

ONLINE APPENDIXES

4

**Physician and other health
professional services**

ONLINE APPENDIX

4-A

**Access to physician and other
health professional services**

**TABLE
4-A1**

Access to physician care for Medicare beneficiaries is similar to that for privately insured individuals in urban and rural areas, 2012

Survey question	Medicare (age 65 or older)			Private insurance (age 50–64)		
	All	Urban	Rural	All	Urban	Rural
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”						
For routine care						
Never	73% ^a	73% ^a	73%	69% ^a	68% ^{ab}	74% ^b
Sometimes	20	20 ^a	19	23	24 ^a	20
Usually	3	3 ^a	4	4	5 ^{ab}	2 ^b
Always	3	3	2	3	3	3
For illness or injury						
Never	82 ^a	81 ^a	82	77 ^a	77 ^{ab}	82 ^b
Sometimes	14 ^a	14 ^a	13	17 ^a	18 ^a	15
Usually	2	2	1	3	3	2
Always	1	1	2	2	2	1
Not accessing a doctor for medical problems: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”						
(Percent answering “Yes”)	8 ^a	8 ^a	9	11 ^a	11 ^a	10
Looking for a new primary care physician: “In the past 12 months, have you tried to get a new...?” (Percent answering “Yes”)						
Primary care physician	7	7	8	8	8	7
Specialist	14	15	13	16	16 ^b	13 ^b
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, “How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it...”						
Primary care physician						
No problem	70	71	67	67	67	65
<i>Percent of total insurance group, by area</i>	5.2	5.2	5.0	5.2	5.3	4.6
Small problem	11	12	5	15	16	9
<i>Percent of total insurance group, by area</i>	0.8	0.9	0.4	1.2	1.3	0.6
Big problem	17	15	27	18	17	24
<i>Percent of total insurance group, by area</i>	1.3	1.1	2.0	1.4	1.3	1.7
Specialist						
No problem	86	86	86	87	88	85
<i>Percent of total insurance group, by area</i>	12.4	12.7	10.8	13.9	14.4	11.1
Small problem	8	8	8	6	5 ^b	11 ^b
<i>Percent of total insurance group, by area</i>	1.2	1.2	1.1	0.9	0.8	1.4
Big problem	5	5	6	7	7	4
<i>Percent of total insurance group, by area</i>	0.7	0.7	0.7	1.1	1.1	0.5

Note: Numbers may not sum to 100 percent because missing responses (“Don’t Know” or “Refused”) are not presented. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2013. Sample sizes for individual questions varied.
 MedPAC uses the Census Bureau definitions of “urban” and “rural.” The Census Bureau classifies as urban all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census-block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. In addition, under certain conditions, less densely settled territory may be part of each UA or UC. The Census Bureau’s classification of “rural” consists of all territory, population, and housing units located outside of UAs and UCs.
^a Statistically significant difference between the Medicare and privately insured populations in a given year (at a 95 percent confidence level).
^b Statistically significant difference by area type within the same insurance category in a given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2013.

ONLINE APPENDIX

4-B

Medicare Ambulatory Care Indicators for the Elderly

**TABLE
4-B1****Descriptions of various Medicare Ambulatory Care Indicators for the Elderly (MACIEs)**

Indicator	Description
Diabetes	
1. Eye exam in diagnosis of diabetes mellitus	Comprehensive eye exam at least every 2 years (the measurement year or prior year), for patients with at least 2 outpatient visits or 1 inpatient stay with diabetes mellitus diagnosis code, within a calendar year.
2. Hemoglobin A1c (HbA1c) testing in diagnosis of diabetes mellitus	HbA1c test at least once per year (the measurement year), in patients with at least 2 outpatient visits or 1 inpatient stay with diabetes mellitus diagnosis code, within a calendar year.
3. Lipid testing in diagnosis of diabetes mellitus	Lipid profile at least every year (the measurement year), in patients with at least 2 outpatient visits or 1 inpatient stay with diabetes mellitus diagnosis code, within a calendar year.
4. Clinical assessment in diagnosis of diabetes mellitus	Two outpatient visits (with or without diagnosis code for diabetes mellitus) during the measurement year, in patients identified as having diabetes mellitus (defined as patients with at least 2 outpatient visits or 1 inpatient stay with diabetes mellitus diagnosis code) in the year prior to the measurement year.
5. Follow-up after hospitalization for diabetes mellitus	At least 1 ambulatory, nonemergent visit (with or without diagnosis code for diabetes mellitus) within 4 weeks following discharge of patients hospitalized for diabetes mellitus.
6. Hospital admissions for serious short-term complications of diabetes mellitus <i>(Potentially avoidable hospitalizations indicator)</i>	Hospital admissions for diabetic, hyperosmolar, or ketotic coma and admissions for uncontrolled diabetes mellitus among patients with at least 2 outpatient visits or 1 inpatient stay with diabetes mellitus diagnosis code within a calendar year.
7. Hospital admissions for serious long-term complications of diabetes mellitus <i>(Potentially avoidable hospitalizations indicator)</i>	Hospital admissions for renal, ophthalmologic, neurologic, and circulatory complications of diabetes mellitus, and nontraumatic lower extremity amputation, among patients with at least 2 outpatient visits or 1 inpatient stay with diabetes mellitus diagnosis code within a calendar year.
Coronary artery disease	
8. Lipid testing in diagnosis of coronary artery disease (CAD)	Lipid profile testing at least every year (the measurement year) in patients with at least 2 outpatient visits or 1 inpatient stay with CAD diagnosis codes within a calendar year.
9. Follow-up after hospitalization for acute myocardial infarction (AMI)	At least 1 outpatient, nonemergent visit within 4 weeks following discharge of patients hospitalized for AMI.
10. Clinical assessment in diagnosis of CAD	Two outpatient visits during the measurement year for patients identified as having CAD (those with at least 2 outpatient visits or 2 inpatient stays with a CAD diagnosis code) in the year prior to the measurement year.
11. Emergency department (ED) use for unstable angina <i>(Potentially avoidable ED utilization indicator)</i>	Three or more ED visits for CAD, unassociated with admission, for patients identified with CAD (those with at least 2 outpatient visits or 1 inpatient stay with a CAD diagnosis code) in the measurement year.

**TABLE
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Indicator	Description
Stroke, transient ischemia, atrial fibrillation, hypertension	
12. Carotid imaging at initial diagnosis of carotid artery stroke	Carotid angiogram or noninvasive carotid imaging procedure within 2 weeks of initial diagnosis in patients hospitalized for carotid artery stroke.
13. Carotid imaging in carotid endarterectomy (CEA)	Carotid imaging to CEA interval of less than 2 months in patients with a hospitalization for stroke or transient ischemic attack (TIA) as a primary diagnosis prior to the CEA.
14. Follow-up after hospitalization for stroke or TIA	At least 1 outpatient, nonemergent visit (with or without diagnosis code for stroke or TIA) within 4 weeks following discharge of patients hospitalized for stroke or TIA.
15. Clinical assessment for history of stroke or TIA	Two outpatient visits (with or without diagnosis code for stroke or TIA) during the measurement year, in patients identified as having stroke or TIA (with 2 outpatient visits or inpatient stays with diagnosis code for stroke or TIA) in the year prior to the measurement year.
16. Hospital admissions for hypertension <i>(Potentially avoidable hospitalizations indicator)</i>	At least 1 hospitalization with hypertension as the primary diagnosis, in patients with 2 or more outpatient visits or 1 inpatient stay with a diagnosis code for hypertension in the measurement year.
Heart failure	
17. Left ventricular ejection fraction (LVEF) assessment in diagnosis of heart failure: At initial diagnosis	Diagnostic ultrasound, radionuclide ventriculography (RVG), or left ventriculogram within 3 months before or after initial diagnosis of heart failure. Initial diagnosis defined by 1 year look-back period free of diagnosis codes for heart failure.
18. LVEF assessment in diagnosis of heart failure: Associated with hospitalization	Diagnostic ultrasound, RVG, or left ventriculogram within 3 months before or after hospitalization for heart failure.
19. Laboratory testing in heart failure	Laboratory tests to measure electrolytes and renal function during the measurement year, in patients with 2 outpatient visits or 1 inpatient stay with heart failure diagnosis codes within the previous calendar year.
20. Electrocardiogram (EKG) after initial diagnosis of heart failure	EKG within 1 month before or 3 months after initial diagnosis of heart failure. Initial diagnosis requires 12-month look-back period free of heart failure diagnosis codes.
21. Chest X-ray (CXR) after initial diagnosis of heart failure	CXR within 1 month before or 3 months after initial diagnosis of heart failure. Initial diagnosis requires 12-month look-back period free of heart failure diagnosis codes.
22. Follow-up after hospitalization for heart failure	At least 1 ambulatory, nonemergent visit (with or without diagnosis code for heart failure) within 4 weeks following discharge of patients hospitalized for heart failure.

**TABLE
4-B1****Descriptions of various Medicare Ambulatory Care Indicators for the Elderly (MACIEs)**

Indicator	Description
23. Clinical assessment in heart failure	At least 2 outpatient visits (with or without diagnosis code for heart failure) during the measurement year in patients identified as having heart failure (with 2 outpatient visits or 1 inpatient stay with heart failure diagnosis code) in the year prior to the measurement year.
24. Hospital admissions for heart failure <i>(Potentially avoidable hospitalizations indicator)</i>	Hospital admissions for heart failure in the measurement year among patients with 2 outpatient visits or 1 inpatient stay with heart failure diagnosis code in the year prior to the measurement year.
Cancer	
25. Breast cancer screening	Mammogram every 2 years in female patients age 65–74.
26. Biopsy to therapy interval in diagnosis of breast cancer	Breast biopsy to definitive therapy (surgical, radiation, chemotherapy) interval less than 3 months in patients diagnosed with breast cancer (at least 1 outpatient visit or inpatient stay with breast cancer diagnosis code) and eventual definitive therapy.
27. Chest X-ray at initial diagnosis of breast cancer	CXR within 3 months before or 3 months after initial diagnosis of breast cancer. Index diagnosis of breast cancer must occur 3 months or longer before the end of the measurement year. Index diagnosis of breast cancer must be preceded by at least 12 months free of breast cancer diagnosis codes.
28. Breast imaging at initial diagnosis of breast cancer	Mammogram or other breast imaging within 3 months before or 3 months after initial diagnosis of breast cancer. Index diagnosis of breast cancer must occur 3 months or longer before the end of the measurement year. Index diagnosis of breast cancer must be preceded by at least 12 months without breast cancer diagnosis codes.
29. Mammography surveillance in diagnosis of breast cancer	At least 1 mammogram (inpatient or outpatient) within a 12-month period that includes inpatient stay or outpatient visit with diagnosis of breast cancer.
30. Colonoscopic surveillance after diagnosis of colorectal cancer	At least 1 inpatient stay or outpatient visit coded for colonoscopy within 12 months of inpatient stay coded for resection of colorectal cancer.
31. Gastrointestinal (GI) tract work-up after initial diagnosis of iron-deficiency anemia	Colonoscopy or barium enema within 1 month before or 3 months after initial diagnosis of iron-deficiency anemia. The index diagnosis of iron-deficiency anemia must be preceded by a 12-month period free of the iron-deficiency anemia diagnosis.
Anemia and gastrointestinal bleeding	
32. Follow-up visit after hospitalization for GI bleed	At least 1 visit (with or without diagnosis code for GI bleed) within 4 weeks following discharge of patients hospitalized for GI bleed.
33. Follow-up visit after initial diagnosis of GI bleeding	At least 1 outpatient visit or inpatient stay, with or without diagnosis code for GI bleed, within 4 weeks following initial diagnosis of GI bleed (outpatient only). Index diagnosis of GI bleed must be preceded by a 12-month period free of diagnosis of GI bleed.
34. Follow-up lab test after hospitalization for GI bleeding	At least 1 hemoglobin or hematocrit test within 4 weeks following discharge of patients hospitalized for primary diagnosis of GI bleed.

**TABLE
4-B1****Descriptions of various Medicare Ambulatory Care Indicators for the Elderly (MACIEs)**

Indicator	Description
35. Follow-up lab test after initial diagnosis of anemia	Hemoglobin or hematocrit test within 1 to 6 months after an initial diagnosis of anemia. Index diagnosis of anemia must be preceded by at least 12 months free of anemia diagnosis codes.
Chronic obstructive pulmonary disease	
36. Clinical assessment in diagnosis of chronic obstructive pulmonary disease (COPD) or asthma	At least 2 outpatient visits (with or without diagnosis code for COPD or asthma) during the measurement year, in patients identified as having COPD or asthma (at least 2 outpatient visits or inpatient stays with diagnosis of COPD or asthma) in the year before the measurement year.
37. Hospital admissions for respiratory diagnosis in diagnosis of COPD or asthma <i>(Potentially avoidable hospitalizations indicator)</i>	Hospital admissions for respiratory diagnoses among patients with COPD, including asthma (defined as patients with at least 2 outpatient visits or inpatient stays with diagnosis code for COPD or asthma), in the measurement year.
Depression	
38. Follow-up after hospitalization for depression	At least 1 outpatient visit (with or without diagnosis code for depression) within 2 weeks following discharge of patients hospitalized for depression.