicare at age 65 led to a 14 percent increase in visits to primary care providers and a 31 percent increase in visits to other providers (Lee and Li 2025). Another analysis of NHIS 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 2023). And analysis of the Behavioral Risk Factor Surveillance System survey has found that, compared with people with employer-sponsored or individually purchased private 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).

Our analysis of CMS's 2023 Medicare Current Beneficiary Survey also found that Medicare beneficiaries reported good access to care. Because CMS's lengthy survey is fielded among a large sample of Medicare beneficiaries and merged with administrative data, this data source allows us to isolate the experiences of FFS beneficiaries, specifically (in contrast to our own survey, which does not differentiate between FFS beneficiaries and MA enrollees). In 2023, CMS's survey found that 92 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, and 85 percent reported that their usual care provider was a primary care physician. CMS's survey found that 87 percent of FFS beneficiaries reported having seen their usual care provider in the past year, and 95 percent felt that this care provider usually or always spent enough time with them. In addition, 89 percent of FFS beneficiaries were satisfied with the availability of care by specialists. CMS's survey also found that a relatively small share of FFS beneficiaries (9 percent) reported experiencing trouble getting care in the past year—most often because the wait for an appointment was too long (cited by 3 percent of beneficiaries). A small share of FFS beneficiaries reported forgoing care that they thought they should have gotten in the past year (7 percent)—most often because they believed that it wasn't serious (cited by a third of this subset of beneficiaries). Most beneficiaries (87 percent) said they were satisfied with their out-of-pocket costs for medical services, but small shares had a problem paying a medical bill (4 percent) or reported delaying care due to cost in the past year (5 percent). Overall, 95 percent of FFS beneficiaries were satisfied with the ease with which they could get to a doctor from where they lived and 88 percent were satisfied with the availability of care on nights and weekends.

Beneficiaries under age 65 reported having more problems accessing care One group of Medicare beneficiaries that reported notably worse access to care than other beneficiary groups in CMS's 2023 survey is beneficiaries under age 65.[6] For example, beneficiaries under age 65 were twice as likely as beneficiaries ages 65 and over to report having trouble getting health care (15 percent vs. 8 percent) and to report forgoing care that they thought they should have received (13 percent vs. 6 percent). They were much more likely to report having a problem paying a medical bill (17 percent vs. 5 percent) and to report delaying care because of cost in the past year (13 percent vs. 5 percent). Part of the reason for these difficulties may be that beneficiaries under age 65 tend to report being in much worse health and require more health care services than beneficiaries ages 65 and over, yet they have much lower incomes and are less likely to have supplemental insurance (Medicare Payment Advisory Commission 2025b).

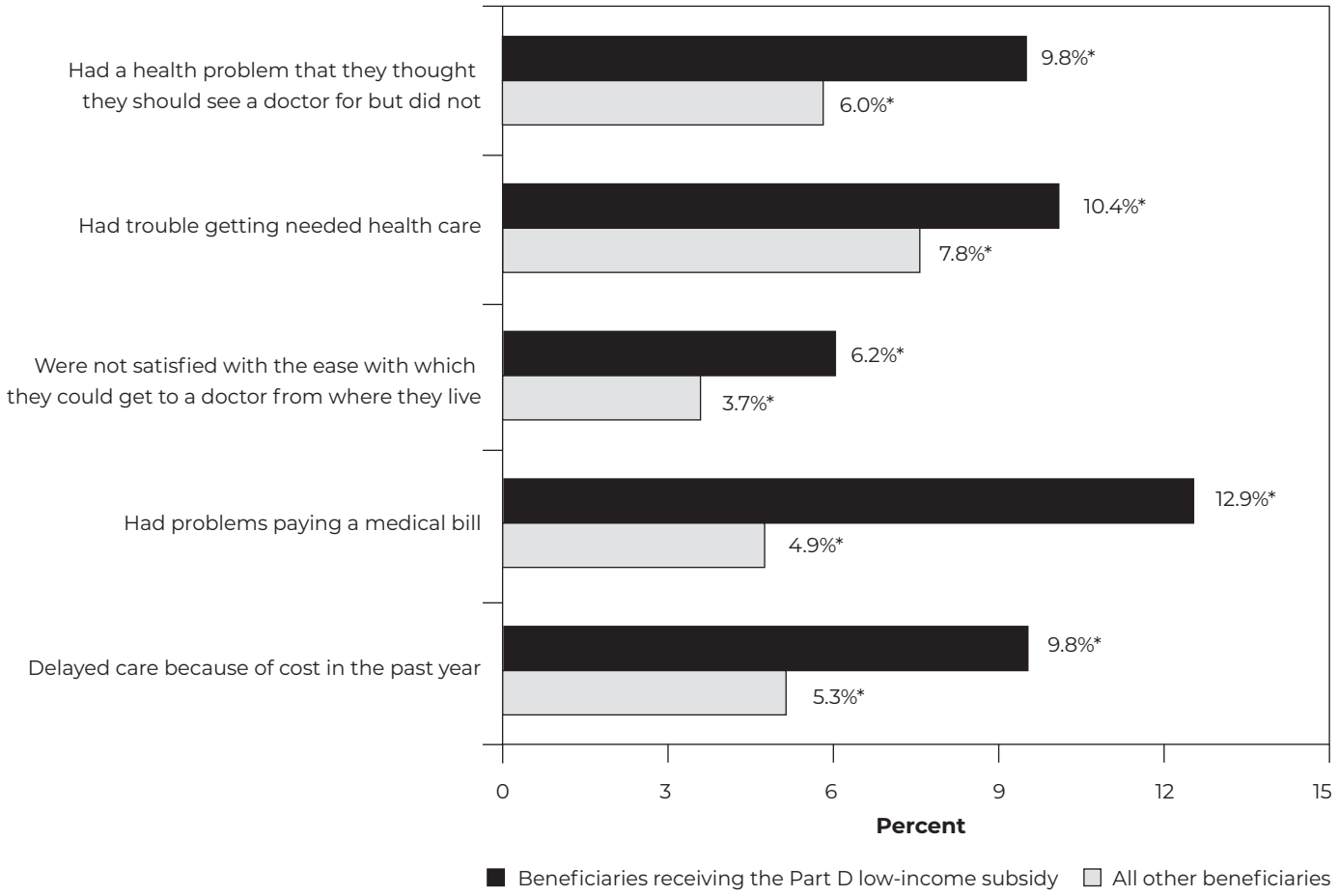
Beneficiaries with very low incomes reported more problems accessing care Beneficiaries with very low incomes also reported worse access to care compared with higher-income beneficiaries (Figure 4-4, p. 112) in our analysis of CMS's 2023 survey. For example, 9.8 percent of Medicare beneficiaries with incomes and assets low enough to qualify for the Part D low-income subsidy (LIS) reported forgoing care that they thought they should have received in the past year, compared with 6.0 percent of higher-income beneficiaries. LIS beneficiaries were more likely to report having trouble getting health care compared with higher-income beneficiaries (10.4 percent vs. 7.8 percent). And a greater share of LIS beneficiaries was dissatisfied with the ease with which they could get to a doctor from where they live (6.2 percent vs. 3.7 percent). (Our own survey, which uses higher income cut-offs, also found that lower-income beneficiaries were less likely to obtain health care than middle- and higher-income beneficiaries; see Table 4-A2, p. 142.)

One of the reasons some low-income Medicare beneficiaries may experience problems accessing health care is that clinicians often receive less payment for treating them. Beneficiaries who are dually enrolled in Medicare and Medicaid are not required to pay cost sharing for the services they receive, and some states' Medicaid programs do not pay this cost sharing either.

Concerns with low-income Medicare beneficiaries' access to care prompted the Commission to recommend in March 2023 that the Congress enact a safety-net add-on payment for fee schedule services delivered to beneficiaries who are dually enrolled in Medicare and Medicaid. Starting in 2025, CMS is now offering payment for advanced primary care management through codes (G0556, G0557, G0558)

FIGURE 4–4

Low-income Medicare beneficiaries reported worse access to care than higher-income beneficiaries, 2023



Note: Beneficiaries are eligible for the Part D low-income subsidy if (1) they have limited assets and incomes of 150 percent of the federal poverty level or less or (2) they are dually enrolled in Medicare and Medicaid. Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries in 2023 (including beneficiaries with fee-for-service Medicare and beneficiaries enrolled in Medicare Advantage plans).
* Statistically significant difference between beneficiaries eligible and automatically receiving the Part D low-income subsidy versus all other beneficiaries (at a 95 percent confidence level).

Source: MedPAC analysis of CMS's 2023 Medicare Current Beneficiary Survey.

that are billable each month and are much larger for qualified Medicare beneficiaries (QMBs), who generally have low incomes and limited resources.[7] (In 2026, the codes pay $117 per month for QMBs, compared with $16 or $54 per month for all other beneficiaries who have zero to one chronic condition or two or more chronic conditions, respectively.) These new codes are directionally consistent with the Commission's recommendation and should increase clinicians' incentives to treat low-income Medicare beneficiaries.

Rural beneficiaries reported having better access to primary care than urban beneficiaries Urban and rural Medicare beneficiaries reported similar experiences accessing care according to most questions in our survey and in CMS's survey. That said, there were some differences related to access to PCPs. As with past years, a higher share of rural beneficiaries in our 2025 survey reported receiving "all" or "most" of their primary care from an NP or PA (28 percent) compared with urban beneficiaries (16 percent). Interestingly,

among beneficiaries looking for a new PCP, more rural beneficiaries reported that it was "not a problem" to find a new one (65 percent) compared with urban beneficiaries (48 percent)—reflecting a steady improvement in rural beneficiaries' ability to find PCPs in recent years. Wait times for an appointment with a new PCP were also shorter for rural beneficiaries than urban beneficiaries, with 57 percent of rural beneficiaries reporting being seen within two weeks versus 33 percent of urban beneficiaries (among those looking for a new PCP in our survey). In contrast, rural and urban beneficiaries reported more comparable experiences finding a new specialist (with nearly identical wait times for a first appointment with a new specialist in our survey, for example). (See Table 4-A3, p. 143, in this chapter's appendix for additional results from our survey for rural and urban beneficiaries.) In CMS's 2023 survey, rural beneficiaries were slightly less likely to have a usual care provider (91 percent vs. 93 percent), and among such beneficiaries, a smaller share of rural beneficiaries reported seeing a specialist in the past year (68 percent vs. 75 percent). Rural beneficiaries were more likely to be dissatisfied with the availability of specialists (13 percent vs. 9 percent).

A few differences in access to care by race/ethnicity

White, Black, and Hispanic Medicare beneficiaries reported similar experiences accessing care according to most questions in our survey. (See Table 4-A4, p. 144, for additional results from our survey for White, Black, and Hispanic beneficiaries.) In CMS's lengthier survey, access was comparable on many key questions but a few differences did emerge; for example, we found that Black and Hispanic beneficiaries were more likely than White beneficiaries to report having a problem paying a medical bill (13 percent and 9 percent vs. 5 percent, respectively). Black and Hispanic beneficiaries were also less likely than White beneficiaries to have seen a specialist in the past year (61 percent and 64 percent vs. 77 percent), despite being twice as likely to report being in "fair" or "poor" health (28 percent and 34 percent vs. 17 percent).

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 insurers' payment rates.

In a 2024 survey by the American Medical Association (AMA), among nonpediatric physicians accepting new patients, 85 percent reported accepting "all" new Medicare patients and another 10 percent reported accepting "some" new Medicare patients; only 3 percent said they only accepted new privately insured patients (American Medical Association 2025b). In our focus groups, the majority of clinicians reported accepting MA plans, but some reported that they do not accept all MA plans in their area and noted that such decisions are made at an organization level.

The AMA survey found that acceptance of Medicare varied by hospital ownership and medical specialty. Among those accepting new patients, larger shares of physicians in hospital-owned practices accepted "all" new Medicare patients (90 percent) compared with physicians in private practice (80 percent). And among those accepting new patients, larger shares of non-primary care physicians accepted "all" new Medicare patients (e.g., 93 percent of general surgeons, 96 percent of radiologists) compared with primary care physicians (e.g., 84 percent of internal medicine physicians, 79 percent of family medicine physicians). The one exception was psychiatry: Among psychiatrists taking new patients, only 55 percent accepted "all" new Medicare patients. Findings from our survey and other sources suggest that mental health professionals generally accept health insurance (of any kind) at lower rates than other medical specialties (American Psychological Association 2024, Ochieng et al. 2022). This observation suggests that psychiatrists' low acceptance of Medicare may reflect a larger issue with health insurance more broadly rather than an issue confined to Medicare.

A survey that focused on the subset of physicians who work only in office-based settings (and not in facilities like hospitals) found that comparable shares of physicians accepted Medicare and private insurance. The 2021 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).

Our own survey has found that Medicare beneficiaries are less likely to encounter a doctor's office that does not accept their insurance compared with privately

insured people. In 2025, among Medicare beneficiaries who had problems finding a new primary care provider in the past year, 17 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries). In contrast, among privately insured people who had problems finding a primary care provider, 32 percent encountered a doctor's office that did not accept their insurance (equivalent to 3 percent of all privately insured people). A similar trend was observed for specialists: Among Medicare beneficiaries who had problems finding a new specialist, 14 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 2 percent of all Medicare beneficiaries), while among privately insured people who experienced a problem finding a new specialist, 31 percent encountered a doctor's office that did not accept their insurance (equivalent to 4 percent of all privately insured people).

CMS administrative data also confirm that a high share of clinicians accept Medicare. In 2023, 98 percent of clinicians billing the PFS were participating providers, meaning they agreed to accept Medicare's fee schedule amount as payment in full. Clinicians who wish to collect somewhat higher payments (of up to 109.25 percent of Medicare's payment rates) can "balance bill" patients for additional cost sharing if they sign up as a nonparticipating provider and choose not to "take assignment" on a claim, but very few clinicians choose this option.[8] In 2024, 99.7 percent of fee schedule claims were paid at Medicare's standard payment rate. If clinicians elect to opt out of the program entirely, they can choose the price they charge patients and bill beneficiaries directly for their services but receive no payment from Medicare. The number of clinicians who opted out of Medicare as of September 2025 (52,500) was extremely low compared with the 1.5 million clinicians who participated in the program in 2024, which is consistent with prior years (Centers for Medicare & Medicaid Services 2025b).[9]

There are many reasons why clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A sizable share of most clinicians' patients are covered by FFS Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their schedules. In addition, almost all hospitals accept FFS Medicare patients and may require their employed physicians to also take FFS Medicare patients. And although commercial insurers' payment rates are typically higher than FFS Medicare's rates, commercial insurers do not pay all claims submitted to them. In contrast, FFS Medicare pays all "clean" claims within 30 days of receiving a claim (and owes providers interest on any late payments). Commercial insurers also often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to complete prior-authorization paperwork. A 2024 survey by the AMA found that among physicians that indicated that they completed any prior authorizations in a typical week of practice, physicians reported completing an average of 39 such requests per week (requiring 13 hours per week) and 40 percent reported having dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2025a). In contrast, FFS Medicare generally does not require prior authorization.[10] The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates.

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

From 2019 to 2024, the total number of clinicians billing the fee schedule increased by an average of 2.2 percent per year, faster than FFS Medicare enrollment growth. The mix of clinicians has also changed over time.

We limit this part of our analysis to clinicians who billed for more than 15 FFS Medicare beneficiaries in a given year. This minimum threshold helps to (1) better measure clinicians who substantially participate in Medicare and therefore are likely critical to ensuring beneficiary access to care and (2) reduce 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).[11] 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 provides both the absolute number of clinicians who billed the fee schedule for more than 15 beneficiaries and the number of clinicians who met that threshold per 1,000 FFS Medicare beneficiaries.[12,13] Although this measure has shortcomings (because by

TABLE 4–1

The number of clinicians billing Medicare's physician fee schedule increased, and the mix of clinicians changed, 2019–2024

	Number (in thousands)					Number per 1,000 FFS 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
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	16.9	11.4	6.8	39.5
2024	133	491	348	193	1,165	4.8	17.6	12.5	6.9	41.7

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). "Physicians" includes only clinicians who are licensed as a doctor of medicine (MD) or doctor of osteopathic medicine (DO). "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, and social workers. This category also includes podiatrists, optometrists, dental surgeons, and chiropractors, which are defined as physicians in Section 1861 of the Social Security Act. This table includes only physicians with a caseload of more than 15 FFS beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in FFS Medicare Part B. 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 2025 annual report of the Boards of Trustees of the Medicare trust funds.

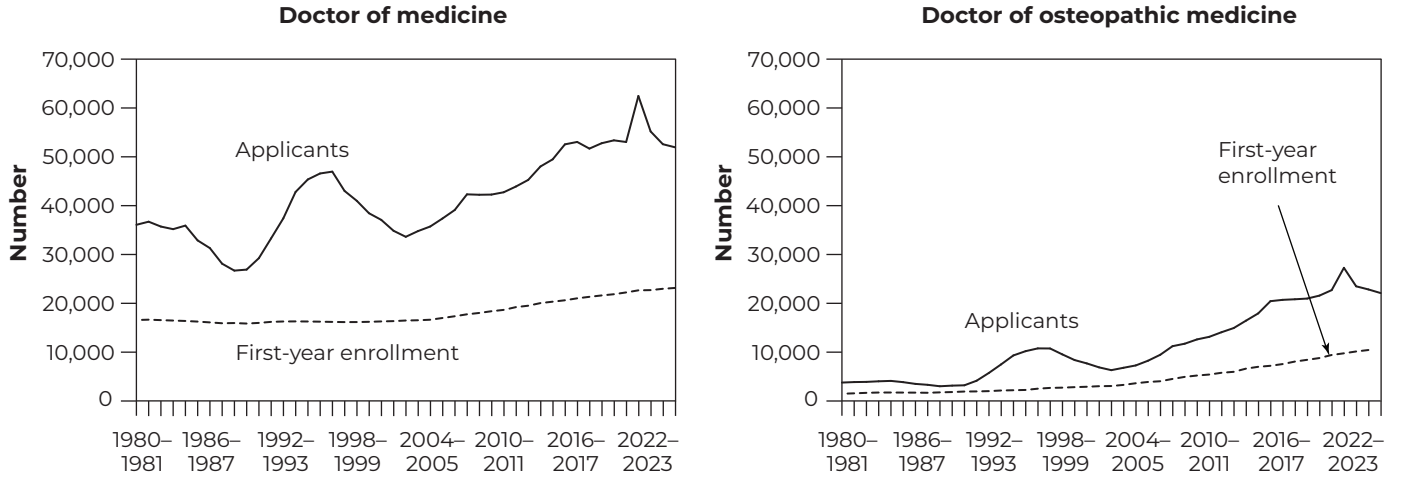
excluding clinicians who treat only beneficiaries in MA it does not provide the broadest view of how many clinicians are caring for Medicare beneficiaries) a FFS-only approach is consistent with the way we calculate encounters, service units, and allowed charges per 1,000 beneficiaries. We plan to continue analyzing MA encounter data to identify MA-only clinicians and possibly include them in future analyses of access to care.

Using our threshold, we found that the total number of clinicians billing the fee schedule between 2019 and 2024 grew from about 1.0 million to almost 1.2 million. In addition to the absolute number of clinicians, we also calculate the number of clinicians billing the fee schedule per FFS Medicare beneficiary. This measure provides an indication of trends in access to clinician care among FFS beneficiaries. If the ratio of clinicians to beneficiaries is declining, it indicates that there are fewer clinicians available to care for FFS beneficiaries and patients may have more difficulty accessing care; if the ratio is increasing, it is an indication that access to care is stable or increasing. Over the 2019 to 2024 period, the total number of clinicians per 1,000 FFS Medicare beneficiaries increased from 31.6 to 41.7.

While the total number of clinicians billing the fee schedule rose between 2019 and 2024, trends varied by type and specialty of clinician. Since 2019, the number of primary care physicians (which include physicians specializing in family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists) billing the fee schedule declined from 138,000 to 133,000—a net decrease of about 5,000 primary care physicians by 2024 (an average annual decline of 0.7 percent). Some of these clinicians may be continuing to see patients but no longer accepting insurance, instead billing patients directly for an all-inclusive monthly fee (in what are known as "direct primary care"

FIGURE 4–5

First-year enrollment and the number of medical school applicants increased over the last two decades



Note: For the "doctor of medicine" figure, matriculant data are used but referred to as "first-year enrollment" for comparability across figures. Matriculant and first-year enrollment data capture slightly different populations. For example, first-year enrollment data include students who repeat their first year of medical school, while matriculant data do not include such students. At the time this report was written, first-year enrollment data for doctors of osteopathic medicine were not available.

Source: Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine.

practices). One recent study estimated that a few thousand physicians and other types of clinicians now work in such practices (Zhu et al. 2025). (Another few thousand are estimated to work in "concierge" practices, which continue to accept insurance but charge patients an additional annual or monthly retainer fee.) That said, the number of beneficiaries enrolled in FFS Medicare also declined over time, as the share of beneficiaries enrolled in MA plans increased; as a result, the number of primary care physicians per 1,000 FFS Medicare beneficiaries increased from 2019 to 2024, from 4.2 to 4.8.

The total number of specialist physicians grew from 468,000 to 491,000 from 2019 to 2024, and the ratio of specialist physicians to every 1,000 FFS beneficiaries increased from 14.2 to 17.6 (an average annual increase of 4.4 percent). Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 258,000 to 348,000 (an average increase of 6.2 percent per year), or from 7.8 per 1,000 FFS beneficiaries to 12.5 per 1,000 FFS beneficiaries.[14] Meanwhile, the number of other practitioners, such as physical therapists and podiatrists, increased, as did the ratio of these practitioners per 1,000 FFS beneficiaries.

Interest in becoming a clinician remains high

In the long term, access to health care also depends on new physicians and other types of clinicians entering the workforce. While less immediately related to the adequacy of fee schedule payment rates than some of our other measures, we examine applications to medical school and first-year enrollment as proxies for students' interest in and ability to become physicians. To supplement this analysis, we also examine the growth of other clinician specialties, such as NPs and PAs.

Physicians in the U.S. hold a degree as either a doctor of medicine (MD) or doctor of osteopathic medicine (DO). Despite year-to-year variations (e.g., an increase in medical school applications during the coronavirus pandemic), the long-term trend reflects an increasing number of applicants at both MD- and DO-granting educational institutions (Figure 4-5). From the 1980–

1981 academic year to the 2024–2025 academic year, the number of applicants to MD-granting institutions rose from about 36,000 to 52,000, an average increase of 0.8 percent per year, and the number of applicants to DO-granting institutions climbed from about 4,000 to 22,000, an average increase of 4.1 percent per year (Figure 4-5). First-year enrollment has grown as well, exceeding total U.S. population growth and accelerating in more recent years. From the 1980–1981 academic year to the 2023–2024 academic year, the combined first-year enrollment in MD or DO programs increased by an average of 1.4 percent per year compared with total U.S. population growth of 0.9 percent per year over the same period. In the most recent decade (from the 2013–2014 to the 2023–2024 academic years), first-year enrollment in MD or DO programs increased even faster (2.3 percent per year), while the total U.S. population grew more slowly (0.6 percent per year).[15]

In addition to physicians, APRNs and PAs represent an increasingly large share of the clinician workforce, and the number of these clinicians has grown rapidly, suggesting robust interest in becoming an APRN or PA. A record number of PAs—about 12,400—earned their board certification for the first time in 2024 (National Commission on Certification of Physician Assistants 2025b). As a result of the increased entry, the number of certified PAs in the U.S. has more than quadrupled from 2003 to 2024, increasing from about 43,500 to 189,900 (National Commission on Certification of Physician Assistants 2025a, National Commission on Certification of Physician Assistants 2014). Similarly, according to the Bureau of Labor Statistics, the estimated total employment for nurse practitioners roughly tripled from 2012 to 2024 (Bureau of Labor Statistics 2025). One estimate found that, in 2025, the number of licensed nurse practitioners reached about 461,000 (American Association of Nurse Practitioners 2025).

The total number of clinician encounters per FFS beneficiary grew from 2019 to 2024

We use the quantity of beneficiaries' encounters with clinicians as another measure of access to care. We use a claims-based definition of encounters.[16] Clinicians submit a claim when they furnish one or more services to a beneficiary in FFS Medicare. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would count that as one encounter. In 2024, about 98 percent of beneficiaries enrolled in FFS Medicare had at least one encounter.[17]

The total number of encounters per FFS Medicare beneficiary grew from 22.3 in 2019 to 24.3 in 2024 (Table 4-2, p. 118), with an average annual growth rate of 1.8 percent over that period.

Encounters with all types of clinicians declined by 11.2 percent in 2020 due to the effects of the pandemic. Total encounters then grew by an average of 5.6 percent over the 2020 to 2023 period as the effects of the pandemic subsided, and increased by 4.5 percent in 2024. The change in the number of encounters per FFS beneficiary varied by specialty and type of provider. For instance, the number of encounters furnished by primary care physicians declined by 10.2 percent during the first year of the pandemic, increased by an average of 0.1 percent from 2020 to 2023, and grew by 1.7 percent in 2024. Encounters furnished by specialist physicians decreased by 12.0 percent in 2020, increased by an average of 4.0 from 2020 to 2023, and grew by 2.8 percent in 2024.

Encounters with APRNs and PAs experienced a relatively small decrease in 2020 (-2.8 percent), and then grew by an average of 11.7 percent from 2020 to 2023, and by 11.8 percent in 2024. There was broad growth across different types of services in APRN and PA encounters: From 2023 to 2024, APRNs and PAs delivered 13.5 percent more encounters for E&M services, 14.7 percent more "other procedures," 9.2 percent more treatment services, 13.3 percent more imaging, and 14.9 percent more tests (APRNs and PAs furnish services in both primary care and non–primary care practices) (data not shown).

The number of encounters with APRNs and PAs has grown rapidly, yet we are likely undercounting the number of fee-schedule encounters provided by these clinicians due to "incident-to" billing. 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 about 40 percent of office visits provided by APRNs and PAs in 2018 were indirectly billed incident to a physician visit (Patel et al. 2022), which is consistent with the Commission's own research on this topic (Medicare Payment Advisory

TABLE 4–2

Total encounters per FFS beneficiary were higher in 2024 compared with 2019, and the mix of clinicians furnishing them changed

	Encounters per FFS beneficiary						Percent change		
Specialty category	2019	2020	2021	2022	2023	2024	2019–2020	Average annual 2020–2023	2023–2024
Total (all clinicians)	22.3	19.8	21.6	22.3	23.3	24.3	–11.2%	5.6%	4.5%
Primary care physicians	3.5	3.1	3.1	3.1	3.1	3.2	–10.2	0.1	1.7
Specialists	12.9	11.4	12.3	12.4	12.8	13.1	–12.0	4.0	2.8
APRNs/PAs	2.5	2.4	2.7	3.0	3.3	3.7	–2.8	11.5	11.8
Other practitioners	3.4	2.9	3.5	3.7	4.0	4.3	–15.2	11.4	6.1

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 the 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 the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Commission 2019). 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 substituting for physician primary care visits or specialty care services.

We also measure changes in the number of encounters by type of service. From 2019 to 2023, the number of encounters per beneficiary increased for all types of services, but growth over that period was restrained by the effects of the pandemic (Table 4-3). From 2023 to 2024, encounters grew more rapidly, with some differences across broad service categories. For example, the number of E&M encounters per beneficiary (which includes E&M office visits, hospital outpatient visits, and services provided during an inpatient stay) provided by all clinicians rose 4.8 percent, from 13.1 to 14.1. In 2024, encounters for anesthesia declined (–0.8 percent), while encounters involving treatment (such as physical therapy, treatment for cancer, and dialysis)[18] had the highest growth rate (5.5 percent).

Quality of clinician care is difficult to assess

The quality of clinician care is difficult to assess, but the indicators we track suggest it has remained relatively stable. 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 (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) that, 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

TABLE 4–3

Encounters per FFS beneficiary across service types, 2019–2024

	Encounters per FFS beneficiary			Percent change	
Type of service	2019	2023	2024	Average annual 2019–2023	2023–2024
Total (all services)	22.3	23.3	24.3	1.1%	4.5%
Evaluation and management	13.1	13.5	14.1	0.7	4.8
Major procedures	0.2	0.2	0.2	0.2	2.5
Other procedures	2.4	2.4	2.5	0.5	3.0
Treatments	2.7	3.2	3.4	4.0	5.5
Imaging	4.1	4.2	4.3	0.6	3.1
Tests	2.2	2.3	2.4	0.8	4.1
Anesthesia	0.6	0.6	0.6	0.4	–0.8

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 totals because encounters with multiple service types are counted separately for each type of service but counted only once for the total. For example, if an imaging service and a test were billed in the same encounter, we count that as one encounter for imaging and one for tests (for a total of two encounters), but we count the services as one encounter for the total row. All numbers in the table are rounded, but calculations were made on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

hundreds of measures; this makes it harder to compare clinicians since only a few clinicians may report any given measure and allows clinicians to use measure-selection as a strategy to maximize their performance score. Also, many clinicians are exempt from reporting quality data for MIPS (e.g., if they see 200 or fewer Medicare Part B beneficiaries or bill less than $90,000 for Part B–covered professional services), 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 allow a substantial portion of services performed by APRNs and PAs to be billed by physicians, undermining efforts to assess clinician quality.

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)). This approach is consistent with the Commission's principles for quality measurement (Medicare Payment Advisory Commission 2018a).

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

The Commission worked with a contractor to specify two claims-based outcome measures—ACS hospitalizations and ED visits—to compare quality of care within and across different populations (e.g., FFS Medicare in different local-market areas), given the adverse impact on beneficiaries and high cost of these events (RTI International 2024). Two categories of ACS conditions are included in the measures: chronic (e.g., diabetes, asthma, hypertension, heart failure) and acute (e.g., bacterial pneumonia, cellulitis). Conceptually, an ACS hospitalization or ED visit entails hospital use that

TABLE 4–4

National risk-adjusted rates of ambulatory care–sensitive hospitalizations and emergency department visits per 1,000 FFS Medicare beneficiaries, 2019–2024

	Risk-adjusted rate per 1,000 FFS Medicare beneficiaries						
	2019	2020	2021	2022	2023	2024	Change 2019–2024
Ambulatory care–sensitive hospitalizations	43.9	30.8	29.9	30.2	31.6	31.6	–12.3
Ambulatory care–sensitive ED visits	68.3	46.9	47.0	51.3	53.6	55.0	–13.3

Note: FFS (fee-for-service), ED (emergency department). Lower rates are better. 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: Analysis of 2019–2024 FFS Medicare claims data.

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. However, measure results may also reflect differences in health care access, referral patterns, and specialist availability across market areas. The measures also may not pinpoint the exact areas in ambulatory care where improvements are needed.

The national risk-adjusted ACS-hospitalization rate remained relatively stable from 2021 to 2024 and below prepandemic rates, while the ACS-ED visit rate increased over this period (Table 4-4). For example, in 2019 the risk-adjusted ACS hospitalization rate was 43.9 per 1,000 FFS beneficiaries, which declined to 29.9 per 1,000 FFS beneficiaries in 2021 but rose in 2023 to 31.6 per 1,000 FFS beneficiaries where it remained in 2024. During the coronavirus pandemic, there was a significant drop in overall hospitalizations, so we would expect some accompanying decline in ACS hospitalizations. ACS hospitalization rates remain below prepandemic levels, and it is difficult to untangle whether and how much of the decline in these services is due to changes in hospital use or because of improved access to or quality of care.

Consistent with prior years, we have found differences in rates of ACS hospitalizations and ED visits across groups of Medicare beneficiaries, which could indicate differential access to high-quality ambulatory care (Medicare Payment Advisory Commission 2023). In 2024, beneficiaries receiving the Part D low-income subsidy (a proxy for low income) had ACS hospitalization and ED visit rates that were 1.3 times higher than those of other beneficiaries. Black beneficiaries had a rate of ACS hospitalizations that was 1.6 times higher than that of Asian/Pacific Islander beneficiaries and a rate of ACS ED visits that was almost two times higher than that of Asian/Pacific Islander beneficiaries. Beneficiaries residing in rural areas had about the same ACS hospitalization rate as beneficiaries living in urban areas. However, beneficiaries in rural areas had ACS ED–visit rates that were 1.4 times higher than beneficiaries residing in urban areas.

Consistent with previous years, in 2024, the distribution of risk-adjusted rates of avoidable hospitalizations and ED visits per 1,000 FFS Medicare beneficiaries varied widely across Dartmouth Atlas Project–defined hospital service areas (HSAs) (data not shown).[19] This variation signals opportunities to improve the quality of ambulatory care. 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 2.3 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

TABLE 4–5

Medicare FFS–CAHPS performance scores, 2020–2024

CAHPS composite measure	2020	2021	2022	2023	2024	Score change, 2020–2024
Getting needed care and seeing specialists	83	81	80	80	81	–2
Getting appointments and care quickly	78	76	75	82	83	N/A*
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	85	85	85	86	87	2
Rating of health plan (FFS Medicare)	84	83	83	83	84	0
Rating of health care quality	86	85	85	85	86	0
Annual flu vaccine	77	77	77	73	69	–8

Note: FFS (fee-for-service), CAHPS (Consumer Assessment of Healthcare Providers and Systems), N/A (not applicable). Questions related to "getting needed care and seeing specialists," "getting appointments and care quickly," and "care coordination" have response options of "never," "sometimes," "usually," and "always." CMS converts these responses to linear mean scores on a 0 to 100 scale. Questions of "rating of health plan" and "rating of health care quality" have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. The "annual flu vaccine" question is a yes/no response converted to a percentage. CAHPS responses are case-mix adjusted for the predictable effects of the response tendencies of the people who complete them (e.g., age, sex, health status). FFS–CAHPS response rates from 2020 to 2024 range from 28 percent to 29 percent. Years represent experiences of care during the last six months from the survey. For example, 2024 scores are based on beneficiaries' self-reported experience in the last six months from surveys collected in the spring of 2025.
* CMS revised which CAHPS survey items are scored in the "getting appointments and care quickly" composite measure, which may cause fluctuation in scores compared with prior years. Therefore, we do not report the change in scores over time.

Source: FFS–CAHPS mean scores reported by CMS.

care systems, while relatively good performance on the measures can indicate best practices for ambulatory care systems.

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. (In the text box, pp. 122–123, we also present Medicare Shared Savings Program (MSSP) accountable care organization (ACO) CAHPS results, as another measure of FFS Medicare beneficiaries' experiences with care.[20])

Between 2020 and 2024, FFS–CAHPS scores were relatively stable. The 2024 FFS–CAHPS score for "getting needed care and seeing specialists" was 81 (score on a scale of 0 to 100), which was an increase of one from 2023, but the score has been trending downward over the past several years (Table 4-5). The score for "rating of health plan (FFS Medicare)" was 84, and the score for "rating of health care quality" was 86;

Medicare Shared Savings Program accountable care organizations' patient-experience scores

Medicare Shared Savings Program (MSSP) accountable care organization (ACO) patient-experience results serve as another indicator of fee-for-service (FFS) Medicare beneficiaries' experiences with access to and quality of care. About 40 percent of all FFS beneficiaries are assigned to an MSSP–ACO, a permanent part of the Medicare program established through the Affordable Care Act of 2010 (ACA) (Medicare Payment Advisory Commission 2025b). MSSP–ACOs are required to field Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) surveys to a subset of assigned beneficiaries to measure those beneficiaries' experiences with care across various domains, such as access to care, rating of providers, and care coordination. ACOs must meet a designated minimum attainment level on the CAHPS for MIPS measures, as well as other quality measures, in order to share in savings. National MSSP–CAHPS for MIPS measure results, although measuring experience for a subset of FFS beneficiaries, can also serve as an indicator of access and quality of care for Medicare FFS beneficiaries. Some of the MSSP–CAHPS for MIPS measures are conceptually the same as the FFS–CAHPS measures discussed above, such as measuring beneficiaries' experiences obtaining timely care. However, the FFS–CAHPS measures and MSSP–CAHPS measures are not directly comparable because there are some differences in the survey items used to calculate the measures. For example, the MSSP–CAHPS for MIPS survey items focus on the beneficiaries' experiences with their provider or provider's offices that are part of the MSSP–ACO, while the FFS–CAHPS survey items ask more broadly about beneficiary experiences across their providers and the program.

Between 2019 and 2024, changes in MSSP–ACO–CAHPS for MIPS scores were mixed. The 2024 score for "getting timely care, appointments, and information" was 84 (score on a scale of 0 to 100), which was the same as the previous two years, but trending downward from 2019 (Table 4-6). The 2024 score for "access to specialists" was 76, which was the same as 2023, but a reduction of 6 from 2019. This decline may signal that beneficiaries are finding it harder to get appointments with specialists, which is consistent with some findings from the Medicare Current Beneficiary Survey analysis and our beneficiary focus groups (discussed on pp. 109–110). The MSSP–ACO–CAHPS for MIPS scores were relatively stable and high for "how well providers communicate" and "patient's rating of provider." The "care coordination" score was 86 in 2024 and has been relatively stable over the years. ■

(continued next page)

both scores have been stable over the past few years. In 2024, 69 percent of surveyed beneficiaries reported receiving an annual flu vaccine, which was a decline of 4 percentage points from 2023, and 8 percentage points from 2020. All 2023 FFS–CAHPS measure scores for urban residents were similar to the national average (Centers for Medicare & Medicaid Services 2024b). FFS–CAHPS scores for rural residents were similar to the national average, except for the annual flu vaccine rate, which was below the national average (data not shown).

Clinicians' revenues and compensation have increased, and inflation growth has moderated in the last few years

Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries or to their full panel of patients more generally. Instead, we rely on indirect measures of clinicians' payments and their costs to provide services. We find that PFS spending per beneficiary has increased markedly over time—driven by substantial growth in the volume and

Medicare Shared Savings Program accountable care organizations' patient-experience scores (cont.)

TABLE 4–6

MSSP–ACO–CAHPS for MIPS performance scores, 2019–2024

CAHPS composite measure	2019	2020*	2021	2022	2023	2024	Score change, 2019–2024
Getting timely care, appointments, and information	86	—	85	84	84	84	–2
Access to specialists	82	—	79	77	76	76	–6
How well providers communicate (e.g., provider explains things in a way that is easy to understand)	94	—	94	93	94	94	0
Patient's rating of provider	92	—	92	92	92	93	1
Care coordination (e.g., provider has relevant medical record)	87	—	86	85	86	86	–1

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization), CAHPS (Consumer Assessment of Healthcare Providers and Systems), MIPS (Merit-based Incentive Payment System). A subset of the CAHPS for MIPS measures scored in the MSSP are presented in this table. Questions related to "getting timely care, appointments, and information," "access to specialists," "how well providers communicate," and "care coordination" have response options of "never," "sometimes," "usually," and "always." CMS converts these responses to linear mean scores on a 0 to 100 scale. The question related to "patient's rating of provider" has a response of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. CAHPS responses are case-mix adjusted for the predictable effects of the response tendencies of the people who complete them (e.g., age, sex, health status). Years represent the MSSP–ACO performance year. For example, 2024 scores are based on self-reported experience during the past six months from the survey collection period from October 2024 to January 2025. CMS does not publicly report response rates for the CAHPS for MIPS survey.
* CMS did not report 2020 performance year results because of the coronavirus pandemic.

Source: Analysis of CMS Medicare Shared Savings Program Performance Year Financial and Quality Results datasets.

intensity of services delivered per FFS beneficiary.[21] Since peaking in 2022, growth in input costs has moderated but remains slightly elevated. Clinicians' annual compensation from all sources continues to rise.

Allowed charges per FFS beneficiary grew at a higher rate from 2023 to 2024 than during previous years

The total payments that clinicians received per FFS beneficiary grew from 2023 to 2024, in part because of increases in the volume and/or intensity of services they deliver. We measure the total payments a clinician receives using allowed charges (which include Medicare payments and beneficiary cost-sharing liabilities) for services furnished to FFS beneficiaries that are paid under the PFS.[22]

From 2023 to 2024, across all services, allowed charges per beneficiary rose by 4.1 percent (Table 4-7, p. 124). Among broad service categories, growth rates were 5.1 percent for E&M services, 4.0 percent for imaging services, 2.2 percent for other procedures

TABLE 4–7 **Growth in allowed charges per FFS beneficiary varied by type of service, 2019–2024**

Type of service	Change in units of service per FFS beneficiary		Change in allowed charges per FFS beneficiary		Share of allowed charges, 2024
	Annual average 2019–2023	2023–2024	Annual average 2019–2023	2023–2024	
All services	**1.9%**	**7.1%**	**2.3%**	**4.1%**	**100%**
Evaluation and management	0.8	10.9	3.2	5.1	52.1
Imaging	0.9	3.3	1.5	4.0	10.7
Major procedures	–0.2	3.1	–1.5	–0.3	6.7
Other procedures	1.4	3.6	1.2	2.2	12.5
Treatments	6.5	7.6	4.4	4.9	10.3
Tests	0.9	3.2	1.7	3.7	5.0
Anesthesia	–0.4	1.7	–1.4	–0.3	2.4

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. The Restructured BETOS Classification System (RBCS) is used to group clinically similar services into categories and subcategories. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

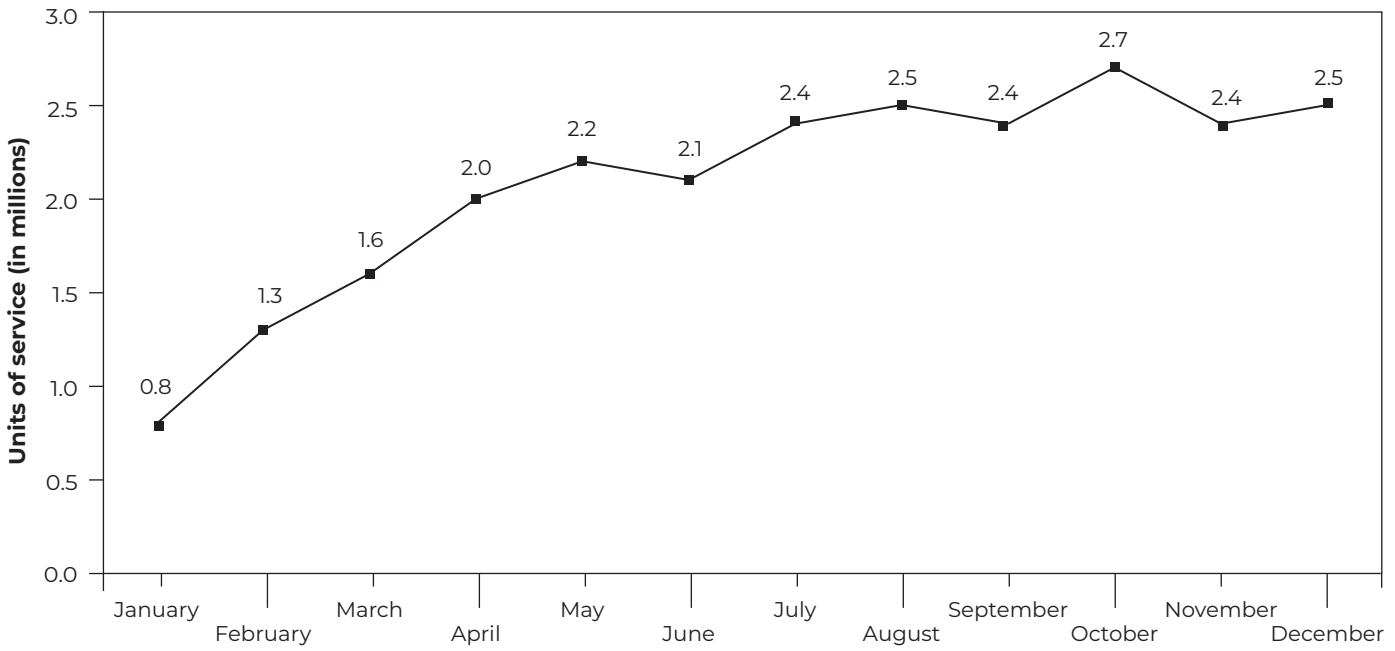
(i.e., procedures that are not considered major procedures), 4.9 percent for treatments, and 3.7 percent for tests. Allowed charges per FFS beneficiary for major procedures and anesthesia each fell by 0.3 percent. Growth in five of the seven service categories was higher in 2024 than the average annual growth rates during the 2019 to 2023 period (allowed charges declined for major procedures and anesthesia in 2024, but less than they declined from 2019 to 2023). The 2019 to 2023 period included slow or negative growth during the pandemic, but spending largely rebounded in 2021 and 2022. For most categories, the growth in allowed charges in 2024 was also higher than the average annual rate of growth in the years immediately prior to the pandemic, which averaged 2.0 percent from 2015 to 2019 (data not shown). The exceptions were major procedures and anesthesia, which declined or grew more slowly from 2023 to 2024 than they did over the 2015 to 2019 period.

We also present data on changes in units of service per beneficiary. For most types of services, a unit represents one individual service, such as an office visit, surgical procedure, or imaging scan. As measured by units of service per beneficiary, the volume of clinician services grew more quickly over the 2023 to 2024 period (7.1 percent) than it did from 2019 to 2023 (1.9 percent per year), which included the pandemic, during which volume for various types of services experienced relatively slow growth or declined (Table 4-7). Volume growth during both periods varied by type of service, but growth rates for all types of service were higher in 2024 than during the 2019 to 2023 period.

Overall volume grew more than spending growth in 2024, suggesting that much of the growth that year was driven by increased volume. Spending can also be affected by increased intensity of the services being delivered, which often does not result in changes in volume. For example, if providers substitute CT scans with contrast for CT scans without contrast (which results in an increase in relative value units (RVUs)), the allowed charges for imaging services would increase at a higher rate than would units of service for imaging.

FIGURE 4–6

Monthly utilization of the G2211 complexity add-on code increased during 2024



Note: G2211 is an add-on code that can be billed with certain office/outpatient evaluation and management (E&M) visit codes. It can be billed when a clinician is furnishing an eligible E&M visit to an existing patient for management of a serious or complex medical condition.

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

Differences in allowed charges from volume may also be partly attributable to increases or decreases in Medicare's payment rates for certain services, such as the recent increases in rates for E&M services. Decreases in allowed charges relative to service volume changes can also be related to the shift of services from freestanding offices to the outpatient hospital setting, where fee schedule payments are generally still made but payment rates under the PFS are lower.[23]

Among the broad service categories shown in Table 4-7, E&M had the highest rate of growth in allowed charges and units of service in 2024. A substantial portion of the increase in E&M units and allowed charges is the result of clinicians billing for a new add-on code, which was introduced in 2024. G2211 is an add-on code that clinicians may use with traditional office/outpatient E&M visits but not with procedures or most other codes. Code G2211 can be billed when the clinician is serving as the focal point for all of a patient's ongoing care or is treating a patient's single, serious condition—such as managing a complex illness over an extended period of time.[24] As long as all requirements for billing G2211 are met, there is no limit on how often it can be used and the code can billed by multiple clinicians (e.g., both a primary care provider and a specialist) for the same patient.

In 2024, Medicare paid for the G2211 add-on code approximately 25 million times. As shown in Figure 4-6, monthly utilization of G2211 increased steadily during the first part of 2024 but stabilized toward the end of the year. Code G2211 is responsible for approximately half of the 10.9 percent volume growth that took place among all E&M codes in 2024 (data not shown). The add-on code accounted for about $400 million in

allowed charges in 2024, which is responsible for about one-fifth of the overall 5.1 percent increase in spending on E&M services. The effect attributable to G2211 on E&M spending growth was not as large as its effect on volume because the payment rate for the add-on code is relatively small at about $16.

Utilization and allowed charges in the treatment category of services also grew at a rapid rate (7.6 percent and 4.9 percent, respectively) in 2024. Treatment categories include services such as administration of dialysis and cancer treatments, physical therapy, and spinal manipulation. Among all treatments, increases in volume and spending among physical therapy services (which includes physical, occupational, and speech therapy (PT/OT/ST) services) were the primary drivers of growth. Spending per FFS beneficiary on these types of services rose by 8.0 percent from 2023 to 2024 and grew by a total of 54 percent over the 2019 to 2024 period (data not shown). Increases in allowed charges for PT/OT/ST were mirrored by utilization growth for these services.

Among all PT/OT/ST services, physical therapy represents more than 80 percent of spending and had the greatest impact on overall growth from 2019 to 2024. During that period, growth in physical therapy was driven by a combination of increases in the share of beneficiaries receiving physical therapy (26 percent), number of therapy services furnished to each beneficiary (54 percent), and number of clinicians who furnish these services (23 percent). The growth in volume of and spending on physical therapy services may be related to the elimination of previous annual caps on spending on physical therapy services for each beneficiary unless a medical exemption was granted. Providers who treat beneficiaries whose spending on physical therapy exceeds a specified spending threshold are now permitted to exceed those thresholds by including a modifier on claims to attest to medical necessity.

Growth in input costs is moderating from recent highs but remains slightly elevated

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 increases in 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. Unlike many other market baskets, the MEI has long been adjusted for a measure of productivity growth. Therefore, reported MEI growth figures include a built-in adjustment for total-factor 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).

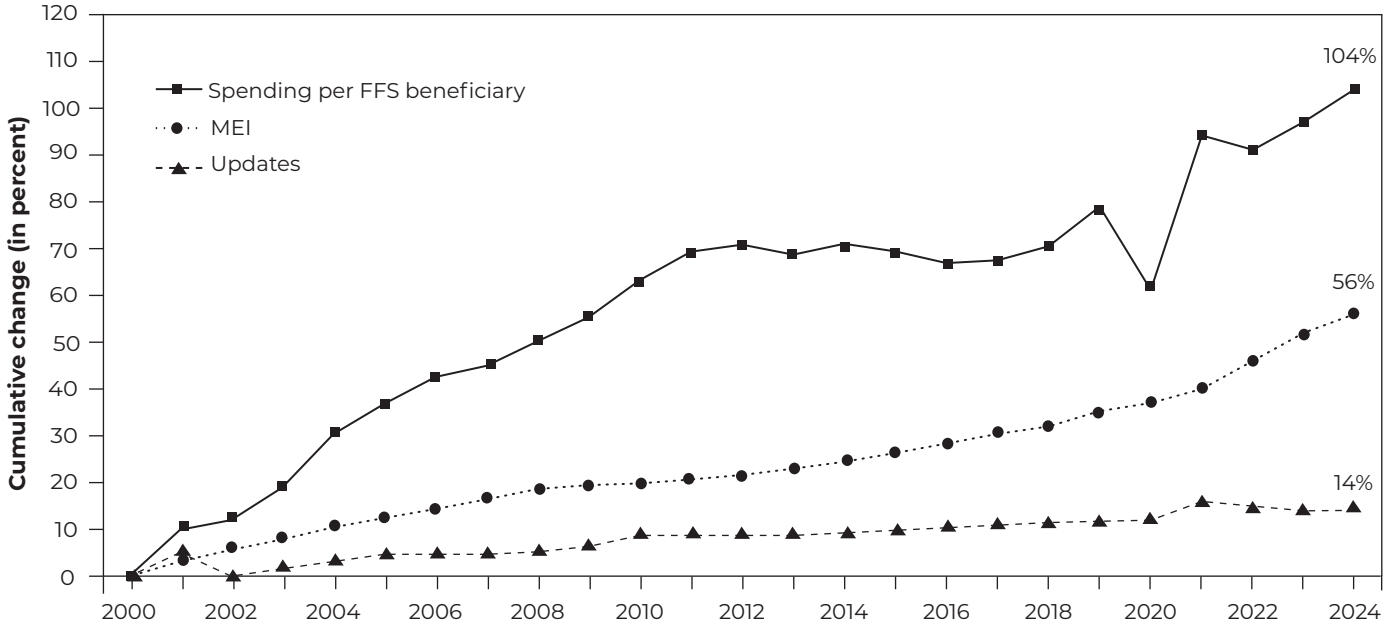
MEI growth was 1 percent to 2 percent per year for several years before the coronavirus pandemic and was 1.9 percent in 2020.[25] MEI growth then increased to 4.3 percent in 2022. MEI growth slowed to 3.0 percent in 2024 and is projected to moderate further in the coming years—to 2.7 percent in 2025, 2.2 percent in 2026, and 2.1 percent in 2027.[26]

From 2000 to 2024, cumulative MEI growth has far exceeded updates to PFS payment rates (Figure 4-7). Over that period, the MEI increased cumulatively by 56 percent compared with 14 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 104 percent over the same time period.[27] The substantial growth in volume and intensity (and the Commission's broader finding that Medicare beneficiaries report relatively good access to care) suggests that below-MEI updates have not impeded access and that simply comparing changes in fee schedule updates with MEI growth is insufficient to capture changes over time in clinicians' ability to provide services to Medicare beneficiaries.

Some stakeholders have suggested that the large increases in volume and intensity over the last two decades represent clinicians' responses to fee schedule payment rates that declined (after adjusting for inflation) over that period, and some early studies finding a negative relationship between fee schedule payment rates and volume and intensity of fee schedule services supported this view (Congressional Budget Office 2007, Office of the Actuary 1998). However, some more recent research contradicts this theory, with multiple rigorous studies estimating a positive relationship between payment rates and volume and intensity (Hayford et al. 2025). That is, these studies find that volume and intensity *increase* as payment

FIGURE 4–7

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). The MEI measures the change in clinician input prices. 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 percent in 2021, 3.0 percent in 2022, 2.5 percent in 2023, and a weighted average of 1.25 percent and 2.93 percent 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.

rates increase. For example, one study found that, among 40- to 55-year-old physicians, a 10 percent increase in payment rates was associated with physicians billing 4.4 percent more RVUs—3.9 percent more procedures (nearly all of which is driven by performing procedures on additional patients rather than doing procedures more frequently for the same number of patients) and additional shifts to relatively higher-paid procedures (Gottlieb et al. 2023).[28] That study also found that increasing Medicare payment rates decreases physicians' likelihood of retiring. Other research has found that the relationship between payment rates and the volume of care is greater for elective procedures, such as cataract surgery, than it is for less discretionary services (Clemens and Gottlieb 2014). Yet not all studies have consistent results: in one specific clinical area, another recent study found that when a 10 percent bonus for primary care providers expired, clinicians responded by increasing the volume and intensity of the services they furnished by 4 percent (Brunt 2023). This evolving body of research suggests that the effects of changing PFS rates can vary depending on a number of factors, such as the type of service, but that in aggregate the slower growth in PFS rates relative to the MEI is unlikely to account for the growth in volume and intensity over the same period.

Clinician compensation growth has averaged 3 percent to 4 percent per year in recent years

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 all-payer profitability. Clinician compensation levels suggest that clinicians' total all-payer revenues are greater than their costs and that providing clinician services is therefore profitable. These compensation levels also give some assurance that there is an incentive for individuals to pursue careers as clinicians. We note, however, that Medicare constitutes only a portion of the revenue clinicians receive since Medicare is only one of the insurers clinicians typically receive payments from. In addition, some health systems may choose to subsidize clinicians' compensation using profits from non-PFS sources (e.g., profits from payments through the hospital outpatient prospective payment system or from 340B drug discounts). Some clinicians' compensation arrangements may also not be directly tied to Medicare PFS payment rates (especially among employed clinicians paid a salary that reflects demand and supply in a local market). That said, academic research suggests that changes in Medicare fee schedule payment rates directly affect physician earnings. One study found that a 10 percent increase in Medicare payment rates was associated with a 2.4 percent increase in professional earnings of 40- to 55-year-old physicians (Gottlieb et al. 2023).

In SullivanCotter's latest physician compensation and productivity survey, median physician compensation grew by 6 percent from 2023 to 2024—twice as fast as inflation (which was 3 percent).[29,30] And according to the U.S. Bureau of Labor Statistics, median PA compensation grew by 2.5 percent and median NP compensation grew by 2.3 percent over this period (Bureau of Labor Statistics 2025).

But compensation growth from one year to the next is somewhat erratic—with robust growth in some years and more modest growth in others—so it is useful to look at compensation growth over a multiyear period. From 2019 to 2024, median physician compensation grew by an average of 3.7 percent per year, median PA compensation grew by an average of 3.5 percent per year, and median NP compensation grew by an average of 3.3 percent. All of these growth rates are somewhat slower than inflation from 2019 to 2024—which was higher than usual, at 4.2 percent per year.

From 2019 to 2024, compensation grew more quickly for some physician specialties than others. Higher growth was observed among a number of specialties that commonly furnish E&M office visits, such as family medicine (averaging 5.0 percent per year) and internal medicine (4.6 percent), neurology (4.8 percent), endocrinology (4.4 percent), rheumatology (4.8 percent), and oncology and hematology (5.4 percent). Higher growth was also observed for some surgical specialties: cardiovascular and cardiothoracic surgery (4.5 percent), general surgery (4.4 percent), and some other less-common surgical specialties (4.7 percent).[31]

By 2024, median compensation was $369,000 for physicians, $133,000 for PAs, and $129,000 for NPs.[32] As shown in Figure 4-8, physician compensation varied substantially by specialty, with much lower median compensation for primary care physicians ($308,000) than for surgical specialties ($525,000). Compensation differences by specialty for NPs and PAs tend to be much smaller.

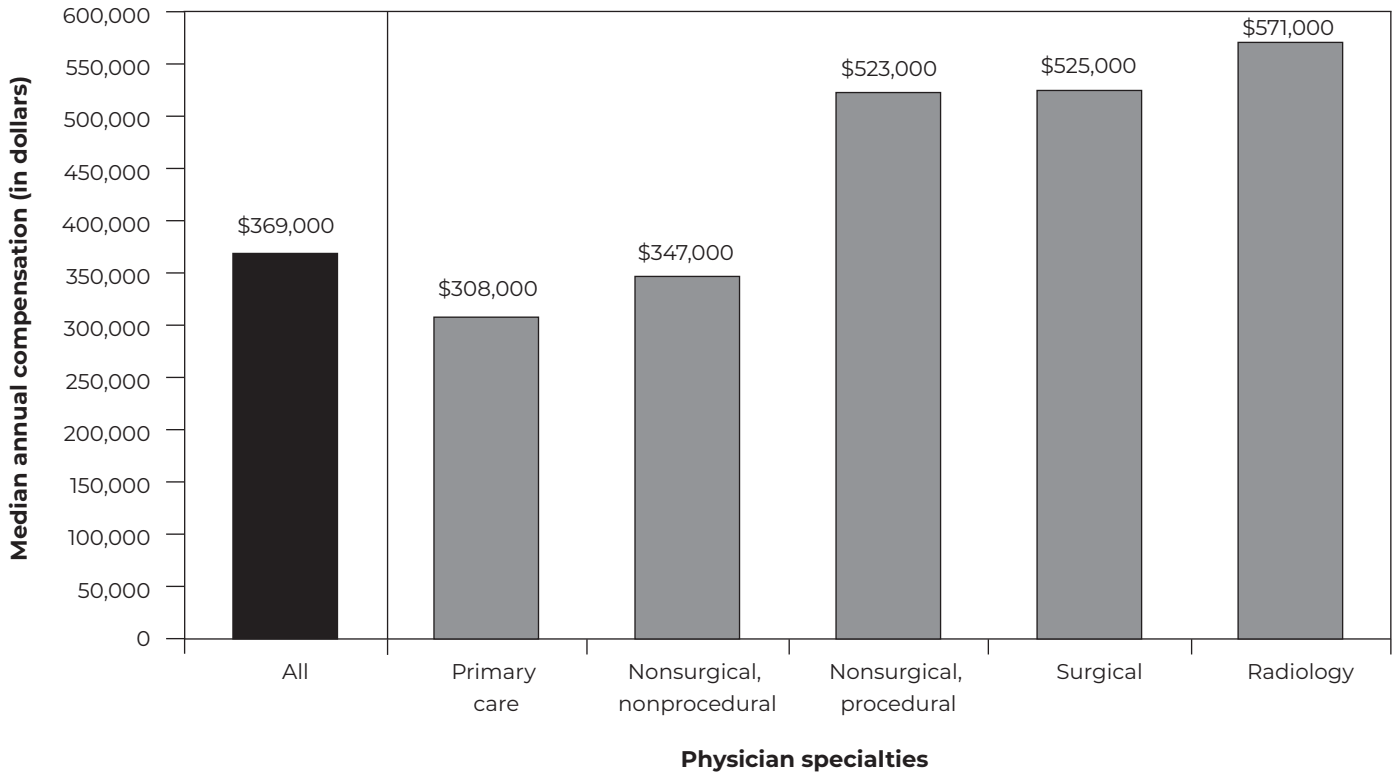
The large compensation gap between primary care physicians and most specialists may help explain why a declining share of physicians are pursuing careers in primary care. In recent years, CMS has pursued several payment policies that have the potential to disproportionately benefit primary care providers (see text box, pp. 130–133).

Average payment rates of private-insurance preferred provider organizations grew faster than, and remained higher than, Medicare payment rates for clinician services

Most clinicians see patients with a variety of types of insurance, and profitability varies by payer. We therefore compare trends in the rates paid by private-insurance plans with trends in Medicare rates for clinician services to gain insight into clinicians' revenues and incomes. We also examine these trends 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

FIGURE 4–8

Compensation for primary care physicians is lower than for most specialists, 2024



Note: Figure reflects all physicians whose 2024 annual compensation was reported in the survey (*n* = 124,193). 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 (endocrinology, rheumatology, psychiatry) had lower median compensation than primary care physicians.

Source: SullivanCotter's 2025 Physician Compensation and Productivity Survey (reflecting 2024 compensation).

organization (PPO) health plans that are part of a large national insurer that covers a wide geographic area across the U.S.[33] In 2024, the average PPO payment rate for clinician services was 147 percent of FFS Medicare's average payment rate, up from 140 percent in 2023.

The ratio in 2024, as in prior years, varied by type of service. For example, private-insurance rates were 124 percent of Medicare rates for care-management and coordination E&M visits but 213 percent of Medicare rates for CT scans.

The gap between private-insurance rates and Medicare rates has grown over time as Medicare rates have increased more modestly than private-insurance rates: In 2011, private-insurance rates were 122 percent of Medicare rates. However, as we noted earlier, clinicians accept Medicare at rates similar to those of private

Primary care providers may benefit from recent changes to Medicare's physician fee schedule

The Commission has called for increasing payment rates for certain services commonly provided by primary care providers and reducing payment rates for certain services commonly provided by specialists. Evidence suggests that many procedures are overvalued because Medicare's payment rates have not fully accounted for increases in efficiency in furnishing these services. At the same time, services that cannot be performed more efficiently with practice and advances in technology, such as office visits, tend to become passively devalued over time (Medicare Payment Advisory Commission 2018a).

In recent years, CMS has adopted new payment policies that have the potential to increase

(continued next page)

TABLE 4–8

New codes disproportionately used by primary care providers

Year added	Billing code	Service description	Payment in 2026
Chronic care management (CCM)			
2015	99490	CCM, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHCP) (e.g., nurse practitioner) per month	$66.13
2021	+99439	Each additional 20 minutes per month	+$50.44
2017	99487	Complex CCM, first 60 minutes of clinical staff time directed by a physician/QHCP per month	$144.29
2017	+99489	Each additional 30 minutes per month	+$78.16
2019	99491	CCM, first 30 minutes provided personally by physician/QHCP per month	$89.18
Transitional care management (TCM)			
2013	99495	TCM with patient contact within 2 business days of discharge, moderate medical decision-making, and a visit within 14 days of discharge	$220.11
2013	99496	TCM with patient contact within 2 business days of discharge, high medical decision-making, and a visit within 7 days of discharge	$298.60
Advanced primary care management (APCM) *(can use instead of above codes)*			
2025	G0556	APCM by clinical staff under direction of physician/QHCP of a patient with 0–1 chronic condition, per month	$16.37
2025	G0557	APCM of a patient with 2+ chronic conditions, per month	$53.78
2025	G0558	APCM of a QMB patient with 2+ chronic conditions, per month	$117.24
Behavioral health integration			
2018	99484	Care management for behavioral health conditions, 20+ minutes of clinical staff time under direction of physician/QHCP per month	$57.45
Social determinants of health (SDOH) assessment			
2024	G0136	Administration of a SDOH risk assessment by clinical staff/physician/QHCP, 5–15 minutes	$20.04
2024	G0019	Community health integration services by clinical staff, 60 minutes per month	$86.17
2024	+G0022	Each additional 30 minutes per month	+$54.11

Primary care providers may benefit from recent changes to Medicare's physician fee schedule (cont.)

Medicare's total payments to primary care providers. Although Medicare does not specify which medical specialty a clinician must have to use a particular billing code, a number of codes added in the past decade are being used disproportionately by primary care providers (Table 4-8). (New codes for procedures, tests, and imaging disproportionately used by specialists are not shown.) Many of these new codes pay for care management and coordination by clinical staff (e.g., nurses, medical assistants) working under the supervision of a physician or other qualified health care professional as part of a care team. Some of these codes have seen greater uptake than others (Figure 4-9, p. 132) and CMS has expanded and refined these code sets over the years.

(continued next page)

TABLE 4–8 **New codes disproportionately used by primary care providers (cont.)**

Year added	Billing code	Service description	Payment in 2026
Remote physiologic monitoring (RPM)			
2019	99453	Initial set-up and patient education on use of equipment	$21.71
2026	99445	Device supply with daily recordings or programmed alerts transmission, 2–15 days in a 30-day period	$52.11
2019	99454	Device supply with daily recordings or programmed alerts transmission, 16–30 days in a 30-day period	$52.11
2026	99470	Patient-provider communication re: RPM data, first 10 minutes by clinical staff/physician/QHCP per month	$26.05
2019	99457	Patient-provider communication re: RPM data, first 20 minutes by clinical staff/QHCP per month	$51.77
2020	+99458	Each additional 20 minutes	+$41.42
Advance care planning			
2016	99497	Advance care planning, first 30 minutes of physician/QHCP time	$86.84
2016	+99498	Each additional 30 minutes	+$78.16
Visit complexity add-on code			
2024	+G2211	Add-on code for office/outpatient E&M visit when clinician's care is continuing focal point for all needed care or part of ongoing care re: a patient's single serious or complex condition	+$17.37

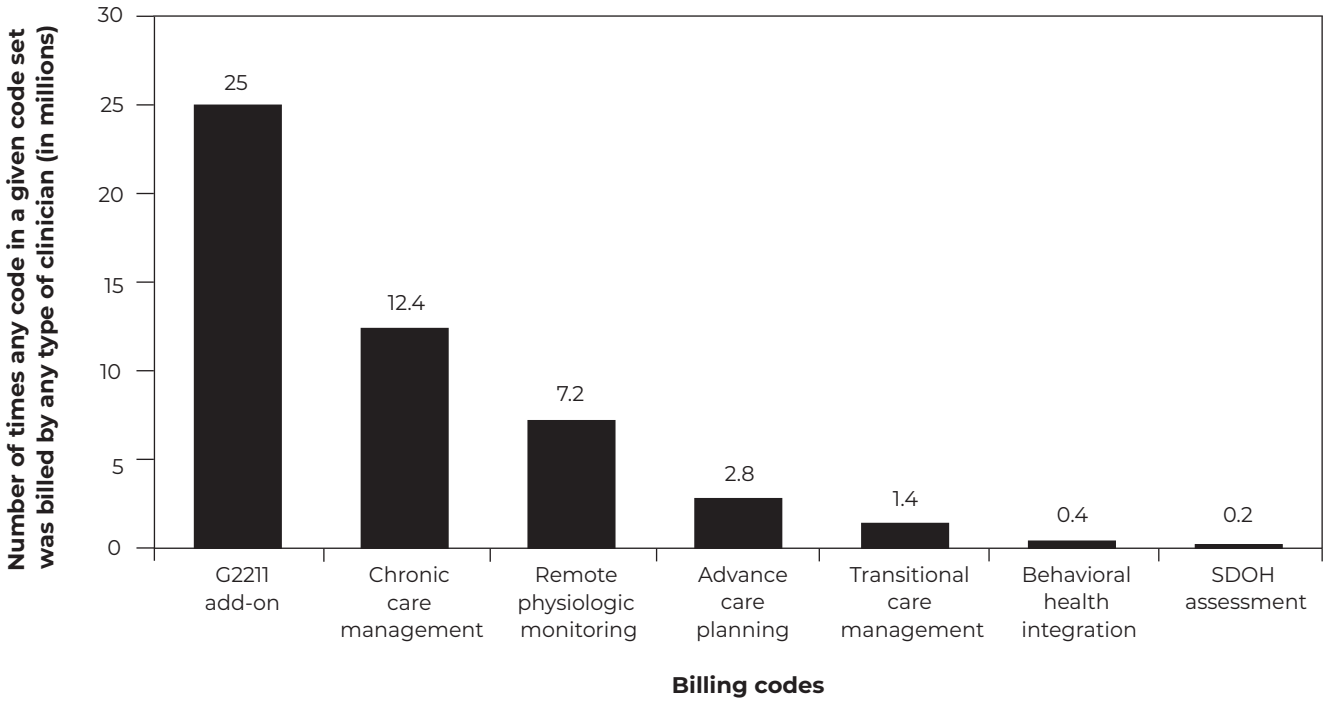
Note: QMB (Qualified Medicare Beneficiary), E&M (evaluation and management). "Year added" refers to the year that Medicare first started making payments for a given code. "Service description" presents our brief summaries of code descriptions. "Payment in 2026" reflects national payment amounts for a nonfacility setting (e.g., office); actual payment amounts vary based on geography and other factors. Some codes that are infrequently used are not shown (e.g., for e-visits, virtual check-ins). We include two billing codes that become payable in 2026 and are expected to be disproportionately used by primary care providers.

Source: American Medical Association RBRVS Data Manager.

Primary care providers may benefit from recent changes to Medicare's physician fee schedule (cont.)

FIGURE 4–9

Utilization of common primary care–focused codes, 2024



Note: SDOH (social determinants of health). Figure shows the number of times a code in a given code set was billed by a clinician (including non–primary care providers) in 2024. Numbers are rounded to the nearest hundred thousand. The advanced primary care management code set is not shown since it was not yet billable in 2024.

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

In addition, in 2021, CMS increased payment rates for evaluation and management (E&M) office and outpatient visits (shown later in Figure 4-10, p. 136). This is estimated to have reduced the compensation gap between specialists and primary care providers (PCPs) by 2 percent, since office visits are billed more frequently by PCPs than by specialists (Neprash et al. 2023).

In 2024, CMS began offering the G2211 code, which adds $16 to the payment rate for E&M visits when a clinician's services are the continuing focal point for all needed health care services and/or a clinician's services are part of ongoing care related to a serious or complex condition (described earlier, pp. 125–126, and shown in Table 4-8, pp. 130–131). This add-on code was used disproportionately by primary care providers and frequently used by some specialists as well (e.g., cardiologists, urologists); In 2024, it was billed 25 million times (Figure 4-9). G2211 can be billed by multiple clinicians treating the same beneficiary, and there is no limit on the number of times it can be used per month.

In 2025, CMS began offering a monthly payment per beneficiary for advanced primary care management

(continued next page)

Primary care providers may benefit from recent changes to Medicare's physician fee schedule (cont.)

(APCM) services (G0556, G0557, and G0558). These APCM codes have the potential to see greater uptake than predecessor care-management codes since they do not have strict requirements about how much time must be spent engaging in specified activities per month. The APCM codes pay clinicians $16 per month for FFS Medicare beneficiaries with zero to one chronic condition, $54 per month for beneficiaries with two or more conditions, and $117 per month for beneficiaries with two or more conditions who are also qualified Medicare beneficiaries (who generally have low incomes and limited resources and qualify for financial assistance). Only one clinician may bill an APCM code for a given patient in a given month, and patients must give consent for a clinician to begin billing the codes (since they will increase cost sharing for beneficiaries who lack supplemental insurance). Since payment rates for the APCM codes are higher for beneficiaries with low incomes, the codes are directionally consistent with our March 2023 recommendation that Medicare make safety-net add-on payments for physician fee schedule services delivered to low-income beneficiaries (Medicare Payment Advisory Commission 2023).

Finally, in 2026, CMS applied a new "efficiency adjustment" of –2.5 percent to the work relative value units (RVUs) of thousands of non-time-based services commonly provided by specialists (e.g., procedures). This adjustment will improve the accuracy of payment rates for services that clinicians can perform more quickly with practice, and is supported by the Commission (Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2018a). (When the RVUs assigned to a billing code are higher than empirically justified, it results in "passive devaluation" of the other codes in the fee schedule, because it prevents a two-step process from occurring. If relatively overvalued services' RVUs had been reduced, it would have been accompanied by positive budget-neutrality adjustments to the fee schedule's conversion factor—which would have increased payment rates for all other services (e.g., time-based services such as 30-minute office visits).) CMS applied an efficiency adjustment to non-time-based codes in 2026 and plans to do so again in 2029 and every three years thereafter. Under budget-neutrality rules, these adjustments are expected to cause modest increases to payment rates for time-based codes (such as E&M visits).

The Commission has generally supported these various changes, which have the potential to reduce the size of the large compensation gap between specialists and primary care providers and make primary care a more financially appealing specialty. Although some of these policies may have contributed to compensation growing slightly more quickly for primary care specialties than many other specialties in the past few years (p. 128), the compensation gap between specialists and primary care providers nevertheless remains large and is likely continuing to influence physician trainees' choice of specialty (Figure 4-8, p. 129). The codes and adjustments described in this text box have the potential to play a larger role in the future, as more of these changes take effect and uptake of new codes increases. We will continue to monitor use of these codes, the supply of different types of clinicians, beneficiaries' access to care, and care quality. ■

insurance, and some academic research suggests that increasing Medicare fee schedule rates might not necessarily narrow the gap between Medicare and private-insurance rates. Specifically, one paper found that a $1.00 increase in Medicare rates was associated with a $1.16 increase in private-insurance rates (Clemens and Gottlieb 2017).

The growth in private-insurance rates may result in part from greater consolidation of physician practices and hospitals' acquisition of physician practices that give providers greater leverage to negotiate higher prices for clinician services with private plans (Medicare Payment Advisory Commission 2020). In recent years, the share of physicians in larger groups and employed by hospitals has risen substantially. For example, according to an AMA survey, from 2012 to 2024, the share of physicians who were either directly employed by a hospital or in a practice with hospital ownership increased from about 29 percent to 47 percent (Kane 2025).

Studies have found 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, Harris et al. 2025, 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 most cited reason physicians gave for selling their practice to a hospital, hospital system, health system, private equity group, or insurer was to enhance their ability to negotiate higher payment rates with payers (71 percent of physicians working in an acquired practice indicated this reason was important); other commonly cited reasons were to improve access to costly resources and get help complying with payers' regulatory and administrative requirements (cited by just under two-thirds of respondents in these practices) (Kane 2025).[34] Another recent study found that physicians most likely to become hospital-integrated were those who generated less revenue per Medicare patient, treated more clinically complex patients, and who struggled to perform well on pay-for-performance quality measures (Alinezhad et al. 2024).

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 2024, Medical Group Management Association 2023, Medical Group Management Association 2022, Post et al. 2024, Whaley et al. 2021). A 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. The top drawbacks were having less autonomy and having to comply with more workplace rules (McKenna 2022).

In contrast to private insurance, Medicaid tends to have lower payment rates for clinician services compared with Medicare. One study found that Medicaid rates were 72 percent of Medicare rates for 27 common procedures in 2019 (Zuckerman et al. 2021). Research has also shown that fewer physicians accept new Medicaid patients compared with patients who have Medicare or private insurance (Medicaid and CHIP Payment and Access Commission 2025, National Center for Health Statistics 2021). Multiple factors could influence clinicians' decisions to accept Medicaid patients, including Medicaid's relatively high administrative burdens.

How payment rates are updated

Medicare's payment rates for clinicians are updated each year by updating the PFS's conversion factor.[35] (Increasing the conversion factor by 1 percent, for example, 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 and (2) a budget-neutrality adjustment if necessary. Statutory updates to the conversion factor are currently specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (shown in the first two rows of Table 4-9); MACRA specified that clinicians' payment rates were to be updated by 0 percent from 2020 to 2025. Meanwhile, the budget-neutrality adjustment is required by law and is a percentage calculated by CMS to ensure that any changes it has made to the relative values of specific billing codes in the fee schedule do not, in and of themselves, increase or decrease total fee schedule spending by more than $20 million. During years in which the relative values for some services are increased, for example, and CMS anticipates that these changes would result in an increase in

TABLE 4–9

Physician fee schedule payment-rate updates and performance payment adjustments under current law

	2021	2022	2023	2024	2025	2026	2027
Updates							
Clinicians in A–APMs	—	—	—	—	—	0.75%	0.75%
Clinicians not in A–APMs	—	—	—	—	—	0.25%	0.25%
All clinicians *(not cumulative)*	3.75%	3.0%	2.5%	1.25%, 2.93%	—	2.5%	—
Performance payment adjustments							
Bonus for clinicians in A–APMs *(not cumulative)*	5%	5%	5%	5%	3.5%	1.88%	—
MIPS adjustments *(not cumulative)*	–7% to +1.8%	–9% to +1.9%	–9% to +2.3%	–9% to +8.3%	–9% to +2.2%	–9% to TBD	–9% to TBD

Note: A–APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System), TBD (to be determined). "Not cumulative" updates and adjustments apply in a given year only and are not included in subsequent years' payment rates. The fee schedule update in 2024 equaled 1.25 percent from January 1, 2024, through March 8, 2024, and was replaced by an update of 2.93 percent from March 9, 2024, through December 31, 2024, at which point the update expired. A "sequester" reduces Medicare payment rates by 2 percent in most years (not shown); the sequester was waived during the pandemic.

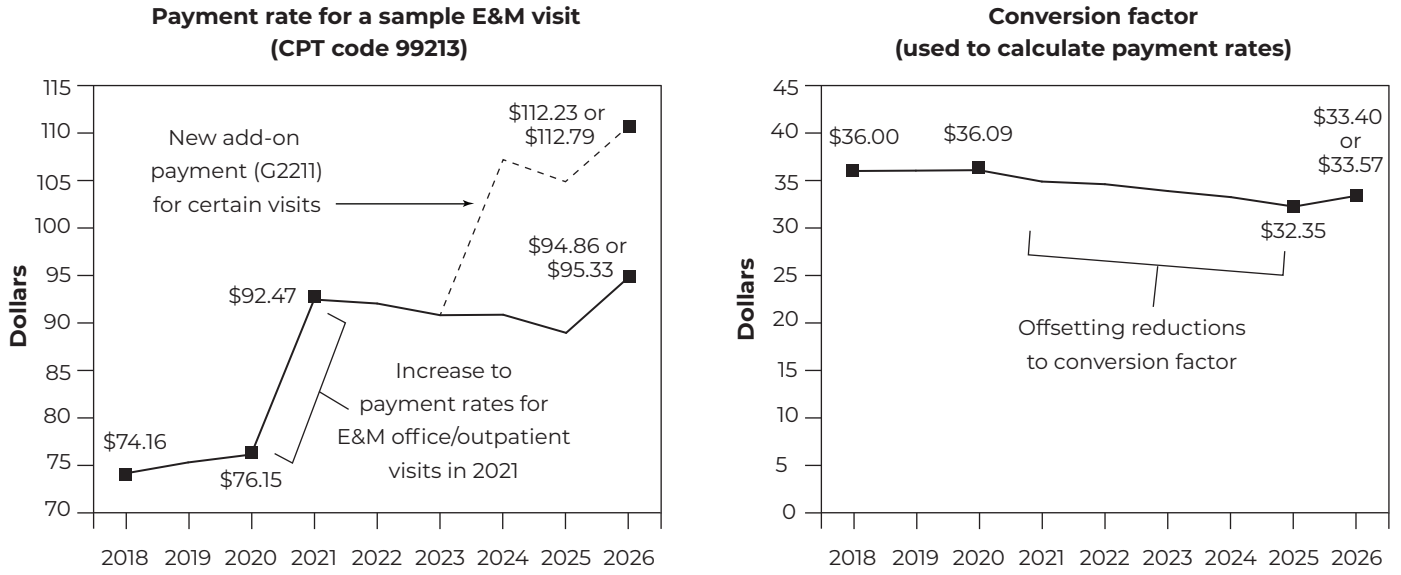
Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); the Coronavirus Aid, Relief, and Economic Security (CARES) Act; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes; the Protecting Medicare and American Farmers from Sequester Cuts Act; the Consolidated Appropriations Act, 2023; the law colloquially known as the One Big Beautiful Bill Act (PL 119-21); CMS QPP Participation and Performance Results At-A-Glance fact sheets; CMS's final rules for the physician fee schedule.

total fee schedule spending, a negative budget-neutrality adjustment is made to offset those costs. The net effect of an increase in relative values for some services and an across-the-board downward adjustment to the conversion factor redistributes fee schedule spending among different services but does not increase or decrease total expected spending. Nearly all other Medicare payment systems have budget-neutrality provisions, and they accomplish the same basic objective—ensuring that changes in relative weights do not increase or decrease overall spending.

Because of the fee schedule's budget-neutrality requirement, a recent increase in the values for some commonly used billing codes has resulted in a decrease in the conversion factor over the past few years. Specifically, in 2021, CMS increased the payment rates for many types of E&M visits in the office and outpatient setting, upon the recommendation of the AMA/Specialty Society Relative Value Scale Update Committee. Increasing the payment rates for these billing codes required an offsetting –6.8 percent budget-neutrality adjustment to the fee schedule's conversion factor so that the change in payment rates for E&M visits did not increase total expected spending under the fee schedule. 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 temporary increases to the conversion factor from 2021 through 2024 (shown in

FIGURE 4–10

Increases to payment rates for E&M office/outpatient visits (including a new add-on payment) required offsetting decreases to the fee schedule's conversion factor



Note: E&M (evaluation and management), CPT (Current Procedural Terminology). The E&M office/outpatient visit code set comprises 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. Code G2211 is an add-on code available to be billed with office/outpatient E&M visit codes when a clinician has a longitudinal relationship with a patient and meets other requirements. After 2021, CMS increased values for E&M services in other clinical settings as well, which contributed to declines to the conversion factor in subsequent years. In 2026, there are two different conversion factors (and therefore payment rates), depending on whether a clinician is a qualifying participant in an advanced alternative payment model.

Source: CMS. Physician fee schedule (interactive billing code payment rate look-up website), https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

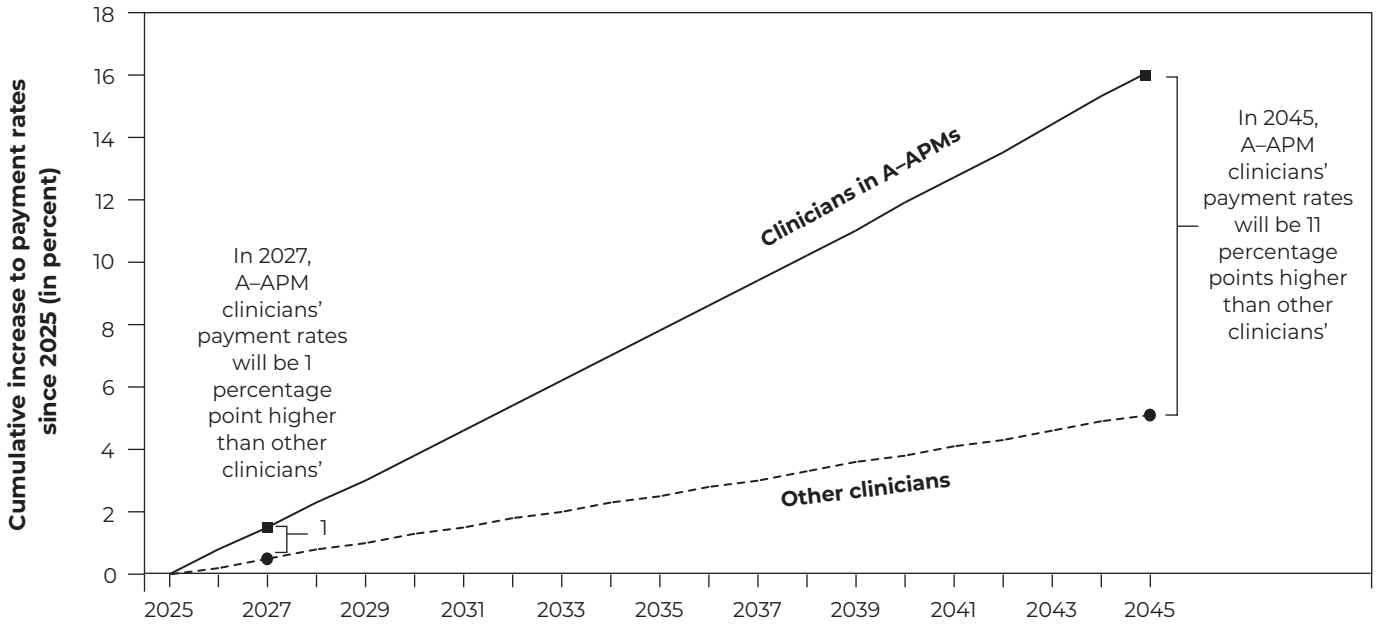
the third row of Table 4-9, p. 135). These increases effectively phased in the 6.8 percent reduction to the conversion factor over time. As a result, payment rates for office and outpatient E&M visits (which are provided by a wide variety of clinicians) have increased substantially (shown at left in Figure 4-10), while the conversion factor has gradually declined (shown at right in Figure 4-10).

Part of the decline in the conversion factor (shown at right in Figure 4-10) also offsets the cost of the new G2211 add-on payment for E&M office/outpatient visits (described earlier in the chapter). This add-on code can be billed by clinicians who have an ongoing relationship with a patient or are treating a patient's single serious condition (shown as the dotted line in the left graph of Figure 4-10). This add-on code is expected to be used by primary care clinicians and some specialists (Centers for Medicare & Medicaid Services 2023).

Although the decline in the conversion factor may seem like it would reduce clinicians' Medicare payments, it is important to remember that the accompanying increase to payments for E&M office/outpatient visits is expected to have produced a net increase in Medicare payments for clinicians who commonly provide E&M office or outpatient visits.

FIGURE 4–11

Under current law, the difference between payment rates for clinicians in A–APMs and other clinicians will be small in the 2020s but large by the 2040s



Note: A–APM (advanced alternative payment model). Graph does not show adjustments to payment rates prompted by budget-neutrality requirements, which take into account additions, deletions, or modifications of fee schedule billing codes and can result in payment updates that are larger or smaller than specified in statute. Graph also does not show (1) annual Merit-based Incentive Payment System adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or (2) annual A–APM participation bonuses available from 2019 through 2026 because these adjustments are one time only and not built into subsequent years' payment rates. Graph also does not show the effects of the expiration of the 2 percent sequester that applies to payment rates through February 2033.

Source: MedPAC analysis of Medicare Access and CHIP Reauthorization Act of 2015 and subsequent laws.

Current law calls for two conversion factors starting in 2026

Starting in 2026, MACRA calls for payment rates to increase by 0.75 percent per year for qualifying clinicians in advanced alternative payment models (A–APMs) and by 0.25 percent for all other clinicians.[36] (Examples of A–APMs include accountable care organization models that put participating providers at risk of owing financial penalties if they miss cost and quality targets.) The difference between these two sets of clinicians' payment rates will initially be small but then grow large (shown in Figure 4-11). For example, in 2027, A–APM clinicians' payment rates will be only 1 percentage point higher than other clinicians' rates, but by 2045, A–APM clinicians' rates will be 11 percentage points higher. An incentive this large could be unwarranted and unfair, especially if many clinicians continue to have limited access to A–APMs because of their geographic location, medical specialty, or other circumstances.

How should FFS Medicare payments change in 2027?

Current law calls for PFS payment rates to decline in 2027 by 1.7 percent for qualifying clinicians in A–APMs and to decline by 2.2 percent for all other clinicians,

relative to 2026 payment rates. These declines reflect the net effects of two statutory provisions: (1) the expiration of a one-year increase of 2.5 percent that applies in 2026 only, and (2) positive updates of 0.75 percent and 0.25 percent for qualifying clinicians in A–APMs and all other clinicians, respectively, in 2027 pursuant to MACRA.[37]

Based on many of our indicators, current payments to clinicians appear to be adequate to ensure access to care. However, going forward, clinicians are projected to face moderate rates of input cost growth. While evidence suggests that full MEI updates have not been necessary to maintain access to care, ongoing cost increases that substantially exceed payment updates could be difficult for clinicians to absorb.

RECOMMENDATION 4

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.

RATIONALE 4

In aggregate, on the basis of many of our indicators (all of which measure conditions before a temporary 2.5 percent statutory increase took effect in 2026), fee schedule payment rates appear to be adequate. Overall, access to clinician services for Medicare beneficiaries appears to be comparable with, or better than, that of privately insured individuals. Quality of care is difficult to assess, but the metrics that we track suggest care quality has remained stable in recent years. Over the past two decades, clinicians' total annual fee schedule payments per FFS beneficiary have risen substantially faster than both payment rate updates and input costs as measured by the MEI. In addition, all-payer compensation for clinicians has continued to rise steadily.

However, input costs are projected to continue to grow faster than Medicare's payment rates in coming years. While evidence suggests that full MEI updates have not been necessary to maintain access to care, the Commission is concerned that ongoing cost increases that substantially exceed payment updates could be difficult for clinicians to absorb. The Commission is also concerned that differences in compensation between specialists and primary care clinicians may be contributing to fewer clinicians practicing primary care, thereby negatively affecting beneficiary access to primary care. Actions taken by CMS to introduce primary care–focused codes (including higher paying codes for primary care furnished to low-income beneficiaries), and increased payments for existing primary care services, hold promise, and we will monitor their effects on beneficiaries' access and quality in the coming years.

Current law calls for payment rates to increase by 0.25 percent or 0.75 percent in 2027, depending on whether a clinician is participating in a qualified A-APM. The Commission's recommendation would allow the temporary 2.5 percent statutory increase to expire at the end of 2026 and then increase current-law updates by an additional 0.5 percentage points each. In light of the fact that most of our payment adequacy indicators have been positive without the addition of the temporary 2.5 percent payment increase, the Commission does not recommend continuing the increase beyond 2026.

Therefore, under our recommendation, after the expiration of the temporary 2.5 percent increase, rates in 2027 would increase by a total of 1.25 percent for clinicians participating in qualified A-APMs and by a total of 0.75 percent for other clinicians. Because of the expiration of the 2.5 percent increase, on net we expect our recommendation to result in 2027 payment rates for each group declining by 1.2 percent and 1.7 percent, respectively, relative to 2026 levels. These decreases would be smaller than what would otherwise occur under current law. It is worth noting that, after the expiration of 2026's temporary 2.5 percent update, the average impact of our recommended 1.25 percent and 0.75 percent increases would be very similar in magnitude to our June 2025 recommendation to replace all future current-law updates with a default update of MEI minus 1 percentage point (which would have yielded an estimated update of 1.1 percent in 2027) (Medicare Payment Advisory Commission 2025d).

In the Commission's view, this recommendation for 2027 strikes an appropriate balance between the need to provide adequate payments to clinicians and the need to limit growth in beneficiaries' cost sharing and premiums and maintain financial pressure on clinicians to constrain their costs.

IMPLICATIONS 4

Spending

- This recommendation would increase program spending relative to current law by $750 million to $2 billion in one year and by $1 billion to $5 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 while limiting increases to beneficiaries' cost sharing and Part B premiums. ■

APPENDIX 4–A

Key findings from the Commission's 2025 access-to-care survey

TABLE 4–A1

In MedPAC's annual survey, Medicare beneficiaries ages 65+ generally report better access to care than privately insured people ages 50–64

	Medicare beneficiaries (ages 65 and older)				Privately insured (ages 50–64)			
Survey question	**2022**	**2023**	**2024**	**2025**	**2022**	**2023**	**2024**	**2025**
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	–	94%[a]	95%[a]	94%[a]	–	91%[ab]	91%[a]	92%[a]
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 ("very" or "somewhat")	–	96[ab]	97[a]	97[a]	–	91[ab]	93[a]	93[a]
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 ("very" or "somewhat")	–	87[ab]	88[ab]	90[a]	–	77[ab]	79[a]	81[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]	96[a]	96[a]	92[a]	92[a]	91[ab]	92[a]
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 routine care								
"Never" or "sometimes"	88[a]	87[a]	87[a]	89[a]	80[a]	77[ab]	78[ab]	80[a]
"Always" or "usually"	12[a]	13[a]	13[a]	11[a]	20[a]	23[ab]	22[ab]	20[a]
For illness or injury								
"Never" or "sometimes"	93[a]	92[a]	93[a]	93[a]	87[a]	85[ab]	86[a]	87[a]
"Always" or "usually"	7[a]	8[a]	7[a]	7[a]	13[a]	15[ab]	14[a]	13[a]
Tried to get a new clinician: "In the past 12 months, have you tried to get a new . . . ?" (Share answering "Yes")								
Primary care provider	11[a]	12[a]	11[a]	12[a]	14[a]	15[a]	16[ab]	14[a]
Specialist	26[ab]	32	31[a]	33	29[ab]	33	34[a]	33
Mental health professional	–	3[a]	3[a]	3[a]	–	7[a]	8[a]	7[a]
Problems finding a new clinician: Among those who tried to get a new clinician in the past 12 months, "How much of a problem was it finding a primary care provider/specialist/mental health professional who would treat you?" (Percentages in parentheses are among all respondents with this insurance, not just those looking for a new clinician.)								
"Big problem" finding a. . .								
Primary care provider	22[a] (2[a])	23[a] (3[a])	24[a] (2[a])	21[a] (2[a])	29[a] (4[a])	33[a] (5[a])	31[a] (5[a])	28[a] (4[a])
Specialist	10[a] (3[ab])	13[a] (4[a])	11[a] (3[a])	11[a] (4[a])	15[a] (4[ab])	18[a] (6[a])	18[a] (6[a])	17[a] (5[a])
Mental health professional	–	38 (1[a])	37 (1[a])	29 (1[a])	–	45[b] (3[a])	42 (3[a])	36 (3[a])
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]	20[ab]	18[a]	17[a]	24[ab]	27[a]	27[a]	27[a]

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "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, 2024, and 2025; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For "a" footnotes, corrections were applied per year to Medicare vs. privately insured comparisons; for "b" footnotes, corrections were applied within each insurance group across years. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.
[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 2025 and a prior year within the same insurance group (at a 95 percent confidence level).

Source: MedPAC's Access to Care Surveys conducted July–September 2022, 2023, 2024, and 2025.

TABLE 4–A2

Lower-income beneficiaries reported obtaining less care than others in 2025

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
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	92%[a]	95%[ab]	97%[ab]	88%[a]	91%[a]	94%[ab]
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 ("very" or "somewhat")	97[a]	98[a]	98[a]	91[a]	94[a]	93[a]
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 ("very" or "somewhat")	92[a]	88[a]	90[a]	82[a]	82[a]	80[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	95[a]	96[a]	98[ab]	90[a]	91[a]	93[a]
Tried to get a new clinician "In the past 12 months, have you tried to get a new . . . ?" (Share answering "Yes")						
Primary care provider	12	12	11	15	14	13
Specialist	25	34[b]	42[ab]	24	29	36[ab]
Problems finding a new clinician: Among those who tried to find a new clinician, "How much of a problem was it finding a primary care provider/specialist who would treat you?" (Percentages in parentheses are among all respondents with this insurance and household income, not just those looking for a new clinician.)						
"Big problem" finding a primary care provider	23 (3)	18 (2[a])	21 (2)	25 (4)	32 (4[a])	28 (4)
"Big problem" finding a specialist	12 (3)	11 (4)	10[a] (4)	22 (5)	17 (5)	16[a] (6)
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, "How long did you have to wait to have an appointment with your new primary care provider/specialist?"						
Primary care provider						
0 to 2 weeks	37	41	36	40	25	26
3 to 5 weeks	20	24	22	19	22	23
6 weeks or more	31	24	28	31	37	34
I have not scheduled an appointment	10	9	12	7	15	15
Specialist						
0 to 2 weeks	37	29	33	32	24	29
3 to 5 weeks	30	29	31	26	32	28
6 weeks or more	25	37[b]	31[a]	36	36	38[a]
I have not scheduled an appointment	5	4	3	6	5	4
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	19[a]	17[a]	14[ab]	28[a]	29[a]	26[a]

Note: "Lower income" refers to respondents with annual household incomes of $0 to $49,999; "middle income" refers to household incomes of $50,000 to $79,999; and "higher income" refers to 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: "I don't remember" and "Refused." Survey sample consists of approximately 5,000 Medicare beneficiaries and 5,000 privately insured people; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For "a" footnotes, corrections were applied within each income category to Medicare vs. privately insured comparisons; for "b" footnotes, corrections were applied within each insurance group to compare lower-income respondents with middle- or higher-income respondents. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.

[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-income respondents or between lower-income and higher-income respondents within the same insurance group (at a 95 percent confidence level).

Source: The 2025 MedPAC Access to Care Survey, conducted July 18–September 8, 2025.

TABLE 4–A3

Urban and rural patients generally reported comparable care in 2025

Survey question	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
	Urban	Rural	Urban	Rural
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%[ab]	92%[b]	92%[a]	92%
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 ("very" or "somewhat")	97[a]	98[a]	93[a]	92[a]
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 ("very" or "somewhat")	89[a]	92[a]	80[a]	81[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[a]	92[a]	93[a]
Tried to get a new clinician "In the past 12 months, have you tried to get a new . . . ?" (Share answering "Yes")				
Primary care provider	12[a]	11	14[a]	11
Specialist	34[b]	28[b]	34[b]	26[b]
Problems finding a new clinician: Among those who tried to find a new clinician, "How much of a problem was it finding a primary care provider/specialist who would treat you?" (Percentages in parentheses are among all respondents with this insurance and area type, not just those looking for a new clinician.)				
"Big problem" finding a primary care provider	22[a]	16	30[a]	20
"Big problem" finding a specialist	11[a]	13	17[a]	17
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, "How long did you have to wait to have an appointment with your new primary care provider/specialist?"				
Primary care provider				
0 to 2 weeks	33[ab]	57[b]	26[a]	39
3 to 5 weeks	21	19	22	20
6 weeks or more	32[b]	11[ab]	35	34[a]
I have not scheduled an appointment	10	11	15	7
Specialist				
0 to 2 weeks	34[a]	32	29[a]	28
3 to 5 weeks	29	31	29	27
6 weeks or more	31[a]	30	37[a]	40
I have not scheduled an appointment	4	4	4	4
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	17[a]	19[a]	27[a]	26[a]

Note: "Urban" respondents reside in an urban or suburban part of a metropolitan statistical area (MSA), meaning they live in an urbanized area with a population of 50,000 or more or in adjacent territory that has a high degree of social and economic integration as measured by commuting. "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: "I don't remember" and "Refused." Survey sample size is approximately 5,000 Medicare beneficiaries and 5,000 privately insured people; sample sizes for questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For "a" footnotes, corrections were applied within each area type to Medicare vs. privately insured comparisons; for "b" footnotes, corrections were applied within each insurance group to compare urban and rural respondents. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.
[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 group (at a 95 percent confidence level).

Source: The 2025 MedPAC Access to Care Survey, conducted July 18–September 8, 2025.

TABLE 4–A4

White, Black, and Hispanic patients generally reported comparable care in 2025

Survey question	Medicare beneficiaries (ages 65 and older) White	Black	Hispanic	Privately insured (ages 50–64) 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%	92%[b]	93%[a]	93%	89%[b]
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 ("very" or "somewhat")	98[a]	97	98[a]	93[a]	97	92[a]
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 ("very" or "somewhat")	89[a]	95[ab]	91[a]	81[a]	86[a]	75[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]	95	98[a]	93[a]	93	90[a]
Tried to get a new clinician "In the past 12 months, have you tried to get a new . . . ?" (Share answering "Yes")						
Primary care provider	12	8[a]	12	13	14[a]	16
Specialist	35	20[b]	25[b]	34	25[b]	32
Problems finding a new clinician: Among those who tried to find a new clinician, "How much of a problem was it finding a primary care provider/specialist who would treat you?" (Percentages in parentheses are among all respondents with this insurance and race/ethnicity, not just those looking for a new clinician.)						
"Big problem" finding a primary care provider	20 (2[a])	18 (1)	25 (3)	28 (4[a])	24 (3)	32 (5)
"Big problem" finding a specialist	12[a] (4)	11 (2)	15 (4)	16[a] (5)	15 (4)	22 (7)
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, "How long did you have to wait to have an appointment with your new primary care provider/specialist?"						
Primary care provider						
0 to 2 weeks	38[a]	32	46	26[a]	37	29
3 to 5 weeks	20	19	24	22	21	26
6 weeks or more	30	22	18	35	32	31
I have not scheduled an appointment	9	16	12	15	10	12
Specialist						
0 to 2 weeks	33[a]	43	44[b]	26[a]	39[b]	34
3 to 5 weeks	28	20	30	30	25	24
6 weeks or more	32[a]	27	22[a]	40[a]	21[b]	37[a]
I have not scheduled an appointment	4	7	4	4	11[b]	4
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	17[a]	14[a]	17[a]	26[a]	26[a]	26[a]

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: "I don't remember" and "Refused." Survey sample size is approximately 5,000 Medicare beneficiaries and 5,000 privately insured people; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. Significance tests were adjusted for all pairwise comparisons within each subtable row using the Bonferroni correction. For "a" footnotes, corrections were applied within each race/ethnicity category to Medicare vs. privately insured comparisons; for "b" footnotes, corrections were applied within each insurance group to compare White respondents with Black or Hispanic respondents. Comparisons excluded cells with true 0 percent or 100 percent values or weighted bases <2.

[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 White and Hispanic respondents within the same insurance group (at a 95 percent confidence level).

Source: The 2025 MedPAC Access to Care Survey, conducted July 18–September 8, 2025.

Endnotes

1 Our count includes unique Healthcare Common Procedure Coding System codes for which Medicare made at least one payment during the year. We treat codes that have modifiers as a single code, and we do not include codes that clinicians could have billed for but did not.

2 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_Physician_FINAL_SEC.pdf.

3 Although most clinician services are paid under the PFS, some are paid through federally qualified health centers, rural health clinics, and critical access hospital Method II billing.

4 Our survey was fielded from July 18 to September 8, 2025, among a sample drawn from the Gallup Panel. The Gallup Panel is a probability-based panel generated by random-digit-dial and 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 in English or Spanish and via mail in English. We paid respondents a $5 incentive to complete the survey or $10 if they were a member of a subgroup whose response rate we were trying to increase (e.g., rural respondents). Among eligible individuals invited to participate in our survey, 48 percent completed it. Questions asked of all Medicare beneficiaries ages 65 and over (n = 4,788) have a margin of error of +/− 1.79 percentage points at the 95 percent confidence level, and questions asked of all privately insured people ages 50 to 64 (n = 5,079) have a margin of error of +/− 1.77 percentage points.

5 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 2025, we conducted four focus groups with Medicare beneficiaries residing around St. Louis, Missouri. Beneficiaries included those with only Medicare coverage (divided into separate groups based on interviews to determine enrollment in FFS Medicare vs. MA) and beneficiaries who are eligible for both Medicare and Medicaid ("dually eligible" beneficiaries). We also conducted one virtual focus group with beneficiaries residing in rural areas. In addition, we conducted three focus groups with clinicians practicing in the St. Louis area: primary care physicians, specialist physicians, and nurse practitioners.

6 Our analyses of subgroups of Medicare beneficiaries in CMS's Medicare Current Beneficiary Survey in this and subsequent paragraphs combine fee-for-service beneficiaries and Medicare Advantage enrollees to maximize our ability to detect statistically significant differences between subgroups of beneficiaries with different characteristics (e.g., beneficiaries under age 65 vs. beneficiaries ages 65 and over).

7 Qualified Medicare beneficiaries must have incomes below 100 percent of the federal poverty level (plus $20) and have limited resources. For example, in 2025, the federal monthly income limit for an individual is $1,325 and the federal resource limit is $9,660. Income limits are higher in Alaska and Hawaii. States can also set higher income and resource limits.

8 The limiting charge for nonparticipating clinicians who submit an unassigned claim is equal to 115 percent of 95 percent of the full Medicare fee schedule rate, which is effectively 109.25 percent. Thus, these clinicians receive up to a total of 109.25 percent of the full fee schedule rate. Medicare's portion of the payment is made to beneficiaries instead of directly to clinicians; beneficiaries are responsible for paying the clinician Medicare's portion and cost-sharing up to the limiting charge.

9 Clinicians who opted out of Medicare were concentrated in the specialties of behavioral and mental health (61 percent), oral health (15 percent), and primary care (8 percent) (Centers for Medicare & Medicaid Services 2025b).

10 An exception to this general approach is a new prior authorization model that will be tested in FFS Medicare from 2026 to 2031 in six states (Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington). The Wasteful and Inappropriate Service Reduction (WISeR) Model will require prior authorization for certain items and services (e.g., skin and tissue substitutes, implantation of electrical nerve stimulators, knee arthroscopy for knee osteoarthritis). Companies that process prior authorization requests will earn a share of any savings they generate from averting wasteful or inappropriate care.

11 A substantial number of clinicians bill for 15 or fewer beneficiaries in a given year, but they account for a small share of services and allowed charges. For example, in 2023, 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.

12 In prior reports, when calculating clinician-to-beneficiary ratios, we have included the total number of Medicare Part B beneficiaries enrolled in either FFS Medicare or MA in the denominator (i.e., the total number of Medicare beneficiaries). However, our analysis of MA encounter data indicates that a small but growing number of clinicians may see only MA beneficiaries and not beneficiaries enrolled in FFS Medicare. Since our count of clinicians is generated from FFS claims, MA-only clinicians would not be included in the numerator (i.e., count of clinicians). Including MA enrollees but not MA-only clinicians created a mismatch between the numerator and denominator in our ratio calculation. Therefore, we now include only Part B beneficiaries enrolled in FFS Medicare.

13 Our definition of physician (both primary care physicians and specialists) includes only clinicians who hold a doctor of medicine (MD) or doctor of osteopathic medicine (DO) degree. Other types of more specialized physicians are included in the other practitioners category.

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

15 At the time this report was written, application data for the 2024-2025 academic year were available for both MD and DO programs, but first-year enrollment data were not.

16 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.

17 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 as reported in the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

18 Physical therapy includes stretching, strength training (with or without weights), and heat or cold therapy. Medicare beneficiaries are also eligible to receive occupational therapy to treat hand and arm disorders and to help with activities of daily living (such as getting dressed and bathing), and speech therapy, which provides treatment to regain and strengthen speech and language skills.

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

20 Both the FFS–CAHPS and MSSP ACO–CAHPS surveys collect information from Medicare beneficiaries enrolled in the FFS program. The FFS–CAHPS survey targets a sample of over 200,000 beneficiaries (Centers for Medicare & Medicaid Services 2024a). CMS anticipates sampling 860 beneficiaries per MSSP ACO for the CAHPS for MIPS survey (Centers for Medicare & Medicaid Services 2025a). In 2024, there were 480 MSSP ACOs serving 10.8 million beneficiaries (Medicare Payment Advisory Commission 2025c). CMS excludes beneficiaries who are included in the MSSP ACO–CAHPS sample from the FFS–CAHPS sample; therefore, the two surveys are measuring the experience of care of different FFS beneficiaries.

21 Intensity growth refers to changes in the mix of services being furnished, which results in increases in the total number of relative value units.

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

23 Total Medicare payments tend to be higher for services furnished in a facility setting since the combined fee schedule and facility payments (e.g., the outpatient prospective payment system) are usually higher than nonfacility fee schedule payments.

24 The full description of code G2211 is as follows: "Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established)."

25 MEI data in this report may vary from previously reported figures because of updates to productivity figures and MEI projections. MEI-growth data included in this chapter differ from data published in PFS rules because of methodological differences. Data in this chapter reflect the MEI growth that occurred or is projected to occur in a given year. In contrast, MEI-growth data in PFS rules reflect the most recently available actual historical data at the time of publication. For example, the final rule for payment year 2025 uses MEI growth from the second quarter of 2024 (i.e., actual historical MEI growth from the third quarter of 2023 to the second quarter of 2024). MEI growth reported in this chapter for 2025 is based on projected MEI growth from the fourth quarter of 2025 (i.e., projected MEI growth from the

first quarter of 2025 to the fourth quarter of 2025). We also incorporate a productivity adjustment to match the period from which MEI growth was analyzed.

26 MEI-growth projections in this chapter are as of the second quarter of 2025 and are subject to change.

27 The growth in fee schedule spending per beneficiary, especially during the second half of this period, was restrained by the shift of services from clinician offices to hospital outpatient departments. For example, the Commission found that from 2012 to 2017, had shifts in site of service not occurred, average annual growth in the total number of relative value units (RVUs) billed (RVUs multiplied by units of service) would have been 1.5 percent per year instead of 1.1 percent, with larger differences for imaging services and tests (Medicare Payment Advisory Commission 2019). These figures represent lower-bound estimates of the effects of site-of-service shifts for fee schedule services because we were unable to adjust for shifts among certain types of services, such as radiation therapy, chemotherapy injections, and other tests. While this trend lowers fee schedule spending (because fee schedule payment rates are lower when a service is furnished in a facility), it increases Medicare's total spending generated by fee schedule services (fee schedule spending plus associated hospital outpatient spending).

28 Research conclusions on the relationship between prices and volume may vary for several reasons, such as the permanence of the price increase and the population studied. For example, the literature studying the effects of price on utilization for Medicaid beneficiaries is mixed (Medicaid and CHIP Payment and Access Commission 2025).

29 A limitation of the SullivanCotter compensation data is that a disproportionately large share of the provider organizations that contributed compensation data for this survey are affiliated with a hospital or health system.

30 The growth rates reported in this sentence were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2024 and 2025.

31 The growth rates reported in this paragraph were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2020 and 2025.

32 The physician compensation amounts in this paragraph and in Figure 4-8 (p. 129) were calculated using 2024 compensation for all staff physicians in SullivanCotter's 2025 sample.

33 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 PFS were included, and anesthesia services were excluded. Data do not include MA claims.

34 Less commonly selected reasons for selling a practice to a hospital in the AMA's survey were to better compete for employees, to increase availability of additional services that patients need, and to make it easier to participate in risk-based payment models.

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

36 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 qualifying for the A–APM bonus, payment adjustments through the Merit-based Incentive Payment System (MIPS), which can be positive, neutral, or negative depending on a clinician's performance on measures of quality, cost, participation in clinical-improvement activities, and use of health information technology. Beginning in 2027, the A–APM bonus will no longer be available, but MIPS payment adjustments will continue for clinicians not in A–APMs. In 2025, about 464,000 clinicians (roughly 33 percent of the clinicians who bill Medicare) received MACRA's A–APM participation bonus. Another 438,000 clinicians received a positive MIPS adjustment to their PFS payments from Medicare, of up to 2.15 percent. About 78,000 clinicians received a negative MIPS adjustment to their payment rates, of up to −9 percent. Another 26,000 clinicians received a neutral (0 percent) MIPS adjustment because their MIPS score was the same as the MIPS performance threshold (see CMS's 2023 QPP Participation and Performance Results At-A-Glance at https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3238/2023-QPP-Results-At-A-Glance.pdf). We estimate that roughly 394,000 clinicians were ineligible for A–APM bonuses or MIPS adjustments (e.g., because they saw a low volume of Medicare beneficiaries).

37 CMS operationalizes these provisions by reverting back to a lower conversion factor, that is no longer multiplied by the temporary 2.5 percent update, and then multiplying that lower conversion factor by one of the two MACRA updates.

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