

CHAPTER 4

**Physician and other health
professional services**

R E C O M M E N D A T I O N

- 4** The Congress should increase payment rates for physician and other health professional services by the amount specified in current law for calendar year 2018.

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

Physician and other health professional services

Chapter summary

Physicians and other health professionals deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. In 2015, Medicare paid \$70.3 billion for physician and other health professional services, accounting for 15 percent of fee-for-service (FFS) Medicare benefit spending. About 919,000 clinicians billed Medicare—over 581,000 physicians and nearly 338,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare pays for the services of physicians and other health professionals using a fee schedule. Under current law, Medicare’s conversion factor for the fee schedule will be updated by 0.5 percent in 2018.

Assessment of payment adequacy

We use the following factors to assess payment adequacy for physicians and other health professionals: beneficiary access to care, volume growth, quality, and Medicare payments and providers’ costs.

Beneficiaries’ access to care—Overall, beneficiary access to physician and other health professional services is comparable with prior years, although our access survey shows a slight decline in the share of beneficiaries reporting that they never had to wait longer than wanted for regular or routine care and

In this chapter

- Are Medicare fee schedule payments adequate in 2017?
- How should Medicare payments change in 2018?

illness or injury care as compared with last year. Most beneficiaries continue to report that they are able to find a new doctor without a problem. A small number of beneficiaries report more difficulty, with a higher share reporting problems obtaining a new primary care doctor than reporting problems obtaining a specialist.

- **Supply of providers**—The number of physicians per beneficiary has remained relatively constant, the number of advanced practice registered nurses and physician assistants per beneficiary has grown slightly, and the share of providers enrolled in Medicare’s participating provider program remains high.
- **Volume of services**—In 2015, across all services, volume per beneficiary grew by 1.6 percent. Among broad categories of service, growth rates were 1.7 percent for evaluation and management, 0.5 percent for imaging services, 1.4 percent for major procedures, 1.9 percent for other procedures, and 1.6 percent for tests.

Quality of care—CMS assesses the quality of Medicare-billing physicians and other health professionals based on clinician-reported individual quality measures. The Commission has raised the following concerns with Medicare’s current clinician quality programs: The reporting requirements are confusing and burdensome to providers, the process does not allow for comparability across providers, many measures are not linked to patient outcomes, and few measures assess low-value care. We report three sets of population-based measures—avoidable hospitalizations and emergency department visits for ambulatory care-sensitive conditions and rates of low-value care in Medicare.

Medicare payments and providers’ costs—CMS currently projects that the increase in 2018 in the Medicare Economic Index (which measures input prices) will be 2.4 percent. In 2015, Medicare payment rates for physician and other health professional services were 78 percent of commercial rates for preferred provider organizations, the same as in 2014. In addition, average annual physician compensation increased by 4 percent in 2015, according to data from the Medical Group Management Association. Average compensation in 2015 was much lower for primary care physicians than for physicians in specialty groups such as radiology and nonsurgical, procedural specialties, continuing to raise concerns about fee schedule mispricing and its impact on primary care.

The evidence suggests that payments for physicians and other health professionals are adequate. Therefore, the Commission recommends an update for 2018 consistent with current law. ■

Background

Physicians and other health professionals billing under Medicare’s Part B fee schedule deliver a wide range of services—office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings.

In 2015, the Medicare program paid \$70.3 billion for physician and other health professional services, or 15 percent of benefit spending in Medicare’s traditional fee-for-service (FFS) program. In 2015, about 919,000 clinicians billed Medicare through the fee schedule—581,607 physicians and 337,723 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare uses a fee schedule to pay for physician and other health professional services based on a list of over 7,000 services and their payment rates. In determining payment rates for each service, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. These three factors are adjusted for variation in the input prices in different markets, and the sum is

multiplied by the fee schedule’s conversion factor (average payment amount) to produce a total payment amount.¹ The conversion factor was \$35.80 in 2016 and is \$35.89 in 2017.²

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new set of updates for clinicians billing under the Medicare fee schedule and repealed the prior framework that set the conversion factor—the sustainable growth rate (SGR) formula. The SGR was established to limit total fee schedule spending by restraining annual updates when spending exceeded certain parameters. MACRA established two paths for clinicians: a payment path for clinicians who participate in advanced alternative payment models (A-APMs) and a payment path for other clinicians (Table 4-1). In 2018, the statutory update for all clinicians is 0.5 percent. The update could be less than 0.5 percent if CMS does not meet its target for adjusting the prices of misvalued services; the target will be equal to 0.5 percent of fee schedule spending in 2018.

CMS issued a final rule in November 2016 implementing MACRA (Centers for Medicare & Medicaid Services 2016a). By statute, the Medicare program will make

**TABLE
4-1**

Statutory payment updates and incentive payments for physicians and other health professionals

	2015												2026 and later
	January–June	July–December	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	
A-APM clinicians													
Update	0%	0.5%	0.5%	0.5%	0.5%	0.5%	0%	0%	0%	0%	0%	0%	0.75%
APM bonus						5%	5%	5%	5%	5%	5%		
Other clinicians													
Update	0%	0.5%	0.5%	0.5%	0.5%	0.5%	0%	0%	0%	0%	0%	0%	0.25%
Potential MIPS adjustments						(-4% to +4%)	(-5% to +5%)	(-7% to +7%)	(-9% to +9%)				

Note: A-APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System). Clinicians who are subject to the MIPS can receive upward or downward adjustments of up to 4 percent in 2019, 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and later. The maximum upward adjustment may exceed these limits or be less than these amounts due to scaling factors and an additional increase for exceptional performance. The basic MIPS adjustments are budget neutral, and there is an additional \$500 million per year from 2019 to 2024 for exceptional performance.

Source: Medicare Access and CHIP Reauthorization Act of 2015.

**TABLE
4-2****Satisfaction with the overall quality of health care received in all settings in the past 12 months, 2016**

	Medicare (ages 65 and older)	Private insurance (ages 50-64)
Very satisfied	66%	55%
Somewhat satisfied	20	25
Somewhat dissatisfied	4	5
Very dissatisfied	2	2

Note: Table excludes the following responses: "Did not receive health care in past 12 months," "Don't know," and "Refused." It does not include Medicare beneficiaries under the age of 65.

Source: MedPAC-sponsored telephone survey conducted in 2016.

incentive payments to clinicians that participate in A-APMs for each year from 2019 to 2024. A-APMs are a subset of all the payment models run by CMS meeting certain criteria. CMS finalized policies that lower the qualifying standards for A-APMs and increase the mechanisms for clinicians to qualify for the A-APM incentive payment. CMS created multiple nominal risk standards; modified existing A-APMs and created new A-APMs; permits alternative calculations for clinicians to qualify in A-APMs; and assesses at both the entity and the individual-clinician level whether clinicians meet the threshold for A-APM participation.

Clinicians that do not receive the A-APM incentive payment will be subject to the Merit-based Incentive Payment System (MIPS). Under the MIPS, clinicians must report information to Medicare in three areas: quality, clinical practice improvement activities, and advancing care information (formerly "meaningful use of electronic health records"). The fourth MIPS component is cost, and clinicians will be scored on this component based on claims (so there is no need for clinician reporting). Clinicians will be scored in each of the four areas and will receive payment adjustments based on their composite performance.

The first year of A-APM eligibility and MIPS reporting is 2017, and those scores will be used for A-APM incentive payments and MIPS payment adjustments in 2019. There are exceptions to the MIPS reporting

requirements for participants in certain types of APMs. In addition, CMS finalized that, for the first year of MIPS reporting (2017), clinicians will be held harmless (or receive a small positive adjustment) if they report one quality measure, report one clinical practice improvement activity, or report the base information in the advancing care information category. CMS estimates that 90 percent of clinicians will be above the performance threshold, so the resulting payment increases under MIPS in the first year will likely be very small (Centers for Medicare & Medicaid Services 2016a). In other words, even clinicians who perform very well under MIPS in the first year are unlikely to receive a high reward.

Are Medicare fee schedule payments adequate in 2017?

We assess payment adequacy by reviewing beneficiary access to care provided by physicians and other health professionals, the supply of physicians and other health professionals, volume growth, quality of care, and Medicare payments and providers' costs. Overall, most indicators show no significant change from prior years.

Beneficiaries' access to care

We use a number of measures to assess beneficiary access to timely, appropriate care, including direct reporting from beneficiaries (through, for example, our own beneficiary telephone survey); focus groups with beneficiaries; and health facility site visits conducted yearly. Supplementing these primary sources, we also review other patient access surveys and clinician surveys.

Each year, the Commission sponsors a telephone survey of 4,000 Medicare beneficiaries ages 65 and over and 4,000 privately insured individuals ages 50 to 64. The goal in surveying these two populations is to assess whether access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year's survey was fielded in the summer and fall of 2016.

The Commission also conducts focus groups in markets around the country to provide a qualitative description of beneficiary experiences with the Medicare program. This year, we conducted 12 focus groups of Medicare beneficiaries in 3 markets (Chicago, Philadelphia, and

**TABLE
4-3**

Selected measures of access and patient experience, 2014

	Age 65 and over with Medicare	Adults under age 65, any private insurance
Always reporting they got an appointment as soon as wanted for...		
Regular or routine care	64%	57%
Illness or injury	74	65
Reporting that their health providers always...		
Listened carefully to them	70	66
Explained things clearly	68	68
Showed respect for what they had to say	73	71
Spent enough time with them	62	57
Percent giving a 9 or 10 rating (out of 10) for health care received	65	54

Note: Rows 2 and 3 reflect those making an appointment; rows 5-8 reflect those who reported going to a doctor's office or clinic in the last 12 months.

Source: Medical Expenditure Panel Survey.

Denver), with roughly half of the beneficiaries dually entitled to Medicare and Medicaid. We also conduct site visits and interviews with providers, and the focus this year was on behavioral health integration.

Overall, findings from our survey and focus groups are consistent with one another and with external sources. Medicare beneficiaries have generally adequate access to clinician services, and their reported access is largely comparable with (or in some cases, better than) access for privately insured individuals.

The survey results that we report for 2016 showed a decrease in beneficiaries' ability to see a doctor as soon as wanted for regular or routine care and illness or injury care among both Medicare beneficiaries and privately insured individuals. This finding could represent either a real change in access or normal variation in year-to-year results. We reviewed other surveys that compare access between Medicare beneficiaries and individuals with private insurance. In general, other surveys did not appear to show a decline in access, and Medicare beneficiaries generally were reported to have comparable access with those who have private insurance.

Two caveats should be noted. First, our ability to analyze contemporaneous sources of data is limited due to the lag

time that occurs in survey processing. Currently, only the Commission's survey has data on 2016 access. Second, a data source that we have relied on in the past is not available: CMS will not release the Medicare Current Beneficiary Survey (MCBS) for 2014 while the survey is redesigned. In prior reports, the MCBS has provided beneficiary wait times and detail on access for Medicare beneficiaries with varying characteristics.

Medicare beneficiaries' overall satisfaction with care is similar to satisfaction among privately insured patients

From our telephone survey, a slightly higher share of Medicare beneficiaries reported that they were very or somewhat satisfied with their care (86 percent) compared with those who have private insurance (80 percent) (Table 4-2).

These overall satisfaction rates are similar to those in other surveys. The Medical Expenditure Panel Survey (MEPS) for 2014 found that patient experience and access for individuals ages 65 and over with Medicare was slightly better than for those under age 65 with private insurance—reporting that they were able to get appointments as soon as needed and felt that their providers were respectful, explained clearly, and listened carefully (Table 4-3).

**TABLE
4-4**

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2012–2016

Survey question	Medicare (ages 65 and older)					Private insurance (ages 50–64)				
	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016
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	77% ^b	73% ^b	72% ^{ab}	72% ^{ab}	68%	72% ^b	69%	69% ^a	69% ^a	67%
Sometimes	17 ^b	20 ^b	20 ^{ab}	19 ^{ab}	22	21 ^b	23	23 ^a	23 ^a	23
Usually	3 ^b	3 ^b	3	4	4	3 ^b	4	4	4	5
Always	2 ^b	3	3	3	3	3	3	3 ^b	3	4
Don’t know/Refused	1	1	2	2	2	*	*	1	1	1
For illness or injury										
Never	84 ^b	82 ^b	83 ^{ab}	82 ^{ab}	79 ^a	80 ^b	77 ^b	79 ^{ab}	77 ^{ab}	75 ^a
Sometimes	12 ^b	14 ^b	12 ^{ab}	13 ^{ab}	16 ^a	16 ^b	17	16 ^{ab}	17 ^a	19 ^a
Usually	2	2	2	3 ^b	2 ^a	2 ^b	3	2 ^b	3	3 ^a
Always	1	1	1 ^a	2	2 ^a	2	2 ^b	2 ^a	2	3 ^a
Don’t know/Refused	1	1	2	1	2	*	1	1	1	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?”										
Share answering “Yes”	8 ^b	8 ^b	10	11	11 ^a	11	11	11	12	12 ^a
Looking for a new doctor: “In the past 12 months, have you tried to get a new...?” (Share answering “Yes”)										
Primary care doctor	7	7	8	7 ^a	8 ^a	7 ^b	8 ^b	8 ^b	9 ^a	10 ^a
Specialist	13 ^b	14 ^b	17	16	18	18	16 ^b	17	18	18
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	72	70	67	67	64	75 ^b	67	63	63	63
Share of total insurance group	4.7	5.2	5.5	4.7	5.1	5.0	5.2	4.9 ^b	5.7	6.1
Small problem	14	11	16	18	15	9 ^b	15	16	18	16
Share of total insurance group	0.9	0.8	1.3	1.2	1.2	0.6 ^b	1.2	1.3	1.7	1.5
Big problem	14	17	15	14	20	15	18	19	17	20
Share of total insurance group	0.9 ^b	1.3	1.2	1.0 ^b	1.6	1.0 ^b	1.4	1.5	1.5	1.9
Specialist										
No problem	87 ^b	86	85	87 ^{ab}	82	86 ^b	87 ^b	85 ^b	82 ^a	79
Share of total insurance group	11.7 ^b	12.4 ^b	14.4	14.2	14.7	15.6	13.9	14.5	14.8	14.4
Small problem	6 ^b	8	7	7	10	7	6	9	8	9
Share of total insurance group	0.7 ^b	1.2	1.2	1.1 ^b	1.8	1.2	0.9 ^b	1.4	1.5	1.6
Big problem	7	5	7	6	8 ^a	7 ^b	7 ^b	6 ^b	9	11 ^a
Share of total insurance group	0.9	0.7 ^b	1.2	1.0 ^a	1.4	1.2 ^b	1.1 ^b	1.0 ^b	1.7 ^a	2.0

Note: Numbers may not sum to 100 percent because of rounding. Sample sizes for each group (Medicare and privately insured) are 4,000. Sample sizes for individual questions varied. “Aged” beneficiaries are those ages 65 or older.

^a Statistically significant difference between the Medicare and privately insured groups in the given year (at a 95 percent confidence level).

^b Statistically significant difference from 2016 within the same insurance category (at a 95 percent confidence level).

*Percentage less than 0.5 percent.

Source: MedPAC-sponsored telephone surveys conducted from 2012 to 2016.

Most beneficiaries report that they are able to see a doctor when they need to

From our 2016 telephone survey, 68 percent of Medicare beneficiaries reported that they never had to wait longer than they wanted for routine care, and 79 percent reported the same for illness or injury care. These rates are statistically lower than those reported for 2015 (which were 72 percent and 82 percent, respectively) (Table 4-4).

In 2016, the share of Medicare beneficiaries reporting that they never had trouble obtaining regular or routine care was the same as the share of privately insured individuals (68 percent for Medicare beneficiaries, 67 percent for the privately insured), and the rates for both groups were lower than five years ago.

From 2012 through 2016, the share of Medicare beneficiaries reporting that they could always get an appointment for regular or routine care fell by 9 percentage points (from 77 percent to 68 percent). The share of privately insured individuals reporting that they could always get an appointment for regular or routine care fell by 5 percentage points over the same time frame (from 72 percent to 67 percent).

For access to illness or injury care, the magnitude of the decline between 2012 and 2016 was 5 percentage points both for Medicare beneficiaries and privately insured individuals. However, the access rate for Medicare beneficiaries was still higher than for privately insured individuals in 2016 (79 percent for Medicare beneficiaries, 75 percent for privately insured).

Beneficiaries report more difficulty accessing primary care than specialty care

Most beneficiaries reported that they were able to find a new doctor without a problem. However, consistent with prior years, beneficiaries seeking a primary care doctor were more likely to report that they had a problem finding a doctor than beneficiaries seeking a specialist (Table 4-4). For primary care, 8 percent were looking for a new doctor, and of those looking, 20 percent reported a big problem, meaning that on net, 1.6 percent of the Medicare population reported a big problem. For specialty care, 18 percent were looking for a new doctor, and of those looking, 8 percent reported a big problem, meaning that on net, 1.4 percent of the total Medicare population reported a big problem.

These results were consistent with beneficiary responses in our focus groups, with some reporting more difficulty

finding new primary care providers than specialists. Medicare beneficiaries overall were about as likely as privately insured individuals to report a big problem finding a new primary care doctor and less likely to report a big problem finding a specialist. In comparison with 2015, a small but statistically significant higher share of Medicare beneficiaries in 2016 reported big problems finding a primary care doctor (1.6 percent of the total Medicare population, up from 1.0 percent in 2015) (Table 4-4).

Beneficiaries in both the focus groups and our telephone survey reported difficulty with certain specialty referrals. Physicians in our site visits reported difficulty obtaining psychiatric referrals for all of their patients (Medicare and other payers) because, in their experience, many psychiatrists did not accept any type of insurance.

Some groups of beneficiaries report more difficulty obtaining care

In our telephone survey, minority beneficiaries were more likely than White beneficiaries to report that they could not obtain care as quickly as they wanted. Differences in reported access between urban and rural beneficiaries were minimal.

Minority beneficiaries report more difficulty receiving care as soon as they want and higher rates of forgoing care

In our 2016 telephone survey, the share of beneficiaries reporting that they never had to wait longer than they wanted for routine care was lower for minority Medicare beneficiaries (64 percent) than for White Medicare beneficiaries (70 percent) (Table 4-5, p. 104). Minority Medicare beneficiaries were more likely than White Medicare beneficiaries to report that they always had to wait longer than they wanted for a routine doctor's appointment (5 percent vs. 3 percent, respectively). Minority Medicare beneficiaries were also more likely than White beneficiaries to say that they did not receive care when they thought they should have (14 percent for minority beneficiaries vs. 10 percent for White beneficiaries).

Minority Medicare beneficiaries were also less likely than White beneficiaries to report that they faced no problem finding a specialist (74 percent for minority beneficiaries, 83 percent for White beneficiaries). Similar differences also exist for privately insured individuals. Minorities generally report worse access to care overall, for all types of insurance (Agency for Healthcare Research and Quality 2016). In addition, minority Medicare beneficiaries are more likely to also be in groups that have poorer access overall: African American and Hispanic beneficiaries

**TABLE
4-5**

Medicare beneficiaries have similar access to physicians compared with privately insured individuals, but minorities in both groups report problems more frequently, 2016

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50-64)		
	All	White	Minority	All	White	Minority
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	68%	70% ^b	64% ^b	67%	67%	68%
Sometimes	22	22	23	23	24	22
Usually	4	4	4	5	5	5
Always	3	3 ^{ab}	5 ^b	4	4 ^a	4
Don't know/Refused	2	1	3	1	1	1
For illness or injury						
Never	79 ^a	80 ^{ab}	76 ^b	75 ^a	76 ^a	72
Sometimes	16 ^a	16 ^a	16	19 ^a	19 ^a	20
Usually	2 ^a	1 ^a	2	3 ^a	3 ^a	3
Always	2 ^a	1 ^{ab}	3 ^b	3 ^a	2 ^{ab}	4 ^b
Don't know/Refused	2	1	2	1	1	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?"						
Share answering "Yes"	11 ^a	10 ^{ab}	14 ^b	12 ^a	12 ^a	14
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care physician	8 ^a	8 ^a	9	10 ^a	10 ^a	9
Specialist	18	19 ^b	14 ^b	18	20 ^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	64	64	64	63	62	66
Share of total insurance group, by race	5.1	5.0	5.4	6.1	6.2	5.9
Small problem	15	15	16	16	17	13
Share of total insurance group, by race	1.2	1.1	1.3	1.5	1.7	1.2
Big problem	20	20	21	20	20	20
Share of total insurance group, by race	1.6	1.6	1.7	1.9	2.0	1.8
Specialist						
No problem	82	83 ^b	74 ^b	79	81	75
Share of total insurance group, by race	14.7	15.9 ^b	10.4 ^b	14.4	16.1 ^b	9.9 ^b
Small problem	10	9	15	9	9	10
Share of total insurance group, by race	1.8	1.8	2.1	1.6	1.8	1.4
Big problem	8 ^a	7	11	11 ^a	10	12
Share of total insurance group, by race	1.4	1.3	1.5	2.0	2.0	1.5

Note: Respondents who did not report race or ethnicity were not included in "White" or "Minority" results but were included in "All" results. Numbers may not sum to 100 percent because of rounding. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2016. Sample sizes for individual questions varied.
^a Statistically significant difference between the Medicare and privately insured populations in the given year (at a 95 percent confidence level).
^b Statistically significant difference by race within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted in 2016.

are more likely to be under 65 (entitled on the basis of disability), qualify as dually eligible for Medicare and Medicaid, have lower incomes, and report fair or poor health status or functional limitations than are White Medicare beneficiaries (Centers for Medicare & Medicaid Services 2015).

Few reported differences in access between urban and rural beneficiaries The Commission’s telephone survey showed no major differences in access between urban and rural beneficiaries (Table 4-6, p. 106). There was no significant difference between the share of urban and rural beneficiaries experiencing an unwanted delay in getting an appointment.

Some measures of access appeared to be better for rural Medicare beneficiaries than for rural individuals with private insurance. For example, rural Medicare beneficiaries were significantly less likely than rural privately insured individuals to report not accessing medical care when needed than rural privately insured individuals (9 percent of rural Medicare beneficiaries vs. 14 percent of rural individuals with private insurance). Rural Medicare beneficiaries were also significantly more likely to report no problem finding a new specialist (13.8 percent of rural Medicare beneficiaries) versus rural privately insured individuals (9.5 percent of rural privately insured individuals).

Although we do not see systematic differences in access by urban and rural Medicare beneficiaries and privately insured individuals, reported access varies across the country for both Medicare and private payers. For example, in a state-based analysis of physician acceptance of insurance, states with high rates of Medicare acceptance among physicians were also likely to have high rates of private insurance acceptance (Hing et al. 2015). There is some evidence that access by one group of beneficiaries who are also eligible for Medicaid—qualified low-income beneficiaries—may be worse if the state pays a lower share of the Medicare cost-sharing amount for clinician services. See our June 2016 report for further discussion.

Nearly all beneficiaries have a regular source of care, with more use of nurse practitioners and physician assistants in rural areas

Nearly all beneficiaries in our focus groups reported that they had a regular source of primary care and that they could access their provider that day or within a few days. From the 2015 National Health Interview Survey, 95 percent of Medicare beneficiaries ages 65 and over

reported that they had a usual source of medical care, with the majority reporting a doctor’s office (80 percent) and 15 percent reporting a clinic (National Center for Health Statistics 2015). Medicare beneficiaries also reported relatively frequent contact with providers: Over 85 percent reported that they had contact with a clinician within the last six months.

In our telephone survey, 13 percent of beneficiaries responded that they saw a nurse practitioner (NP) or physician assistant (PA) for all or most of their primary care, and 28 percent said that they saw an NP or PA for some of their primary care (data not shown). These figures are slightly higher than last year. Similar to prior years, rural beneficiaries were more likely than urban beneficiaries to report seeing NPs and PAs for all or most of their primary care (16 percent for rural beneficiaries vs. 11 percent for urban beneficiaries).

Access findings over time and in context show no significant change

To provide more context for our survey results, we looked at two other sources of trend data on access—the MEPS and the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®). Both surveys show largely stable access.

The MEPS, which has data on the 65 and older Medicare population, does not show a significant change from 2010 to 2014 in the number of respondents indicating that they can always access either routine care or care for illness or injury as soon as wanted, with 64 percent reporting they can always get routine care as soon as wanted and 74 percent reporting they can always get illness or injury care as soon as wanted (Figure 4-1, p. 107) (Agency for Healthcare Research and Quality 2016).

The CAHPS surveys are a suite of surveys that assess patient experience and reported access. CAHPS results are used in the Part C and Part D star ratings that measure quality in the Medicare Advantage program, and a CAHPS module is issued to a sample of beneficiaries in the FFS Medicare population.

Overall, the share of Medicare FFS beneficiaries reporting that they always or usually got the care they needed was generally stable between 2011 and 2015. Beneficiaries were as likely to report that they got appointments and care quickly in 2015 as in 2011 (Table 4-7, p. 108). One measure (the share of beneficiaries reporting that they viewed FFS Medicare as a 9 or 10 on a 10-point scale) remained constant from 2012 to 2014, but fell slightly in 2015.

**TABLE
4-6**

Access to physician care for Medicare beneficiaries is similar to that for privately insured individuals in urban and rural areas, 2016

Survey question	Medicare (ages 65 and older)			Private insurance (ages 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	68%	68%	67%	67%	67%	69%
Sometimes	22	22	23	23	23	23
Usually	4	4	6	5	5	4
Always	3	4	3	4	4	4
Don't know/Refused	2	2	2	1	1	1
For illness or injury						
Never	79 ^a	80 ^a	77	75 ^a	75 ^a	77
Sometimes	16 ^a	16 ^a	17	19 ^a	19 ^a	18
Usually	2 ^a	2 ^a	2	3 ^a	3 ^a	2
Always	2 ^a	1 ^a	2	3 ^a	2 ^a	3
Don't know/Refused	2	2	2	1	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?" (Share answering "Yes")						
	11 ^a	11	9 ^a	12 ^a	12	14 ^a
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care physician	8 ^a	8 ^a	8	10 ^a	10 ^a	7
Specialist	18	18	16	18	19 ^b	14 ^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	64	61	73	63	63	60
Share of total insurance group, by area	5.1	4.8 ^a	5.6	6.1	6.5 ^{ab}	4.0 ^b
Small problem	15	17	8	16	17	8
Share of total insurance group, by area	1.2	1.4	0.6	1.5	1.7 ^b	0.6 ^b
Big problem	20	20	18	20	19	28
Share of total insurance group, by area	1.6	1.6	1.4	1.9	2.0	1.9
Specialist						
No problem	82	81	84 ^a	79	81 ^b	70 ^{ab}
Share of total insurance group, by area	14.7	14.9	13.8 ^a	14.4	15.3 ^b	9.5 ^{ab}
Small problem	10	11	8	9	8 ^b	16 ^b
Share of total insurance group, by area	1.8	2.0	1.3	1.6	1.5	2.2
Big problem	8 ^a	8	8	11 ^a	11	12
Share of total insurance group, by area	1.4	1.4	1.2	2.0	2.0	1.6

Note: Numbers may not sum to 100 percent because of rounding. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2016. Sample sizes for individual questions varied. The Commission 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).

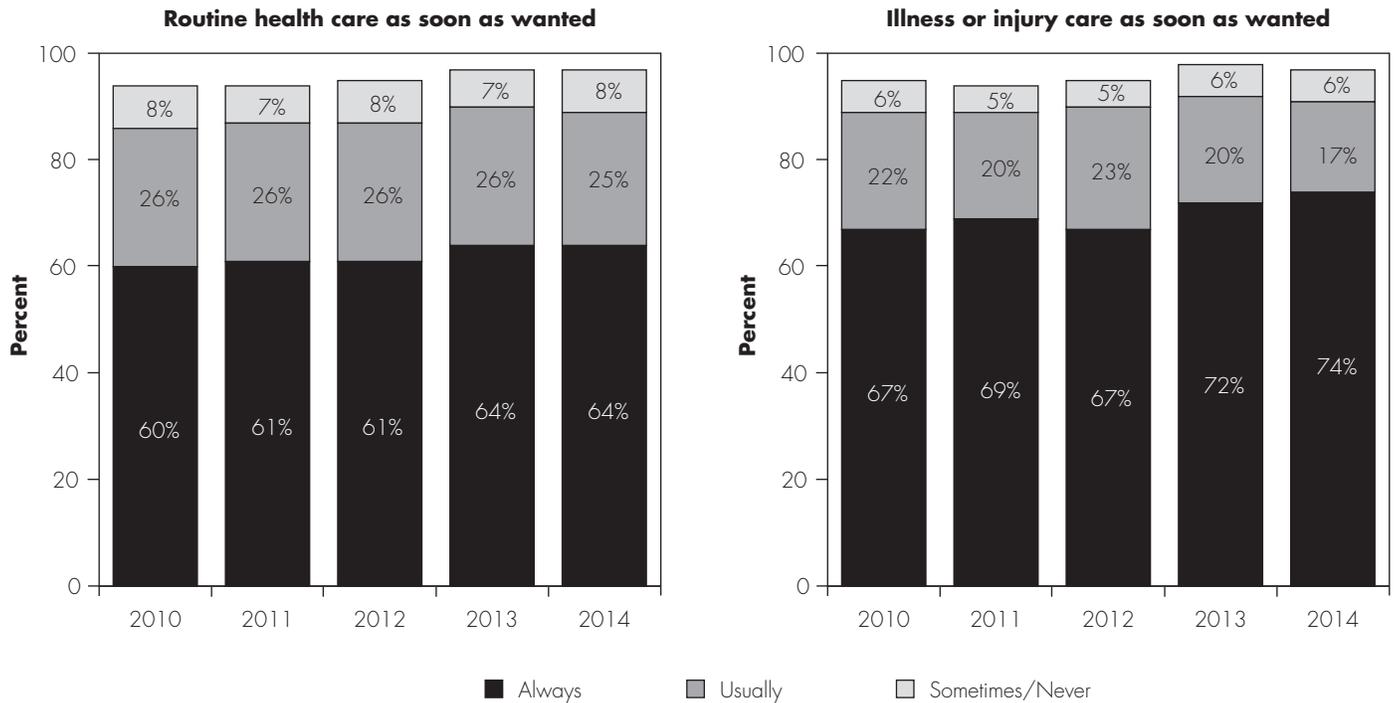
^b Statistically significant difference by area type within the same insurance category in a given year (at a 95 percent confidence level).

* Percentage less than 0.5 percent.

Source: MedPAC-sponsored telephone survey conducted in 2016.

FIGURE 4-1

Medicare beneficiaries over age 65 reported relatively steady levels of accessing care when wanted, 2010–2014



Note: Data include survey respondents age 65 or over with Medicare. Numbers may not sum to 100 percent because missing responses (“Don’t Know” or “Refused”) are not included.

Source: Medical Expenditure Panel Surveys, 2010–2014.

In summary, other surveys that assess similar measures of patient access and experience as the Commission’s survey do not appear to show declining access. And although our survey is the only one with 2016 results, both the MEPS and CAHPS cover time frames during which our telephone survey shows a slight decrease in reported access for regular and routine care. If our survey was revealing a national change in access, it would probably be detectable in either the MEPS (through 2014) or the CAHPS (through 2015).

In addition, the decline in reported access in our survey appears among both the Medicare population and the privately insured population. So the changes reflected in our survey could reflect changes in the health care market overall.

Our access survey and the MEPS data presented above are figures for the entire Medicare population over age 65. Shifts in the types of additional coverage that Medicare

beneficiaries have (e.g., medigap) could have an impact on the overall Medicare access figures. We have reported little difference in perceived access between beneficiaries with Medicare FFS and beneficiaries with Medicare Advantage. But beneficiaries with both Medicare and Medicaid report poorer access to physician services and less satisfaction with their health care overall (Medicare Payment Advisory Commission 2016). Furthermore, beneficiaries with Medicare and other public coverage report lower overall rankings of their care (than do beneficiaries with Medicare only or beneficiaries with Medicare and private coverage) and are less likely to report that their providers explained things clearly (Table 4-8, p. 108).

Wait times for appointments in most recent surveys have fallen slightly

We were not able to obtain updated wait times for Medicare beneficiaries because CMS is not releasing the results from the 2014 MCBS. From the most recent survey (2013), we reported that about half of beneficiaries noted

**TABLE
4-7**

Fee-for-service CAHPS® performance rates, 2011-2015

CAHPS composite measure	2011	2012	2013	2014	2015
Getting needed care and seeing specialists (always or usually)	86%	87%	87%	86%	85%
Getting appointments and care quickly (always or usually)	75	75	75	76	75
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical records, helps with managing care)	N/A	87	86	86	85
Rating of health plan (share rating 9 or 10 on 10-point scale)	82	85	85	84	82
Rating of health care quality (share rating 9 or 10 on 10-point scale)	86	86	86	86	86

Note: CAHPS® (Consumer Assessment of Health Providers and Systems®), N/A (not available).

Source: Fee-for-service CAHPS benchmarks from CMS/Harvard Medical School.

that they could see their doctor in three days or less and that this share had fallen slightly since 2010 (Figure 4-2).

In comparing the wait times in this chart with other questions (such as in the Commission’s survey) that assess whether respondents had to wait longer than wanted, note that respondents may have different expectations about their ability to get an appointment quickly. Their expectations about what constitutes a timely appointment could also change over time.

Clinician acceptance of Medicare beneficiaries is comparable with that of private insurance

The National Electronic Health Records Survey reports that in 2015, 81 percent of office-based physicians reported that they accepted Medicare, slightly less than the share accepting private insurance (89 percent) (National Center for Health Statistics 2016). In other studies using these data, the rates of Medicare acceptance is comparable with private insurance when pediatricians are excluded

**TABLE
4-8**

Reported access for the Medicare 65-and-older population, 2014

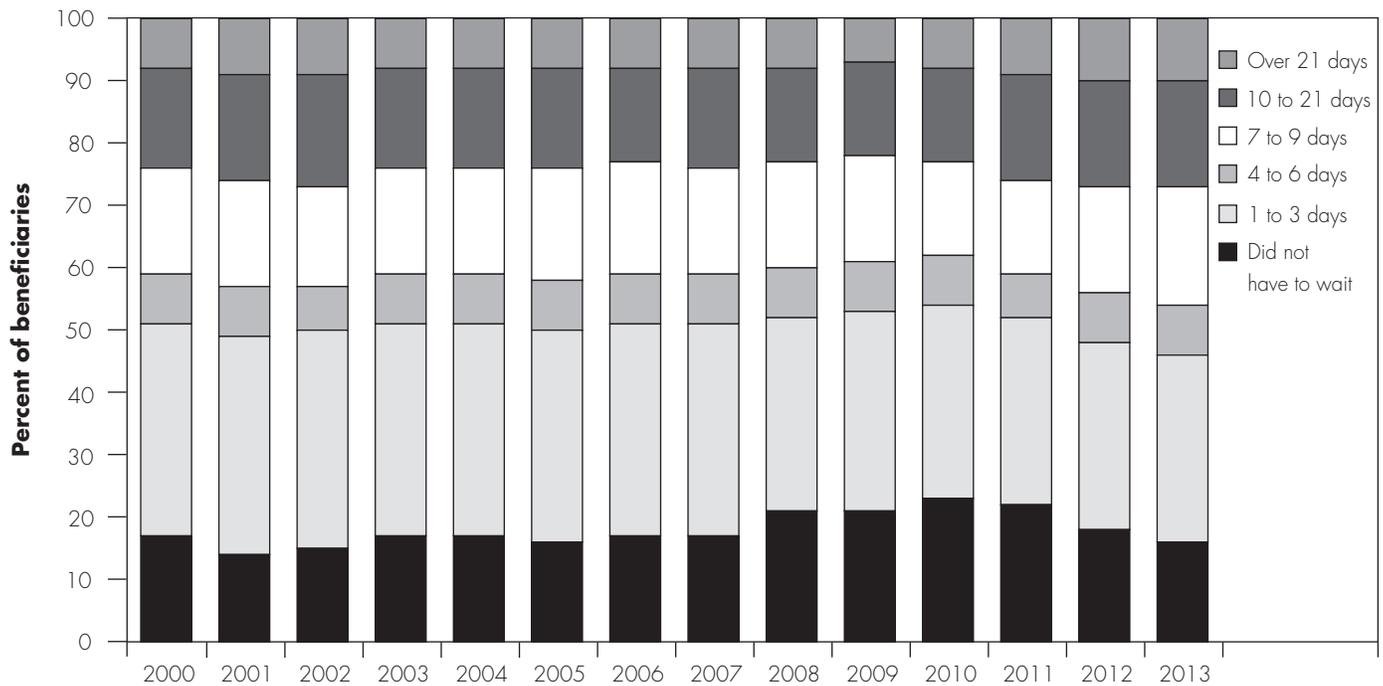
Ages 65 and older

	All Medicare	Medicare only	Medicare and private	Medicare and other public
Reporting they always got an appointment as soon as wanted for...				
Regular or routine care	64.2%	63.0%	65.3%	61.3%
Illness or injury	73.7	71.4	74.6	73.5
Reporting that their health providers always...				
Listened carefully to them	70.2	69.7	70.3	70.6
Explained things clearly	68.0	69.0	67.9	64.6
Showed respect for what they had to say	73.4	72.1	74.3	70.5
Spent enough time with them	62.1	59.1	64.1	59.9
Share giving a 9 or 10 rating (out of 10) for health care received	64.5	64.4	66.0	55.6

Source: Medical Expenditure Panel Survey.

**FIGURE
4-2**

Slightly less than half of beneficiaries report that they can see their doctor in three days or less, 2000–2013



Note: Data include noninstitutionalized beneficiaries only.

Source: Medicare Current Beneficiary Survey, 2000–2013.

(Boccuti et al. 2013, Hing et al. 2015). Physician surveys over the past decade have consistently shown that a higher share of specialty physicians accept Medicare than primary care physicians (Boccuti et al. 2013, Hing and Schappert 2012). During our site visits, most providers said that they accept Medicare, but they may limit the number of new patients.

A 2015 survey of primary care physicians conducted by the Kaiser Family Foundation and the Commonwealth Fund reported that primary care physicians are less likely to accept new Medicare patients than new privately insured patients (72 percent for Medicare, 80 percent for private insurance) (Boccuti et al. 2015). Another 20 percent of primary care physicians reported that, while they generally participated in Medicare, they were not currently taking *new* Medicare patients (for a total of 92 percent of primary care physicians reporting that they

participated in Medicare). This 20 percent could also include physicians with closed practices not currently accepting any new patients.

Supply of physicians and other health professionals billing Medicare has kept pace with enrollment growth, and most services are paid on assignment

Other indicators of access include the supply of clinicians billing Medicare, the share of physicians and other health professionals that are participating providers (which means that they accept Medicare’s payment as payment in full), and the share of claims that are paid on assignment.

Supply of physicians and other health professionals billing Medicare has kept pace with enrollment growth

Our analysis of Medicare FFS claims data for 2013 to 2015 shows that the number of physicians and other health

**TABLE
4-9**

Physicians and other health professionals billing Medicare, 2013–2015

Year	Physicians				Advanced practice registered nurses and physician assistants		Other practitioners	
	Primary care specialties		Other specialties		Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries
	Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries				
2013	178,404	3.7	394,103	8.2	152,612	3.2	150,466	3.1
2014	180,165	3.6	396,289	8.0	165,164	3.3	150,037	3.0
2015	182,767	3.6	398,840	7.9	182,949	3.6	154,774	3.1

Note: “Primary care specialties” are specialties eligible for the Primary Care Incentive Payment Program: family medicine, internal medicine, pediatric medicine, and geriatric medicine. “Other practitioners” includes physical and occupational therapists, chiropractors, optometrists, psychologists, social workers, and podiatrists. The number billing Medicare includes those with a caseload of more than 15 different beneficiaries during the year. Beneficiary counts used to calculate numbers per 1,000 include those in fee-for-service and Medicare Advantage on the assumption that professionals are furnishing services to both types. Figures exclude nonperson providers such as suppliers or clinical laboratories.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2016 annual report of the Boards of Trustees of the Medicare trust funds.

professionals furnishing services to Medicare beneficiaries has kept pace with enrollment growth in Medicare (Table 4-9). In 2015, the ratio of physicians in primary care specialties to the number of beneficiaries was 3.6 per 1,000, the same as in 2014. Between 2014 and 2015, the ratio of physicians in other specialties declined slightly from 8.0 per 1,000 beneficiaries to 7.9 per 1,000. Meanwhile, between 2014 and 2015, the number of advanced practice registered nurses and PAs billing Medicare grew from 3.3 per 1,000 beneficiaries to 3.6 per 1,000.

Most physicians and other health professionals are part of Medicare’s participating provider program, and nearly all claims are taken on assignment

In 2016, over 95 percent of physicians and other health professionals billing Medicare signed an agreement with Medicare to be part of the participating provider program. Participating providers agree to take assignment for all claims, which means they accept the fee schedule amount as payment in full (most claims are paid on assignment—99.5 percent in 2015). Providers who do not elect to participate receive a 5 percent lower payment amount and can choose whether to take assignment for their claims on a claim-by-claim basis. If they do not assign a claim, providers may “balance bill” up to 109.25 percent of the fee schedule amount, with the beneficiary paying the difference between 95 percent of the fee schedule amount and the amount billed.

Opt-out clinicians are concentrated in dental and behavioral health specialties

Physicians and other health professionals may opt out of the Medicare program by signing an affidavit with Medicare stating that they will not receive any payment from Medicare, directly or indirectly, for any Medicare patient they see. In this arrangement, a provider who wishes to treat Medicare beneficiaries but not enroll in Medicare must file an opt-out affidavit for all of his or her patients, and the patient cannot separately submit the claim to Medicare. Opt-out clinicians must also enter into a contract with Medicare beneficiaries to treat them, which states that no payment will be made from Medicare either to the beneficiary or to the provider for services delivered by the opt-out clinician.

MACRA established that agreements between the opt-out clinician and Medicare are automatically renewed every two years unless the clinician elects to rejoin Medicare.³ Pursuant to MACRA, CMS also publicly released detailed information on opt-out clinicians in 2016 for the first time. As of November 2016, about 10,000 physicians and other practitioners had an opt-out record on file with the Medicare program, and 7,000 dentists had opted out (Figure 4-3). Of the total, about a third of opt-out practitioners were behavioral health providers (psychologists, clinical social workers, and psychiatrists), and about 40 percent appeared to be dentists (see note in Figure 4-3).

Higher growth in the volume of clinician services

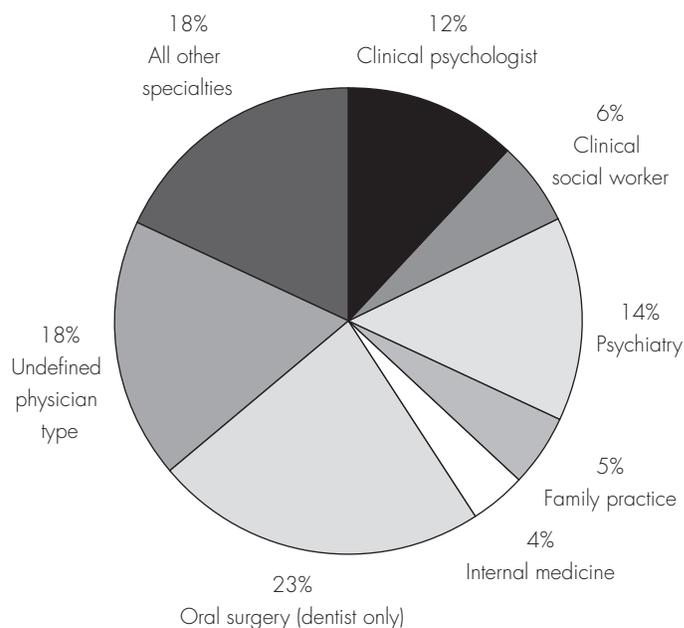
We analyze annual changes in use of services provided by physicians and other health professionals as another indicator of payment adequacy. However, we recommend caution in interpreting such data because factors unrelated to Medicare’s payment rates can influence service volume. Evidence indicates that volume decreases may be related to the movement of services from freestanding offices to hospitals, general practice pattern changes, and concerns expressed by clinicians about overuse of imaging and tests. For example, the number of echocardiograms per beneficiary administered in freestanding offices declined in 2015 by 3.0 percent while the number administered in hospital outpatient departments (HOPDs) rose by 4.7 percent. Increases in volume may signal overpricing if practitioners favor certain services because they are relatively profitable, but other factors—including changes in the population, disease prevalence, Medicare benefits, site of care, technology, and beneficiaries’ preferences—can also explain volume increases.

We used claims data from 2010, 2014, and 2015 to analyze volume changes. We identified the services furnished by physicians and other professionals billing under Medicare’s fee schedule and calculated two measures of changes in service use: units of service per beneficiary and volume of services per beneficiary. Volume is measured as units of service multiplied by each service’s relative value units (RVUs) from the fee schedule. Our volume growth measure thus accounts for changes in both the number of services and the complexity, or intensity, of those services. For example, growth in the volume of imaging services would account not just for any change in the number of such services but also for any change in intensity (e.g., if providers substitute computed tomography scans for less complex X-rays). We used RVUs for 2015 to put service volume for all years on a common scale.

Between 2014 and 2015, across all services, volume per beneficiary grew by 1.6 percent (Table 4-10, p. 112). Among broad service categories, growth rates were 1.7 percent for evaluation and management (E&M), 0.5 percent for imaging services, 1.4 percent for major procedures, 1.9 percent for other procedures, and 1.6 percent for tests. The 2015 growth rate for all services (1.6 percent) was higher than the average annual growth rate from 2010 to 2014 (0.3 percent).

FIGURE 4-3

Clinicians who opt out of Medicare are concentrated in certain specialties



Note: Based on web searches of some of the names of practitioners listed on CMS’s website as “undefined physician type,” it appears they are largely (or exclusively) dentists. Number of clinicians=17,191.

Source: Analysis of opt-out affidavits currently in effect as of November 2016 using data from <http://data.CMS.gov>.

Specific services within a broad service category sometimes experienced more rapid volume growth in 2015 than the overall service category. For example, volume growth was 1.4 percent in the major procedures category, but growth in the volume of knee replacement was 3.9 percent, and growth in the volume of hip replacement was 5.0 percent (Table 4-10, p. 112). Volume growth in the other procedures category was 1.9 percent, but growth in the volume of outpatient rehabilitation was 8.8 percent. Outpatient rehabilitation includes physical therapy, occupational therapy, and speech–language pathology services. Services furnished by physical therapists and occupational therapists accounted for most of the 2015 volume growth in outpatient rehabilitation.

While the imaging increase in 2015 was lower than the average increase for all services and follows decreases from 2010 to 2014, use of imaging services remains much higher than it was in 2000 (Figure 4-4, p. 113). Cumulative

**TABLE
4-10**
Use of clinician services per FFS beneficiary

Type of service	Change in units of service per beneficiary		Change in volume per beneficiary		Share of 2015 allowed charges
	Average annual 2010-2014	2014-2015	Average annual 2010-2014	2014-2015	
All services	0.0%	1.5%	0.3%	1.6%	100.0%
Evaluation and management	0.2	1.0	0.9	1.7	48.3
Office visit—new and established	0.6	1.1	1.2	2.1	27.0
Hospital visit—subsequent	-1.6	-0.5	-1.1	0.0	8.4
Hospital visit—initial	-1.1	-0.1	-1.1	-0.2	4.3
Emergency room visit	1.1	2.0	2.0	2.8	3.4
Nursing home visit	3.2	1.0	3.7	2.2	3.0
Hospital visit—critical care	2.0	0.8	2.0	0.7	1.5
Home visit	0.6	-2.5	0.7	-1.6	0.4
Imaging	-0.8	0.7	-1.8	0.5	10.7
Advanced—CT: other	2.3	5.2	1.6	4.2	1.6
Echography—heart	1.4	0.7	-3.5	-0.8	1.1
Advanced—MRI: other	1.2	3.6	-0.2	3.9	0.9
Echography—other	3.4	-4.2	2.4	-3.4	0.8
Standard—musculoskeletal	0.0	1.4	-0.5	1.2	0.8
Standard—nuclear medicine	-6.8	-3.4	-10.6	-4.9	0.7
Standard—breast	0.4	9.4	-0.4	9.4	0.7
Advanced—PET	0.4	1.2	2.7	3.3	0.6
Advanced—MRI: brain	0.2	1.4	-2.0	1.0	0.4
Advanced—CT: head	1.0	2.6	0.1	3.2	0.4
Standard—chest	-2.9	-1.3	-3.3	-1.1	0.4
Echography—abdomen and pelvis	0.0	0.0	0.1	-0.6	0.4
Major procedures	-0.9	1.2	0.2	1.4	7.5
Cardiovascular—other	-3.8	-0.5	-2.2	-0.4	1.7
Orthopedic—other	-0.3	2.3	1.1	3.2	1.2
Knee replacement	0.2	3.5	0.6	3.9	0.5
Hip replacement	3.1	4.8	3.6	5.0	0.3
Explore, decompress, or excise disc	2.0	-2.5	3.2	-2.6	0.3
Hip fracture repair	-1.0	-0.5	-0.8	-0.3	0.2
Coronary angioplasty	-1.1	1.9	-1.1	1.9	0.2
Coronary artery bypass graft	-5.6	-1.4	-5.2	-0.5	0.2
Other procedures	0.9	3.4	0.6	1.9	21.9
Skin—minor and ambulatory	0.9	0.8	0.8	2.0	4.7
Outpatient rehabilitation	2.1	8.3	2.8	8.8	3.7
Radiation therapy	-2.1	-6.5	-2.1	-3.6	1.9
Minor—other	-1.8	-1.6	-1.4	-1.5	1.8
Minor—musculoskeletal	1.3	2.0	1.6	4.3	1.5
Cataract removal/lens insertion	-0.5	0.6	-0.4	0.5	1.3
Eye—other	6.5	2.7	3.6	1.0	1.1
Colonoscopy	-0.6	0.2	-0.4	0.3	0.8
Upper gastrointestinal endoscopy	-1.1	-1.0	-0.9	-0.6	0.4
Cystoscopy	-0.8	-1.5	-1.4	-1.4	0.4
Tests	0.2	0.3	-1.3	1.6	4.5
Other tests	2.5	0.0	-0.8	0.0	1.7
Laboratory tests—other	0.5	-0.2	1.6	1.5	1.4
Electrocardiograms	-2.1	0.0	-2.5	0.1	0.4

Note: FFS (fee-for-service), CT (computed tomography), MRI (magnetic resonance imaging), PET (positron emission tomography). Volume is measured as units of service multiplied by each service's relative value unit (RVU) from the physician fee schedule. To put service use in each year on a common scale, we used the RVUs for 2015. For billing codes not used in 2015, we imputed RVUs based on the average change in RVUs for each type of service. Some low-volume categories are not shown but are included in the summary calculations. "Laboratory tests" includes tests billable under the fee schedule for physicians and other health professionals and excludes services billable under the laboratory fee schedule.

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

growth in the volume of imaging per beneficiary from 2000 to 2009 totaled 85 percent, compared with a cumulative decrease in imaging volume since then of about 8 percent. The growth in imaging volume from 2000 to 2009 was exceeded only by the 86 percent growth in the use of tests (e.g., allergy tests) during those years. Such growth was more than double the cumulative growth rates from 2000 to 2009 for E&M services and major procedures, which were 32 percent and 34 percent, respectively. In addition, volume increases in 2015 were much higher for certain types of advanced imaging than other types of imaging. The increases follow several years of lower volume growth. For example, in 2015, the volume of computed tomography (CT) for parts of the body other than the head (advanced—CT: other) grew by 4.2 percent (Table 4-10). By contrast, average annual volume growth from 2010 to 2014 for these services was 1.6 percent. Similarly, in 2015, the volume of MRI for parts of the body other than the head increased by 3.9 percent, after falling by 0.2 percent per year from 2010 to 2014.

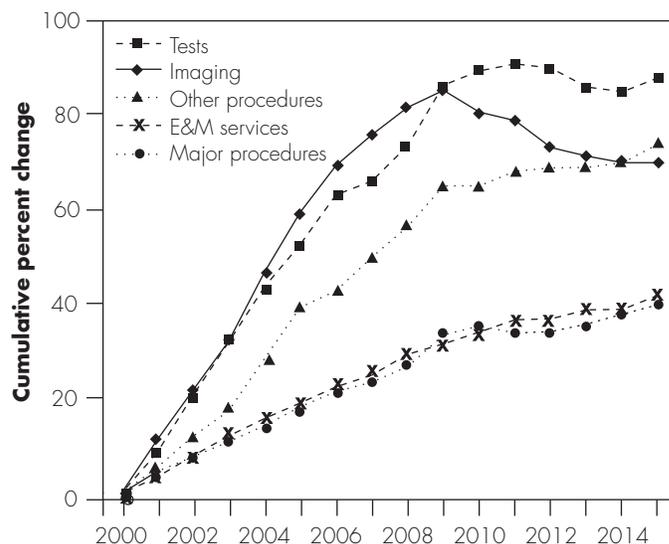
The relatively high use of imaging and tests has led to concerns about appropriate use of these services. Physicians have warned that diagnostic tests are often ordered without an understanding of how the results could change patient treatment (Hoffman and Cooper 2012, Redberg et al. 2011). Others have found that some clinicians routinely repeat tests and diagnostic procedures (Welch et al. 2012). When available, guidelines rarely specify how often to repeat these services. In response to concerns about overuse, the American Board of Internal Medicine (ABIM) Foundation developed the “Choosing Wisely” campaign. As part of this ongoing effort, more than 70 specialty societies have identified over 450 tests and procedures that are often overused (ABIM Foundation 2016). The goal of Choosing Wisely is to promote conversations between clinicians and their patients to help patients choose care that is supported by evidence, not duplicative of other tests or procedures, free from harm, and truly necessary. In addition, CMS is mandated by statute to require that claims for CT, MRI, and nuclear medicine studies include information about whether the services adhere to appropriate use criteria developed by medical societies or other provider-led entities. CMS is in the process of implementing this requirement.

Volume changes reflect shift in billing from freestanding offices to hospitals

Measuring volume growth has two advantages. First, it accounts for both changes in the number of services and

FIGURE 4-4

Growth in the volume of clinician services per fee-for-service beneficiary, 2000–2015



Note: E&M (evaluation and management). Volume growth for E&M from 2009 to 2010 is not directly observable because of a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2015, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

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

changes in the intensity of services (e.g., substitution of advanced imaging for X-rays). Second, together with changes in fees, volume growth has a significant impact on spending growth.

Volume growth, however, is sensitive to shifts in the site of care. The RVUs used to calculate volume include practice expense RVUs, which are often lower for services provided in a facility setting, such as an HOPD, compared with services in a nonfacility setting, such as a freestanding office. In 2016, for example, the most common type of E&M office visit had an average nonfacility fee schedule payment of \$73.⁴ By contrast, the average fee schedule payment for this visit when provided in a facility setting was \$52 because the practice expense RVUs are lower. Medicare makes both a fee schedule payment and a facility payment when a service is provided in an HOPD (the facility payment accounts for the cost of the service in an HOPD). However, the program makes only a fee schedule payment when a service is furnished in a freestanding

TABLE 4-11

Cardiovascular imaging services continue to shift from freestanding physicians' offices to HOPDs, 2014-2015

	Share of services performed in HOPDs, 2015	Per beneficiary change in units of service	
		HOPD	Freestanding office
Echocardiography	42.9%	4.7%	-3.0%
Nuclear cardiology	46.5	0.6	-5.9

Note: HOPD (hospital outpatient department). Echocardiography includes services in ambulatory payment classification (APC) 0269, APC 0270, and APC 0697. Nuclear cardiology includes services in APC 0377 and APC 0398.

Source: MedPAC analysis of outpatient claims and carrier claims for 100 percent of Medicare beneficiaries.

office. For example, in 2016, total payment for the most common E&M office visit when provided in an HOPD was \$154 (\$52 for the fee schedule payment to the clinician plus \$102 for the facility payment to the HOPD) compared with \$73 (the nonfacility fee schedule payment) for this visit when provided in a freestanding office.

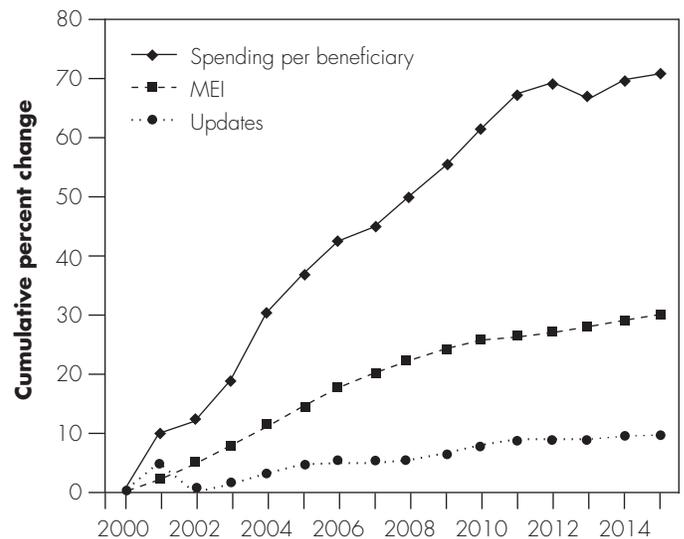
In recent years, there has been a trend toward billing for some services in hospitals instead of freestanding offices. From 2012 to 2015, for example, hospital-based E&M visits per beneficiary grew by 22 percent, compared with a 1 percent decline in physician office-based visits. There has also been a shift of echocardiography and nuclear cardiology from freestanding offices to HOPDs. This change in setting increases overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in HOPDs than in freestanding offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012). For example, we estimate that the Medicare program spent \$1.0 billion more in 2009, \$1.3 billion more in 2014, and \$1.6 billion more in 2015 than it would have if payment rates for E&M office visits in HOPDs were the same as freestanding office rates. In addition, beneficiaries' cost sharing for E&M office visits in HOPDs was \$260 million higher in 2009, \$325 million higher in 2014, and \$400 million higher in 2015 than it would have been had payment rates been the same in both settings.

Decrease in volume of cardiovascular imaging influenced by shift in billing from freestanding offices to hospitals

From 2014 to 2015, the volume of two types of cardiovascular imaging billed under the fee schedule declined: echography—heart, also known as echocardiography, and nuclear cardiology, which is in the nuclear medicine service category (Table 4-10, p. 112). This decrease was influenced by a shift in billing for these services from freestanding offices to HOPDs (Table 4-11). During this period, the number of echocardiograms per beneficiary delivered in HOPDs rose by 4.7 percent, compared with a 3.0 percent decline in freestanding offices. Similarly, the number of nuclear cardiology studies per beneficiary provided in HOPDs increased by 0.6 percent, compared with a 5.9 percent decline in freestanding offices. These changes in billing patterns are consistent with reports of an increase in hospital-owned cardiology practices (American College of Cardiology 2012).

FIGURE 4-5

Growth in the volume of clinician services has caused fee schedule spending to increase faster than input prices and updates, 2000-2015



Note: MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. Spending per beneficiary includes only services paid under the fee schedule for physicians and other health professionals and excludes services paid under the clinical laboratory fee schedule.

Source: 2016 annual report of the Boards of Trustees of the Medicare trust funds; Clemens 2014.

Across all services, volume growth has contributed to an increase in spending

The growth in service volume has contributed significantly to an increase in spending for fee schedule services (Figure 4-5). From 2000 to 2015, payment updates for these services have not kept pace with growth in input prices. Payment updates increased cumulatively by 10 percent—less than the 30 percent cumulative increase in the Medicare Economic Index (MEI), which measures changes in input prices. However, spending per beneficiary for these services grew at a cumulative rate of 71 percent, which includes the effect of the sequester. Volume growth, which accounts for most of the difference between the payment updates and spending growth, may reflect changes in clinical practice, such as the diffusion of new technologies, as well as changes in the demographic and health status of beneficiaries.⁵

In 2015, per beneficiary spending for fee schedule services increased by 0.6 percent. Several factors influenced the size of this change: the small increase in volume, the small increase in the fee schedule conversion factor (0 percent during the first half of 2015 and 0.5 percent during the second half of 2015), and payment adjustments outside of the update process (e.g., the Physician Quality Reporting System (PQRS) payment adjustment).

Quality of care

CMS assesses the quality of Medicare-billing physicians and other health professionals based largely on clinician-reported individual quality measures. Clinicians select a set number of measures to report from about 300 measures in the PQRS measure set. These clinician-reported measures are currently used in the Medicare value-based payment modifier (known as the “value modifier”) and will form the quality component of the Merit-based Incentive Payment System (MIPS). The MIPS will be used to make payment adjustments starting in 2019 based on four areas: quality, resource use, clinical practice improvement activities, and advancing care information (formerly meaningful use of electronic health records) (Centers for Medicare & Medicaid Services 2016a).

The Commission has repeatedly raised concerns with Medicare’s current clinician quality programs and resulting payment adjustments. First, the quality reporting requirements are confusing and burdensome to providers, and the link between performance and the resulting payment adjustment is unclear. Second, the quality

reporting process does not allow creation of a national performance benchmark across the entire universe of clinicians. Third, many of the quality measures are not linked to outcomes of importance for the beneficiary. And fourth, the measures do not generally assess low-value care.

Clinicians can choose the measures from PQRS that they wish to report, resulting in small case sizes and compressed performance. As a result, CMS’s ability to differentiate performance is limited; either clinicians are not found to be different from average (the approach taken in the current value modifier) or clinicians receive different payment adjustments based on minimal differences in performance (the approach that will be used in the MIPS). The most commonly reported quality measure in 2014 was measure 130: *Documentation of current medications in the medical record* (Table 4-12, p. 116).

The current PQRS measure set has few measures assessing low-value care, and few clinicians report these measures. Low-value care is a significant issue in Medicare. For example, a Commission analysis found that between 23 percent and 38 percent of beneficiaries received at least one low-value service in 2013 (see text box, pp. 118–119).

The Commission has also considered ways of assessing aggregate performance on a few key outcomes measures of interest to patients in lieu of a large number of process measures. However, outcome measures such as readmissions, mortality, and avoidable hospitalizations are often unreliable at the individual clinician level and become measurable with some certainty only when clinicians are organized into larger entities or practices. As a result, in this chapter, we present aggregate national data and local market-area data for two population-based measures of potentially avoidable events that can gauge the quality of a community’s ambulatory care environment.

First are the Prevention Quality Indicators (PQIs), developed by the Agency for Healthcare Research and Quality. These measures assess rates of hospitalizations for ambulatory care-sensitive conditions. Figure 4-6 (p. 116) presents results for three common conditions among the Medicare population—diabetes, congestive heart failure, and bacterial pneumonia. The trends show largely falling rates across all three conditions and the age categories, with the exception of potentially avoidable hospitalizations for congestive heart failure in 2014. The increase was likely due to hospitals changing their behavior in response

**TABLE
4-12**

Top five PQRS measures reported by clinicians, 2014

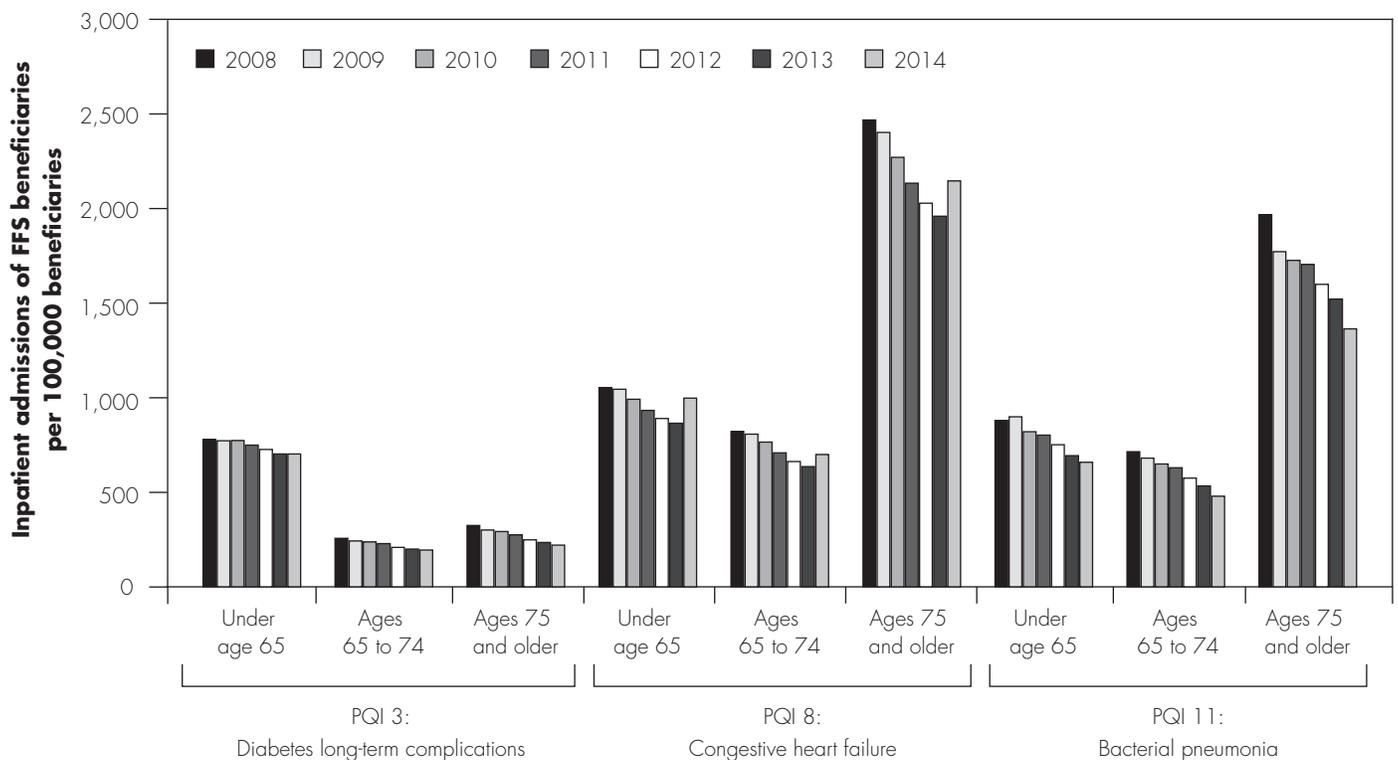
Rank	Measure number	Measure	Number of clinicians reported	Mean performance rate across all reporting options
1	130	Documentation of current medications in the medical record	156,727	84%
2	226	Preventive care and screening: Tobacco use: Screening and cessation intervention	111,522	89
3	128	Preventive care and screening: Body mass index screening and follow-up	104,996	64
4	131	Pain assessment and follow-up	61,385	84
5	111	Pneumonia vaccination status for older adults	60,235	50

Note: PQRS (Physician Quality Reporting System).

Source: Centers for Medicare & Medicaid Services, PQRS Experience Report, 2015 Quality and Resource Use Reports baseline performance.

**FIGURE
4-6**

Trends in selected Prevention Quality Indicators for inpatient admissions of FFS beneficiaries for ambulatory care-sensitive conditions, 2008-2014



Note: FFS (fee-for-service), PQI (Patient Quality Indicator). Figures represent the number of hospital admissions for the identified condition for Medicare beneficiaries in each age range per 100,000 beneficiaries. Only FFS beneficiaries with both Part A and Part B are included. Beneficiaries who died during the year are included.

Source: CMS, data on geographic variation. Figures calculated by CMS from the Chronic Conditions Data Warehouse of 100 percent of claims.

**TABLE
4-13**

Distribution of PPAs and PPVs in 2014 across all market areas

	Rate	
	PPA	PPV
Mean (population weighted)	1.00	1.00
Percentile		
10th (highest performing)	0.85	0.24
25th	0.94	0.72
50th (median)	1.06	0.98
75th	1.19	1.14
90th (lowest performing)	1.32	1.29
Difference between 90th and 10th percentile	0.47	1.05

Note: PPA (potentially preventable admission), PPV (potentially preventable [emergency department] visit). Rates were calculated using 3M™ PPA/PPV software. A market area with a ratio less than 1.00 is a higher performing area; its actual rate of PPAs/PPVs is lower than the rate that is predicted based on the age and disease severity of beneficiaries who reside in that area. An area with a ratio greater than 1.00 is a lower performing area; its rate of PPAs/PPVs is greater than the rate that is predicted based on the age and disease severity of beneficiaries who reside in that area. There are 1,227 local market areas.

Source: Analysis of 2013 and 2014 100 percent Part A and Part B claims data.

to CMS’s “two-midnight” rule that instructed Medicare auditors on how to differentiate between appropriate inpatient admissions and observation status.

Second, we present rates of potentially preventable admissions (PPAs) and potentially preventable visits (PPVs) to the emergency department. PPAs are hospital admissions that may have resulted from a lack of adequate ambulatory care access and coordination. PPVs are emergency department visits that, like PPAs, may reflect the effectiveness of the ambulatory care system. The PPAs and PPVs are based on the premise that, while not every PPA and PPV can be averted, comparatively high risk-adjusted rates of these events can identify opportunities for improvement in an area’s ambulatory care systems.

Rates of these events vary across local market areas.⁶ The rates are presented as a ratio of the actual rate to the rate that would be expected given the population’s age and burden of chronic illness. Rates below 1.00 are better because the market area has fewer than expected PPAs or PPVs. Table 4-13 displays the distribution of percentiles, showing that PPV and PPA rates varied by market area. PPV rates show a wider variation (90th to 10th percentile: 1.05) compared with the rates of PPAs (90th to 10th percentile: 0.47). The geographic variation in PPAs and

PPVs may indicate opportunities for ambulatory care improvement.

The Commission plans to continue to refine a set of population-based outcome measures, such as PPA and PPV, that Medicare can calculate using claims data.

Medicare payments and providers’ costs

Because physicians and other health professionals do not report their costs to the Medicare program, we use other measures to assess the adequacy of Medicare payments relative to clinicians’ costs. The first measure is how Medicare’s payments compare with the commercial rates paid by preferred provider organizations (PPOs). The second measure is whether Medicare’s fee schedule contributes to differences in physician compensation across specialties—even after accounting for the cost of running a practice. The third measure assesses input prices for physicians and other health professionals—the MEI. We also review payment adjustments made in addition to the conversion factor update.

Ratio of Medicare payments to commercial PPO payments did not change

In 2015, Medicare’s payment rates for physician and other health professional services (including cost sharing) were

Research shows substantial use of low-value care in fee-for-service Medicare

Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit (Chan et al. 2013, Kale et al. 2013). In addition to increasing health care spending, low-value care has the potential to harm patients by exposing them to the risks of injury from inappropriate tests or procedures and may lead to a cascade of additional services that contain risks but provide little or no benefit (Keyhani et al. 2013, Korenstein et al. 2012). The “Choosing Wisely” campaign, an initiative of the American Board of Internal Medicine (ABIM) Foundation, identifies services that represent low-value care. In the latest iteration of this ongoing effort, over 70 specialty societies have identified more than 450 tests and procedures that are often overused (ABIM Foundation 2016).

A team of researchers developed 31 measures of low-value care drawn from evidence-based lists (such as Choosing Wisely), recommendations by the United States Preventive Services Task Force, and the medical literature, which they applied to Medicare claims data from 2009 through 2012 (Schwartz et al. 2015, Schwartz et al. 2014). The authors developed two versions of each measure: a broader one with higher sensitivity (and lower specificity) and a narrower one with lower sensitivity (and higher specificity). Increasing the

sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure’s specificity leads to less misclassification of appropriate use as inappropriate, at the expense of potentially missing some instances of inappropriate use.

The Commission contracted with the authors of these studies to obtain the measures’ specifications and their algorithms, which we applied to Medicare claims data from 2013. We developed two versions of each measure based on the original studies: a broader version (more sensitive, less specific) and a narrower version (less sensitive, more specific). For each version, we calculated the number of low-value services per 100 beneficiaries, the share of beneficiaries who received at least one low-value service, and total spending across all fee-for-service (FFS) beneficiaries for each service.

Our results show substantial use of low-value care in FFS Medicare. Based on the broader versions of the measures, our analysis showed 74 instances of low-value care per 100 beneficiaries in 2013, and 38 percent of beneficiaries received at least 1 low-value service. Medicare spending for these services in 2013 was \$7.1 billion, or 2.1 percent of FFS Medicare spending for the beneficiaries in our sample. Based on the narrower versions of the measures, our analysis showed 35 instances of low-value care per 100 beneficiaries in

(continued next page)

78 percent of commercial rates for PPOs, the same ratio as in 2014. The ratio has declined slightly since 2010, when it was 81 percent. The 2015 ratio varied by type of service. For example, Medicare’s fees were 84 percent of commercial rates for office visits for new and established patients, but 72 percent of commercial rates for cataract removal and lens insertion procedures. This analysis used data on paid claims for PPO members of a large national insurer that covers a wide geographic area across the United States. The payments reflect the insurer’s allowed amount with 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. We note that the ratio of Medicare rates to commercial rates may vary by practice type, practice size, and geographic area. For example, some large physician groups in California have been able to negotiate much higher rates with commercial plans than smaller groups (Berenson et al. 2010b).

We also examined information on the growth of prices for professional services from the Health Care Cost Institute (HCCI), which compiles data from four national insurance companies: Aetna, Humana, Kaiser Permanente, and UnitedHealthcare. Professional services include office

Research shows substantial use of low-value care in fee-for-service Medicare (cont.)

2013, and 23 percent of beneficiaries received at least 1 low-value service. Medicare spending for these services totaled \$2.6 billion, or 0.8 percent of FFS Medicare spending for the beneficiaries in our sample. The differences between the broader and narrower versions of the measures demonstrate that the amount of low-value care detected varies substantially based on the measures' clinical specificity.

We used claims data to measure low-value care, and claims do not include detailed clinical information. Therefore, our analysis likely represents a conservative estimate of the number of low-value services in Medicare. In addition, our spending estimates probably understate actual spending on low-value care because they do not include downstream services (e.g., follow-up tests and procedures) that may result from the initial low-value service.

Among the measures' broader versions, measures with the highest volume were imaging for low back pain (11.9 per 100 beneficiaries), prostate-specific antigen (PSA) screening for men ages 75 and over (9.2), and colon cancer screening for older adults (8.4). Those with the highest Medicare spending were percutaneous coronary intervention with balloon angioplasty or stent placement for stable coronary disease (\$1.3 billion), stress testing for stable coronary disease (\$1.3 billion), and spinal injection for low back pain (\$1.3 billion).

Among the measures' narrower versions, measures with the highest volume were PSA screening for men ages 75 and over (5.2 per 100 beneficiaries), carotid artery disease screening in asymptomatic patients (4.3), and parathyroid hormone measurement for patients with early chronic kidney disease (3.8). Those with the highest Medicare spending were spinal injection for low back pain (\$654 million), vertebroplasty or kyphoplasty for osteoporotic vertebral fractures (\$359 million), and screening for carotid artery disease in asymptomatic adults (\$234 million).

For more details on the volume and spending for individual measures, see the Commission's June 2016 data book (<http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-5-quality-of-care-in-the-medicare-program.pdf?sfvrsn=0>).

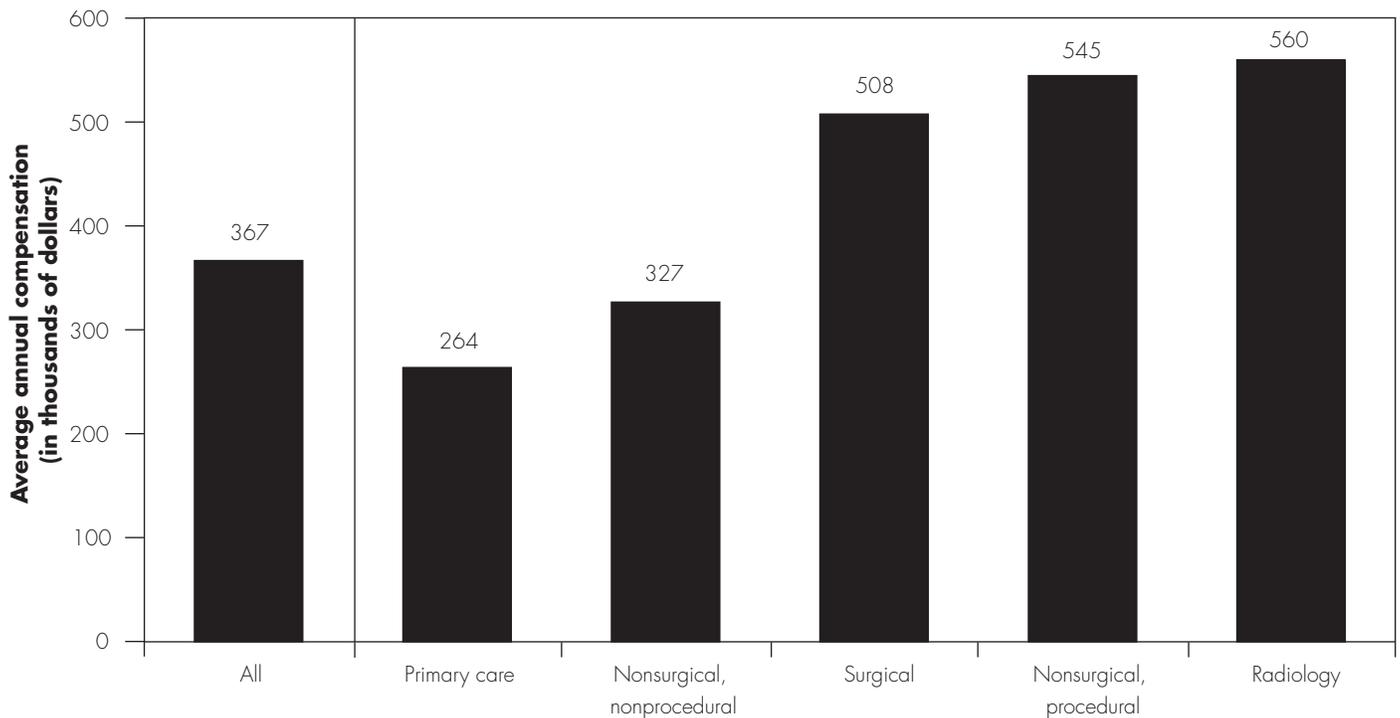
After grouping the 31 measures into 6 larger clinical categories, we found that imaging and cancer screening measures accounted for 60 percent of the volume of low-value care per 100 beneficiaries among the measures' broader versions. However, cardiovascular testing and procedures and other surgical procedures constituted over 70 percent of the spending. Among the measures' narrower versions, two categories (imaging and diagnostic and preventive testing) accounted for 60 percent of the volume of low-value care, while other surgical procedures and imaging made up two-thirds of the spending. ■

visits, surgery, radiology, anesthesia, lab/pathology, and physician-administered drugs. Between 2012 and 2015, the average intensity-adjusted price of a professional service increased at an average annual rate of 2.0 percent (the intensity-adjusted price adjusts for changes in the complexity of services) (Health Care Cost Institute 2016). By comparison, the Medicare update for physician and other health professional services grew at an average annual rate of 0.2 percent from 2012 to 2015. However, a key difference between the HCCI data and the Medicare update is that the HCCI data include prices for physician-administered drugs, which have been growing at a rapid

rate, and the Medicare update does not apply to physician-administered drugs. Therefore, this comparison should be interpreted with caution.

Compensation is much higher for certain specialties than for primary care

The Commission remains concerned that the fee schedule and the nature of FFS payment leads to an undervaluing of primary care and an overvaluing of specialty care. First, the Commission has concerns that the resource-based relative value scale, which forms the basis for the fee schedule, includes mispriced services and that these

**FIGURE
4-7****Disparities in physician compensation are widest when primary care physicians are compared with nonsurgical proceduralists and radiologists, 2015**

Source: MedPAC analysis of data from the Medical Group Management Association's Physician Compensation and Production Survey, 2015.

mispriced services cause an income disparity between primary care and specialty physicians. Second, FFS payment allows some specialties to more easily increase the volume of services they provide (and therefore their revenue from Medicare), while such increases are less likely for other specialties, particularly those that spend most of their time providing E&M services.

For an analysis of the compensation received by physicians—the largest subset of practitioners—we examined data from the Physician Compensation and Production Survey from 2015, conducted by the Medical Group Management Association (MGMA). Averaged across all specialties, physician compensation was about \$367,000 in 2015, 4 percent higher than average compensation in 2014 (\$354,000). Within these averages, compensation was much higher for some specialties than others. The specialty groups with the highest compensation were radiology (average compensation of

\$560,000) and the nonsurgical, procedural group (average compensation of \$545,000) (Figure 4-7).⁷ Compensation for these groups was almost double the compensation of some of the specialties in the nonsurgical, nonprocedural group—such as psychiatry (average compensation of \$289,000)—and was more than double the compensation for primary care physicians (average compensation of \$264,000).⁸ Our analysis of 2012 and 2014 data from MGMA showed similar disparities.

Previous Commission work using MGMA data showed that such disparities also existed when compensation was observed on an hourly basis, thus accounting for variations in hours worked per week.⁹ In addition, the disparities persist when compensation is simulated as if all services physicians provide were paid under Medicare's fee schedule (Berenson et al. 2010a). This finding suggests that the fee schedule is an important source of the disparities in compensation among specialties.

Commission recommendation for a per beneficiary payment for primary care

The Commission has a long-standing concern that primary care is undervalued by the Medicare fee schedule for physicians and other health professionals compared with specialty care. The Commission has also become concerned that the fee schedule is an ill-suited payment mechanism for primary care. The Commission, in its March 2015 report, recommended that the Congress establish a per beneficiary payment for primary care to replace the expired Primary Care Incentive Payment (PCIP) program, which provided a 10 percent bonus payment on fee schedule payments for primary care visits provided by primary care providers (Medicare Payment Advisory Commission 2015). The recommended

monthly per beneficiary payment based on PCIP payments would initially amount to about \$2.60.

The Commission recommended that the additional payments to primary care practitioners be in the form of a per beneficiary payment as a step away from the service-oriented fee-for-service payment approach. Funding for the per beneficiary payment would come from reducing fees for all services in the fee schedule other than PCIP-defined primary care services provided by any practitioner. This method of funding would be budget neutral and would help rebalance the fee schedule to achieve greater equity of payments between primary care and other services. ■

Validation of the fee schedule's RVUs can help correct the fee schedule's inaccuracies and ensure that physicians at the high end of the compensation scale are not overcompensated. CMS has a statutory mandate and resources to validate RVUs, and the Commission has provided CMS with ideas for how to do so (Medicare Payment Advisory Commission 2015). In addition, the Commission made a recommendation in 2015 for a per beneficiary payment for primary care that could help redistribute Medicare spending to primary care from other services (see text box about this recommendation).

To better support primary care and patient-centered care management, CMS introduced new billing codes for chronic care and transitional care management services in recent years. These codes were implemented in a budget-neutral manner. The use of these new services has been growing, and Medicare spent almost \$180 million on them in 2015 (see text box, pp. 124–125). Primary care clinicians provide about 90 percent of these services.

Input costs for physicians and other health professionals are projected to increase from 2017 to 2018

The MEI measures the change in the market basket of input prices for physician and other health professional services and is adjusted for economy-wide productivity.¹⁰ CMS's current forecast is that the MEI will increase by 2.4 percent in 2018 (IHS Markit LTD 2016).

Payment adjustments outside of the update process also affect spending

Medicare spending for the services of physicians and other health professionals is also affected by bonuses, penalties, and payment adjustments. The effect of these adjustments can be large and help explain the portion of spending increases or decreases not explained by updates or volume growth.

Table 4-14 (p. 122) shows these adjustments in two categories: direct payment adjustments and payment adjustments for incentive programs. Some of the incentive programs are changing from payment incentives to payment penalties. The Primary Care Incentive Payment program expired at the end of 2015. In addition, the electronic health record meaningful use requirement, PQRS, and value modifier will be phased out at the end of 2018 and replaced by the MIPS.

How should Medicare payments change in 2018?

The Commission's deliberations on payment adequacy for physicians and other health professionals are informed by beneficiary access to services, volume growth, quality, and input prices for physicians and other health professionals.

**TABLE
4-14**

Payment adjustments for clinicians billing Medicare, 2015

Category	Adjustment	Number of providers	Spending impact (in millions)	Source and notes
Direct payment adjustments	HPSA payment adjustment	52,323	+\$135	2015 analysis of claims
	Work GPCI floor	Not available	+400	CBO estimate of MACRA, 2014
	Sequester	All billing providers (about 1,200,000)	-1,400	Estimate based on 2016 Trustees' report
	Primary Care Incentive Payment	192,211	+686	2015 analysis of claims
Payment adjustments for incentive programs	PQRS payment adjustment	448,872	-400	Provider data for 2013, estimated spending impact. Failure to report resulted in a PQRS penalty of 1.5% in 2015.
	EHR incentive	193,452	+929	CMS payment summary, 2015
	EHR payment adjustment	Not yet released	Not yet released	Failure to meet meaningful use in 2015 resulted in 1% penalty

Note: HPSA (health professional shortage area), GPCI (geographic practice cost index), CBO (Congressional Budget Office), MACRA (Medicare Access and CHIP Reauthorization Act of 2015), PQRS (Physician Quality Reporting System), EHR (electronic health record).

Source: CMS/Office of the Actuary, annual report of the Boards of Trustees of the Medicare trust funds, Congressional Budget Office, Department of Health and Human Services.

We find that, on the basis of these indicators, payments appear adequate.

On measures of access to the services of physicians and other health professionals, the Commission continues to find that beneficiary access to care appears generally stable. Overall, Medicare beneficiaries generally have access comparable with privately insured individuals ages 50 to 64. Our beneficiary access survey shows a small reported decline in recent years among the share of beneficiaries accessing care as soon as wanted. These modest declines in reported access appear to be occurring for both Medicare and privately insured individuals. To the extent there are true changes in access, they may be the result of broader changes in health care delivery, not Medicare policies in particular. In addition, other surveys covering similar time periods do not show a decline in reported access among Medicare beneficiaries. The number of primary care physicians per beneficiary stayed

the same, a slight decline in the number of non-primary care physicians per beneficiary was more than offset by an increase in the number of advanced practice registered nurses and physician assistants per beneficiary, and the share of providers enrolled in Medicare's participating provider program remains high.

In 2015, across all services, volume per beneficiary grew by 1.6 percent. Among broad categories of service, growth rates were 1.7 percent for E&M, 0.5 percent for imaging services, 1.4 percent for major procedures, 1.9 percent for other procedures, and 1.6 percent for tests (Table 4-10, p. 112).

As of the third quarter of 2016, input prices for physicians and other health professionals were projected to increase by 2.4 percent in 2018. We note that this projection is subject to change. In 2015, compensation was much lower for primary care physicians than for physicians in certain

specialties, continuing to raise concerns about fee schedule mispricing and its impact on primary care.

Update recommendation

In recommending an update for physicians and other health professionals, the Commission balanced the following objectives:

- maintain beneficiary access to physician and other health professional services,
- minimize the burden on the taxpayers and beneficiaries who finance the Medicare program, and
- ensure adequate payments for the efficient provision of services.

In balancing these objectives with the overall finding that payments appear adequate, the Commission recommends an update for 2018 consistent with current law.

RECOMMENDATION 4

The Congress should increase payment rates for physician and other health professional services by the amount specified in current law for calendar year 2018.

RATIONALE 4

The Medicare Access and CHIP Reauthorization Act of 2015 established a set of statutory updates for clinicians, including a 0.5 percent update for 2018. Overall, access to clinician services for Medicare beneficiaries appears stable and comparable with that for privately insured individuals. Other measures of payment adequacy are stable and consistent with prior years. Therefore, the Commission does not see a reason to diverge from the current law update of 0.5 percent for 2018.

IMPLICATIONS 4

Spending

- No change as compared with current law.

Beneficiary and provider

- The Commission's recommendation of the current law update is unlikely to affect beneficiaries' access to care and providers' willingness and ability to furnish care. ■

Chronic care management and transitional care management services

To improve payment for and encourage the use of care management services, CMS instituted separate payments for chronic care management (CCM) and transitional care management (TCM) services in recent years.

Chronic care management

In 2015, Medicare began paying separately for non-face-to-face CCM services through the fee schedule. The 2015 base payment rate for a CCM service was \$43 when performed in a physician's office and \$87 when performed in a hospital outpatient department (HOPD). Beneficiaries are responsible for 20 percent coinsurance for these services. Providers are able to bill for this new service when they provide at least 20 minutes of care management services in a calendar month to beneficiaries with 2 or more chronic conditions that place them at a significant risk of death, acute exacerbation/decompensation, or functional decline. CMS established several requirements for providers to bill a CCM service, such as creating an electronic patient-centered care plan, providing 24/7 access to care, and managing care transitions between health care settings. Billing for these services is not limited to primary care clinicians.

We examined the use and spending associated with CCM services in 2015 and the characteristics of beneficiaries who received them. We found the following:

- Clinicians billed for just under 1 million CCM services on behalf of 292,000 beneficiaries, for an average of 3.4 services per beneficiary.
- The number of beneficiaries who received a CCM service in a given month increased steadily from 21,000 in January to 127,000 in December.
- Payments totaled \$41 million, with Medicare paying \$33 million and beneficiaries paying \$8 million.
- Primary care practitioners provided 87 percent of CCM services, with cardiology being the highest billing non–primary care specialty at 5 percent of CCM services.

- Only 7,900 providers billed for a CCM service across the entire year.
- Beneficiaries who received at least one CCM service were older and more likely to be eligible for Medicaid, female, non-White, and residing in an urban area compared with all Medicare fee-for-service (FFS) beneficiaries. They were also less likely to be eligible for Medicare because of disability.

CMS has received feedback from providers that the requirements to bill for a CCM service are burdensome and redundant, which prevents them from providing the services to beneficiaries who could benefit from them (Centers for Medicare & Medicaid Services 2016b). Further, providers said that the service is undervalued, given that they often spend far more than the minimum of 20 minutes per beneficiary per month performing CCM services. Given this feedback and the agency's mandate under the Medicare Access and CHIP Reauthorization Act of 2015 to encourage beneficiaries with chronic conditions to receive CCM services, CMS added multiple new CCM codes and eased the billing requirements for CCM services. In 2017, CMS added a higher paid code for 60 minutes of complex CCM, an add-on code for each additional 30 minutes of complex CCM, and an add-on code for an extensive face-to-face assessment and care planning provided during an evaluation and management (E&M) visit that initiates CCM services. In addition, CMS relaxed several requirements for CCM services. For example, beginning in 2017, CMS no longer requires written beneficiary consent to receive CCM services, access to the electronic care plan outside of normal business hours to those providing the CCM services, or CCM services to be initiated during an E&M visit for established patients.

Transitional care management

In 2013, CMS instituted separate payments for TCM services for beneficiaries who require moderate- or high-complexity medical decision making. TCM services are intended to pay providers for managing a beneficiary's care for 30 days after discharge from

(continued next page)

Chronic care management and transitional care management services (cont.)

certain institutional settings, such as an inpatient acute care hospital, inpatient psychiatric hospital, or skilled nursing facility. To bill for a TCM service, a provider must have interactive contact with the beneficiary, such as a phone call or e-mail, within 2 business days following the beneficiary's discharge; have a face-to-face visit within 14 days of discharge for beneficiaries requiring moderately complex medical decision making or within 7 days for beneficiaries requiring highly complex medical decision making; and perform certain non-face-to-face services as necessary, such as reviewing discharge information, assisting in scheduling follow-up appointments, and establishing referrals for needed community resources. Medicare pays only one practitioner per discharge for a TCM service; Medicare pays the first eligible claim submitted during the 30-day period after discharge. In 2015, the Medicare base payment rate for a TCM service with moderately complex medical decision making was \$166 if provided in a physician's office and \$218 if provided in an HOPD. For a TCM service with highly complex medical decision making, the 2015 payment rate was \$232 if provided in a physician's office or \$268 if provided in an HOPD. Beneficiaries are responsible for 20 percent coinsurance for these services.

We examined the utilization and spending associated with TCM services from 2013 through 2015 and the characteristics of beneficiaries who received them in 2015. We found the following:

- The number of beneficiaries who received a TCM service increased from 267,000 in 2013 to 616,000 in 2015.
- The number of TCM services increased from 298,000 in 2013 to 722,000 in 2015, with most beneficiaries receiving only 1 service per year throughout the time period.
- Total Medicare and beneficiary spending on TCM services has increased from \$56 million in 2013 to \$136 million in 2015.
- The share of TCM services performed in physicians' offices decreased from 91 percent in 2013 to 88 percent in 2015, while the share performed in the more expensive HOPD setting increased from 5 percent to 7 percent over the same time period.
- In each year, about 93 percent of TCM services were performed by primary care providers.
- The number of providers who billed at least 1 TCM service per year increased from about 31,000 in 2013 to about 51,000 in 2015.
- Beneficiaries who received at least one TCM service in 2015 were older and more likely to be eligible for Medicaid and to be female, White, and residing in an urban area compared with all Medicare FFS beneficiaries. They were also less likely to be eligible for Medicare because of disability. ■

Endnotes

- 1 For further information, see the Commission's *Payment Basics: Physician and Other Health Professionals Payment System* at http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_physician_final.pdf?sfvrsn=0.
- 2 The 0.25 percent increase in the conversion factor is smaller than the 0.5 percent statutory update due to three adjustments: a relative value unit budget-neutrality adjustment of -0.013 percent, a misvalued-services target recapture amount of -0.18 percent, and an imaging multiple-procedure payment reduction adjustment of -0.07 percent.
- 3 Under prior law, clinicians had to affirmatively renew them every two years.
- 4 The Current Procedural Terminology code for this visit is 99213. The total nonfacility fee includes work RVUs, practice expense RVUs, and professional liability insurance RVUs.
- 5 The effect of population changes in age and sex on Medicare spending for physician and other health professional services has generally been small in the recent past, and physician spending varies less by age than spending for other services, such as inpatient hospital and post-acute care.
- 6 The Commission has defined market areas that best match insurance markets served by private plans. There are about 1,231 market areas in the 50 states and the District of Columbia. In urban areas, we use collections of counties located in the same state and the same core-based statistical area (CBSA), which is a collective term for both metropolitan and micropolitan areas. Among counties outside CBSAs, we use health service areas, which are collections of counties where most of the short-term hospital care received by beneficiaries living in those counties occurs in hospitals in the same collection of counties.
- 7 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.
- 8 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hematology/oncology, nephrology, neurology, physiatry, rheumatology, hospital medicine, and urgent care. The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.
- 9 To account for differences among specialties in hours worked per week, an earlier analysis based on MGMA data from 2007 included comparisons of hourly compensation. The results were similar to those from the analysis of 2015 data on annual compensation: Hourly compensation for nonsurgical, procedural specialties and radiology was more than double the hourly compensation rate for primary care. Analysis of hourly compensation was not possible with the 2015 data because the newer MGMA survey did not include questions about hours worked.
- 10 The MEI measures the weighted average annual price change for various inputs used by physicians and other health professionals to furnish services.

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