

CHAPTER

4

**Physician and other health
professional services**

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

- 4** For calendar year 2019, the Congress should increase the calendar year 2018 payment rates for physician and other health professional services by the amount specified in current law.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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 2016, Medicare paid \$69.9 billion for physician and other health professional services, accounting for 15 percent of fee-for-service (FFS) Medicare benefit spending. About 952,000 clinicians billed Medicare—nearly 589,000 physicians and almost 363,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners. Medicare pays for the services of physicians and other health professionals using a fee schedule.

Assessment of payment adequacy

We use the following factors to assess payment adequacy for physicians and other health professionals: beneficiaries' access to care, the supply of providers, 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. 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.

In this chapter

- Are Medicare fee schedule payments adequate in 2018?
- How should Medicare payments change in 2019?

- **Supply of providers**—The number of physicians per beneficiary declined slightly, the number of advanced practice registered nurses and physician assistants per beneficiary rose, and the share of providers enrolled in Medicare’s participating provider program remains high.
- **Volume of services**—In 2016, across all services, volume per beneficiary grew by 1.6 percent. Among broad service categories, growth rates were 1.1 percent for evaluation and management services, 1.4 percent for imaging services, 2.8 percent for major procedures, 2.5 percent for other procedures, and 1.7 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. Starting in 2019, clinicians’ Medicare FFS payments will be adjusted through the Merit-based Incentive Payment System, which assesses quality, cost, use of advancing care information (electronic health record technology), and use of clinical practice improvement activities. We report two population-based quality measures—avoidable hospitalizations 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 2019 in the Medicare Economic Index will be 1.8 percent. In 2016, Medicare payment rates for physician and other health professional services were 75 percent of commercial rates for preferred provider organizations, compared with 78 percent in 2015. Average compensation in 2016 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 that the 2019 payment rates for physician and other health professional services be updated by the amount specified in current law. (Subsequent to the Commission’s vote on this update recommendation, the Bipartisan Budget Act of 2018 changed the 2019 current-law update to the fee schedule from 0.5 percent to 0.25 percent.) ■

Background

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

In 2016, the Medicare program paid \$69.9 billion for physician and other health professional services, or 15 percent of benefit spending in Medicare’s traditional fee-for-service (FFS) program. In 2016, about 952,000 health professionals billed Medicare through the fee schedule—nearly 589,000 physicians and almost 363,000 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 clinician 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 \$35.89 in 2017 and is \$36.00 in 2018. The change to the conversion factor for 2018 reflects the net effect of three changes: a statutory update of 0.5 percent, a 0.10 percent reduction due to a relative value unit (RVU) budget-neutrality adjustment, and a 0.09 percent reduction because CMS did not meet its target for adjusting the prices of misvalued services.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—the sustainable growth rate (SGR) formula—that set the conversion factor. The SGR was established to limit total fee schedule spending by restraining annual updates when spending exceeded certain parameters. MACRA provides a new framework for updating clinician payments. It establishes two payment paths: a payment path for clinicians who participate in advanced alternative payment models (A-APMs) and a payment path for other clinicians (Table 4-1).

**TABLE
4-1**

Statutory payment updates and incentive payments for physicians and other health professionals, as established by the Medicare Access and CHIP Reauthorization Act of 2015

	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 under MIPS. The 5 percent incentive payment for A-APM participation expires after 2024.

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, 2017**

	Medicare (ages 65 and older)	Private insurance (ages 50-64)
Very satisfied	69%	57%
Somewhat satisfied	19	25
Somewhat dissatisfied	3	4
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 2017.

Are Medicare fee schedule payments adequate in 2018?

We assess payment adequacy by reviewing beneficiaries' 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's payment rates relative to commercial rates for preferred provider organizations. 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 2017. In the discussion of the survey results that follows, references to Medicare beneficiaries are beneficiaries age 65 and over,

and privately insured individuals are individuals between the ages of 50 and 64.

The Commission also conducts focus groups in a select set of market areas around the country to provide a qualitative description of beneficiary and provider experiences with the Medicare program. This year, we conducted nine focus groups of Medicare beneficiaries in three markets; roughly a third of the beneficiaries we interviewed were dually entitled to Medicare and Medicaid. We also conducted a primary care physician focus group in each location and site visits and interviews with various providers, with a focus this year on telehealth services.

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

Our survey results for 2017, as compared with 2016, show a modest increase in the ability of both Medicare beneficiaries and privately insured individuals to see a doctor as soon as they wanted for regular or routine care and illness or injury care. However, the rate in 2017 is comparable with the rates for years before 2016, which could mean that the 2016 survey results showing a reduction in access reflected normal survey variation. Medicare beneficiaries generally were reported to have comparable access with those who have private insurance.

This year, we continue to lack a supplemental source of data on wait times: CMS has redesigned the Medicare Current Beneficiary Survey (MCBS), and the newly revised version has not yet been released.

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

In our telephone survey, a slightly higher share of Medicare beneficiaries reported that they were very or somewhat satisfied with their care (88 percent) compared with those who have private insurance (82 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. Patients reported that they were able to get appointments

as soon as needed and felt that their providers were respectful, explained clearly, and listened carefully.

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

From our 2017 telephone survey, 73 percent of Medicare beneficiaries reported that they never had to wait longer than they wanted for routine care, and 80 percent reported the same for illness or injury care (Table 4-3, p. 100). In 2017, Medicare beneficiaries were less likely to report trouble obtaining both types of care when needed than privately insured individuals (the rates for privately insured individuals were 69 percent for routine care and 76 percent for illness or injury care). In comparison with last year's results, this year, the share of both Medicare beneficiaries and the privately insured were more consistent with the five-year trend. This finding suggests that the 2016 results (showing a small but significant decrease in timely access) was a normal variation in the results from a small telephone survey, not the beginning of a persistent downward trend.

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. 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 4-3, p. 100). For primary care, 9 percent were looking for a new doctor; of those looking, 14 percent reported a big problem. On net, then, 1.3 percent of the Medicare population reported a big problem. For specialty care, 17 percent were looking for a new doctor; of those looking, 5 percent reported a big problem, meaning that 0.9 percent of the total Medicare population on net reported a big problem.

This pattern of greater difficulty among Medicare beneficiaries in finding a new primary care doctor relative to finding a specialist is consistent with prior years, as well as with privately insured individuals. These results were also consistent with the beneficiary focus group responses: Among those who wanted to switch primary care providers, some felt they did not have the option because of long wait times or practices being closed to new patients. However, Medicare beneficiaries overall were less likely to report big problems obtaining either primary or specialty care than were individuals with private insurance (Table 4-3, p. 100).

Beneficiaries in both the focus groups and our telephone survey reported difficulty with certain specialty referrals, especially dermatologists (which may be due, in part, to specialization in cosmetic dermatology vs. medical dermatology). Some primary care physicians reported challenges with long wait times for orthopedic referrals. Physicians in all three markets also reported difficulty obtaining psychiatric referrals for all of their patients (Medicare and other payers). In their experience, many psychiatrists did not accept any type of insurance. Physicians noted that often they must provide mental health services and prescriptions to their patients because of the lack of access.

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 reported (1) more difficulty receiving care as soon as they wanted and (2) higher rates of forgoing care In our 2017 telephone survey of Medicare beneficiaries, the share of beneficiaries reporting that they never had to wait longer than they wanted for routine care was lower for minority beneficiaries compared with White beneficiaries (69 percent vs. 74 percent, respectively) (Table 4-4, p. 101). Minority 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 (6 percent vs. 2 percent, respectively). Minority beneficiaries were also more likely than White beneficiaries to say that they did not receive care when they thought they should have (14 percent vs. 11 percent, respectively).

Minority beneficiaries were also less likely than White beneficiaries to report that they faced no problem finding a specialist (75 percent vs. 85 percent, respectively), but were more likely to report no problem finding a primary care physician (80 percent vs. 67 percent, respectively). Similar differences also exist for privately insured individuals. Minorities generally reported worse access to care overall, for all types of insurance (Agency for Healthcare Research and Quality 2016). In addition, minority Medicare beneficiaries also were more likely to be in groups that have poorer access overall: African American and Hispanic beneficiaries were more likely

**TABLE
4-3**

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2013-2017

Survey question	Medicare (ages 65 and older)					Private insurance (ages 50-64)				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"										
For routine care										
Never	73%	72% ^a	72% ^a	68% ^b	73% ^a	69%	69% ^a	69% ^a	67%	69% ^a
Sometimes	20	20 ^a	19 ^a	22 ^b	20	23	23 ^a	23 ^a	23	22
Usually	3	3	4	4	3	4	4	4	5	4
Always	3	3	3	3	3	3	3	3	4	3
Don't know/Refused	1	2	2	2	1	*	1	1	1	1
For illness or injury										
Never	82	83 ^{ab}	82 ^a	79 ^a	80 ^a	77	79 ^a	77 ^a	75 ^a	76 ^a
Sometimes	14	12 ^{ab}	13 ^{ab}	16 ^a	15	17	16 ^a	17 ^a	19 ^a	18
Usually	2	2	3	2 ^a	2	3	2	3	3 ^a	2
Always	1	1 ^a	2	2 ^a	1	2	2 ^a	2	3 ^a	2
Don't know/Refused	1	2 ^b	1	2	1	1	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	10	11	11 ^a	11	11	11	12	12 ^a	12
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")										
Primary care doctor	7	8	7 ^a	8 ^a	9 ^a	8	8 ^b	9 ^{ab}	10 ^a	11 ^a
Specialist	14 ^b	17	16	18	17 ^a	16	17 ^b	18 ^b	18	20 ^a
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."										
Primary care physician										
No problem	70	67	67	64	69 ^a	67	63	63	63	59 ^a
Share of total insurance group	5.2	5.5	4.7 ^b	5.1	6.2	5.2	4.9 ^b	5.7	6.1	6.5
Small problem	11	16	18	15	13	15	16	18	16	18
Share of total insurance group	0.8	1.3	1.2	1.2	1.2 ^a	1.2 ^b	1.3 ^b	1.7	1.5	2.0 ^a
Big problem	17	15	14	20	14 ^a	18	19	17	20	22 ^a
Share of total insurance group	1.3	1.2	1.0	1.6	1.3 ^a	1.4 ^b	1.5 ^b	1.5 ^b	1.9	2.4 ^a
Specialist										
No problem	86	85	87 ^a	82	83	87 ^b	85 ^b	82 ^a	79	81
Share of total insurance group	12.4 ^b	14.4	14.2	14.7	14.1	13.9 ^b	14.5	14.8	14.4	16.2
Small problem	8	7 ^b	7 ^b	10	11	6 ^b	9	8	9	11
Share of total insurance group	1.2 ^b	1.2 ^b	1.1 ^b	1.8	1.9	0.9 ^b	1.4 ^b	1.5 ^b	1.6	2.2
Big problem	5	7	6	8 ^a	5 ^a	7	6	9	11 ^a	8 ^a
Share of total insurance group	0.7 ^b	1.2	1.0 ^a	1.4	0.9 ^a	1.1	1.0	1.7 ^a	2.0	1.6 ^a

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 2017 within the same insurance category (at a 95 percent confidence level).

*Percentage less than 0.5 percent.

Source: MedPAC-sponsored telephone surveys conducted from 2013 to 2017.

**TABLE
4-4**

Minorities report problems obtaining specialty care more frequently than non-minorities, 2017

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	73% ^a	74% ^{ab}	69% ^b	69% ^a	70% ^a	66%
Sometimes	20 ^a	20	19	22 ^a	23	23
Usually	3	3 ^b	5 ^b	4	4	5
Always	3	2 ^{ab}	6 ^b	3	3 ^{ab}	4 ^b
Don't know/Refused	1	1	2	1	*	1
For illness or injury						
Never	80 ^a	81 ^a	78 ^a	76 ^a	77 ^b	72 ^{ab}
Sometimes	15 ^a	15 ^a	15 ^a	18 ^a	18 ^{ab}	22 ^{ab}
Usually	2	2	3	2	2	3
Always	1 ^a	1	2	2 ^a	2 ^a	2
Don't know/Refused	1	1 ^a	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	11 ^b	14 ^b	12	12	12
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care physician	9 ^a	8	9	11 ^a	11	10
Specialist	17	18 ^a	15	20	21 ^{ab}	17 ^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	69 ^a	67	80 ^a	59 ^a	58	61 ^a
Share of total insurance group, by race	6.2	5.4	7.2	6.5	6.4	6.1
Small problem	13	14	11	18	20	14
Share of total insurance group, by race	1.2 ^a	1.1 ^a	1.0	2.0 ^a	2.2 ^a	1.4
Big problem	14 ^a	16	8 ^a	22 ^a	22	21 ^a
Share of total insurance group, by race	1.3 ^a	1.3 ^a	0.7 ^a	2.4 ^a	2.4 ^a	2.1 ^a
Specialist						
No problem	83	85 ^b	75 ^b	81	82 ^b	74 ^b
Share of total insurance group, by race	14.1	15.3 ^{ab}	11.3 ^b	16.2	17.2 ^{ab}	12.6 ^b
Small problem	11	11	13	11	11	13
Share of total insurance group, by race	1.9	2.0	2.0	2.2	2.3	2.2
Big problem	5 ^a	3 ^{ab}	11 ^b	8 ^a	7 ^{ab}	13 ^b
Share of total insurance group, by race	0.9 ^a	0.5 ^{ab}	1.7 ^b	1.6 ^a	1.5 ^a	2.2

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 2017. 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).
*Percentage less than 0.5 percent.

Source: MedPAC-sponsored telephone surveys conducted in 2017.

**TABLE
4-5**

Access to physician care for Medicare beneficiaries is similar to that for privately insured individuals in urban and rural areas, 2017

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	73% ^a	73% ^a	74%	69% ^a	68% ^{ab}	74% ^b
Sometimes	20 ^a	20 ^a	21	22 ^a	23 ^a	19
Usually	3	3	2	4	5	3
Always	3	3	3	3	3	4
Don't know/Refused	1	1	*	1	1	*
For illness or injury						
Never	80 ^a	81 ^a	81	76 ^a	76 ^a	80
Sometimes	15 ^a	14 ^a	14	18 ^a	19 ^a	16
Usually	2	2	2	2	2	2
Always	1 ^a	1 ^a	2	2 ^a	2 ^a	2
Don't know/Refused	1	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")						
	11	11	11	12	12	13
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	9 ^a	8 ^a	9	11 ^a	11 ^a	10
Specialist	17 ^a	18 ^a	15	20 ^a	21 ^{ab}	17 ^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	69 ^a	71 ^a	62	59 ^a	59 ^a	60
Share of total insurance group, by area	6.2	5.7	5.6	6.5	6.5	6.0
Small problem	13	12	16	18	18	18
Share of total insurance group, by area	1.2 ^a	1.0	1.4	2.0 ^a	2.0	1.8
Big problem	14 ^a	14 ^a	21	22 ^a	22 ^a	20
Share of total insurance group, by area	1.3 ^a	1.1 ^a	1.9	2.4 ^a	2.4 ^a	2.0
Specialist						
No problem	83	83	87	81	81	79
Share of total insurance group, by area	14.1	14.9	13.1	16.2	17.0	13.4
Small problem	11	13 ^b	4 ^{ab}	11	11	11 ^a
Share of total insurance group, by area	1.9	2.3 ^b	0.6 ^{ab}	2.2	2.3	1.9 ^a
Big problem	5 ^a	4 ^a	8	8 ^a	8 ^a	8
Share of total insurance group, by area	0.9 ^a	0.7 ^a	1.2	1.6 ^a	1.7 ^a	1.4

Note: Numbers may not sum to 100 percent because of rounding. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2017. 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 2017.

**TABLE
4-6**

Medicare FFS CAHPS® performance rates, 2012–2016

CAHPS composite measure	2012	2013	2014	2015	2016
Getting needed care and seeing specialists	87%	87%	86%	85%	84%
Getting appointments and care quickly	75	75	76	75	77
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical records, helps with managing care)	87	86	86	85	86
Rating of health plan (FFS Medicare)	85	85	84	82	84
Rating of health care quality	86	86	86	86	85

Note: FFS (fee-for-service), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). Questions in rows 1 to 3 have responses of “Never,” “Sometimes,” “Usually,” and “Always.” CMS converts these to a linear mean score on a 0 to 100 scale. Questions in rows 4 and 5 have responses of 1 to 10 (which CMS converts to a linear mean score on a 0 to 100 scale).

Source: FFS CAHPS mean scores provided by CMS.

to qualify as dually eligible for Medicaid, have lower incomes, and report fair or poor health status or functional limitations than did White Medicare beneficiaries (data not shown) (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 Medicare beneficiaries (Table 4-5). There was no significant difference between the share of urban and rural beneficiaries experiencing an unwanted delay in getting an appointment.

Generally, rates of access for Medicare beneficiaries in rural and urban areas were comparable. Urban Medicare beneficiaries reported more timely access to routine care than privately insured urban individuals. Differences between rural Medicare beneficiaries and privately insured rural individuals were minimal and not statistically significant in most cases.

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

Nearly all Medicare 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 2017 National Health Interview Survey (NHIS), 97 percent of Medicare beneficiaries ages 65 and over reported that they had a usual source of medical care (National Center for Health Statistics 2017).

The share of respondents ages 65 and over with Medicare in the NHIS reporting that they had to forgo medical care because of cost remains significantly lower than other age groups—between 2 percentage points and 3 percentage points lower over the past decade.

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. 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 (17 percent vs. 12 percent, respectively) (data not shown).

Other sources of access data show steady results over time and across Medicare coverage types

The Consumer Assessment for Healthcare Providers and Systems® (CAHPS®) surveys are a suite of surveys that assess patient experience and reported access. CAHPS results are used for Medicare Advantage (MA) plans’ and Part D drug plans’ star ratings that measure quality in the MA and Part D programs, and a CAHPS survey module is issued to a sample of beneficiaries in the FFS Medicare population.

Overall, Medicare FFS beneficiaries’ rating of their health care quality and self-reported ability to get care quickly was generally stable between 2012 and 2016, although self-reports of getting needed care and appointments to specialists declined slightly (Table 4-6).

**TABLE
4-7**

MA and Medicare FFS CAHPS® performance rates, 2016

CAHPS composite measure	2016		
	MA HMO	MA PPO	FFS
Getting needed care and seeing specialists	83%	84%	84%
Getting appointments and care quickly	76	77	77
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical records, helps with managing care)	85	86	86
Rating of health plan	85	84	84
Rating of health care quality	86	86	85
Annual flu vaccine	72	74	72

Note: MA (Medicare Advantage), FFS (fee-for-service), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), HMO (health maintenance organization), PPO (preferred provider organization). Questions in rows 1 to 3 have responses of "Never," "Sometimes," "Usually," and "Always." CMS converts these to a linear mean score on a 0 to 100 scale. Questions in rows 4 and 5 have responses of 1 to 10 (which CMS converts to a linear mean score on a 0 to 100 scale). The question in row 6 is a yes/no response. Rates are case-mix adjusted for response bias.

Source: MedPAC databook 2017; FFS CAHPS mean scores provided by CMS.

The CAHPS surveys show little difference in reported access between Medicare beneficiaries in FFS and those in MA (Table 4-7).

Clinician acceptance of Medicare beneficiaries is lower than that of private insurance, but when pediatricians are excluded, the rates are comparable

The National Electronic Health Records Survey reports that, in 2015, 81 percent of office-based physicians reported that they accepted Medicare, 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 were comparable with private insurance when pediatricians were excluded (Boccuti et al. 2013, Hing et al. 2015). During our site visits, most providers said that they accept Medicare, but some 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 72 percent of primary care physicians accept new Medicare patients and 80 percent accept new privately insured patients (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 (92 percent of primary care physicians reported that they participated in Medicare). The 20 percent not taking new Medicare patients could include physicians with closed practices not 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 who 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 2014 to 2016 shows that the number of physicians and other health professionals furnishing services to Medicare beneficiaries has generally kept pace with enrollment growth in

**TABLE
4-8**

Physicians and other health professionals billing Medicare, 2014–2016

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					
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
2016	184,905	3.5	403,822	7.8	202,874	3.9	160,040	3.1

Note: “Primary care specialties” are specialties that were 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 2017 annual report of the Boards of Trustees of the Medicare trust funds.

Medicare (Table 4-8). In 2016, the ratio of physicians in primary care specialties to the number of beneficiaries was 3.5 per 1,000, a slight drop from the ratio in 2015 (3.6 per 1,000). Between 2015 and 2016, the ratio of physicians in other specialties declined slightly from 7.9 per 1,000 beneficiaries to 7.8 per 1,000. Meanwhile, between 2015 and 2016, the number of advanced practice registered nurses and PAs per 1,000 beneficiaries grew by 8 percent, from 3.6 per 1,000 beneficiaries to 3.9 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) (Centers for Medicare & Medicaid Services 2017a).³ 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 (Table 4-9, p. 106).

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 clinician for services delivered by the opt-out clinician. Providers opt out for a variety of reasons (see text box on providers who opt out, pp. 108–109).

MACRA established that agreements between the opt-out clinician and Medicare are automatically renewed every two years unless the clinician elects to rejoin Medicare.⁴ Pursuant to MACRA, CMS also publicly released detailed information on opt-out clinicians in 2016 for the first time. As of September 2017, 23,287 physicians, dentists,

**TABLE
4-9**

Illustrative payment amounts for participating, nonparticipating, and opt-out providers

Medicare allowed amount = \$100	Participating provider	Nonparticipating provider billing at the limiting charge	Opt-out provider
Payment from Medicare	\$80	\$76	None
Payment from the beneficiary	20	33.25	Unlimited
Coinsurance	20	19	N/A
Additional balance billing of beneficiary	None	14.25	N/A
Total payment to provider	100	\$109.25	Unlimited

Note: N/A (not applicable). Medicare’s payment to nonparticipating providers is 95 percent of the fee schedule allowed amount. “Limiting charge” is 109.25 percent of the Medicare allowed amount. A nonparticipating provider that does not take assignment may balance bill to recoup 109.25 percent of the allowed amount from Medicare and the beneficiary in total.

and other clinicians had an opt-out record on file with the Medicare program, of which over 7,000 were mental health specialists (psychiatrists, psychologists, and clinical social workers), and nearly 11,000 were dental providers (Figure 4-1).

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, in 2016, the number of echocardiograms per beneficiary administered in freestanding offices declined by 1.1 percent while the number administered in hospital outpatient departments (HOPDs) rose by 5.4 percent. Increases in volume can 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 changes, technology, and beneficiaries’ preferences—can also explain volume increases.

We used claims data from 2011, 2015, and 2016 to analyze volume changes. We identified the services

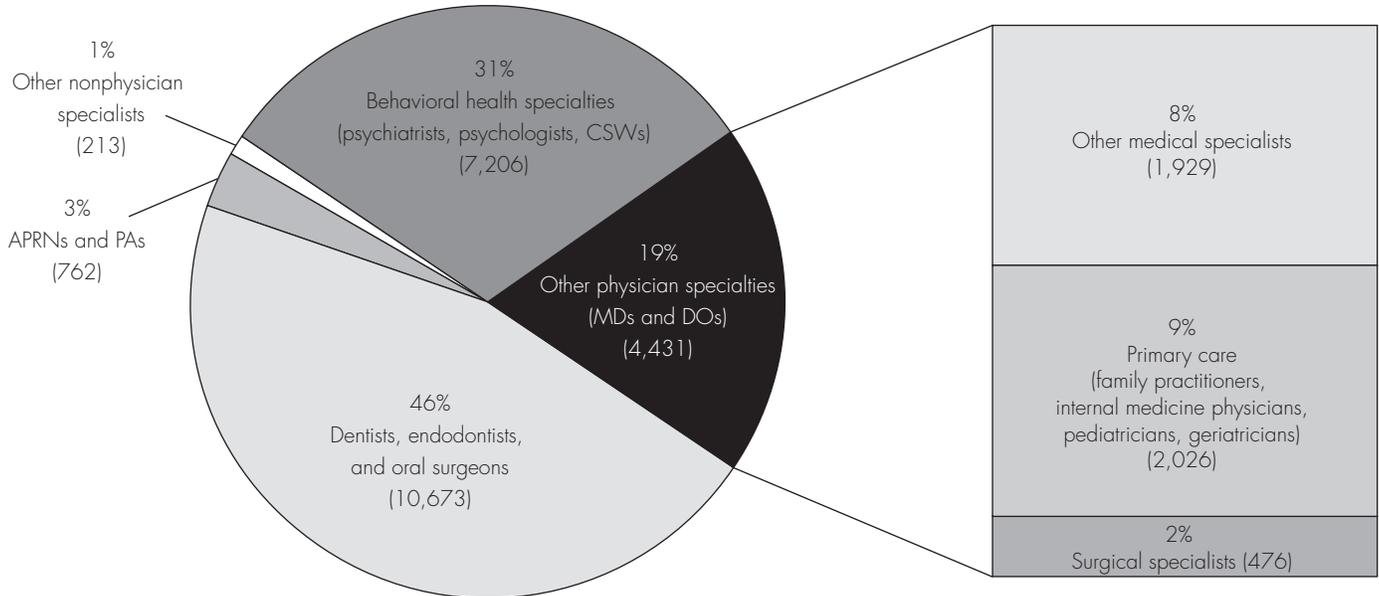
furnished by physicians and other professionals billing under Medicare’s fee schedule and calculated two measures of changes in service use: units of service per beneficiary and volume of services per beneficiary. Volume is measured as units of service multiplied by each service’s RVUs from the fee schedule. 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 (CT) scans for less complex X-rays). We used RVUs for 2016 to put service volume for all years on a common scale. We grouped individual service codes into broad service categories that are clinically meaningful (e.g., evaluation and management (E&M)). Each broad service category contains multiple subcategories of similar services (e.g., E&M contains office visits and outpatient services, hospital inpatient services, and other subcategories).

Between 2015 and 2016, across all services, volume per beneficiary grew by 1.6 percent (Table 4-10, p. 110). Among broad service categories, growth rates were 1.1 percent for E&M, 1.4 percent for imaging services, 2.8 percent for major procedures, 2.5 percent for other procedures, and 1.7 percent for tests. The 2016 growth rates for all services and for broad service categories were higher than the average annual growth rates from 2011 to 2015.

FIGURE 4-1

Clinicians who opted out of Medicare were concentrated in certain specialties, and nearly half were dental providers, 2017

Total number of clinicians and providers who opted out of Medicare = 23,287



Note: CSW (clinical social worker), APRN (advanced practice registered nurse), PA (physician assistant), DO (doctor of osteopathic medicine).

Source: Analysis of opt-out affidavits from CMS.

Subcategories of a broad service category sometimes experienced more rapid volume growth in 2016 than the broad service category. For example, volume growth was 2.8 percent in the “major procedures” category, but volume growth in the subcategories of vascular procedures (e.g., revascularization of lower extremity) and musculoskeletal procedures (e.g., knee replacement) were 5.9 percent and 4.4 percent, respectively (Table 4-10, p. 110). Volume growth in the “other procedures” category was 2.5 percent, but volume growth in the subcategory of physical, occupational, and speech therapy was 7.8 percent. Physical therapy treatments accounted for most of the 2016 volume growth in these therapy treatments.

Care management/coordination had the highest rate of volume growth of all the service subcategories: 15.8 percent per year from 2011 to 2015 and 27.3 percent from 2015 to 2016. CMS created new billing codes for transitional care management (TCM) in 2013 and chronic

care management (CCM) in 2015, and these codes account for most of the growth in care management/coordination. In 2016, the volume of TCM increased by 29.9 percent and CCM by 141.5 percent (data not shown). At the same time, the volume of the other services in this subcategory (physician certification and recertification of home health care, home health care supervision, and hospice care supervision) decreased by 3.0 percent (data not shown).

While volume growth for imaging in 2016 was slightly lower than the average increase for all services and followed decreases from 2010 to 2014, use of imaging services remains much higher than it was in 2000 (Figure 4-3, p. 111). Cumulative growth in the volume of imaging per beneficiary from 2000 to 2009 totaled 85 percent, compared with a cumulative drop in imaging volume since then of about 7 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

Why providers who opt out of Medicare are concentrated in certain specialties

Providers opt out of Medicare for different reasons. Dentists opt out of Medicare in large numbers because their services are only rarely covered by the Medicare benefit. Routine or prophylactic dental services are not covered by Medicare (e.g., cleanings, fillings, extractions, or dentures). Dental services are covered by Medicare only if they address an underlying health problem or are required for a Medicare-covered service to be successful. For example, services provided in the hospital as prerequisite to surgery may be covered, as are some oral surgeries. By opting out of Medicare, dentists avoid, for the few services that Medicare would otherwise cover, the administrative requirements to enroll and bill Medicare and limits on fees for those services.

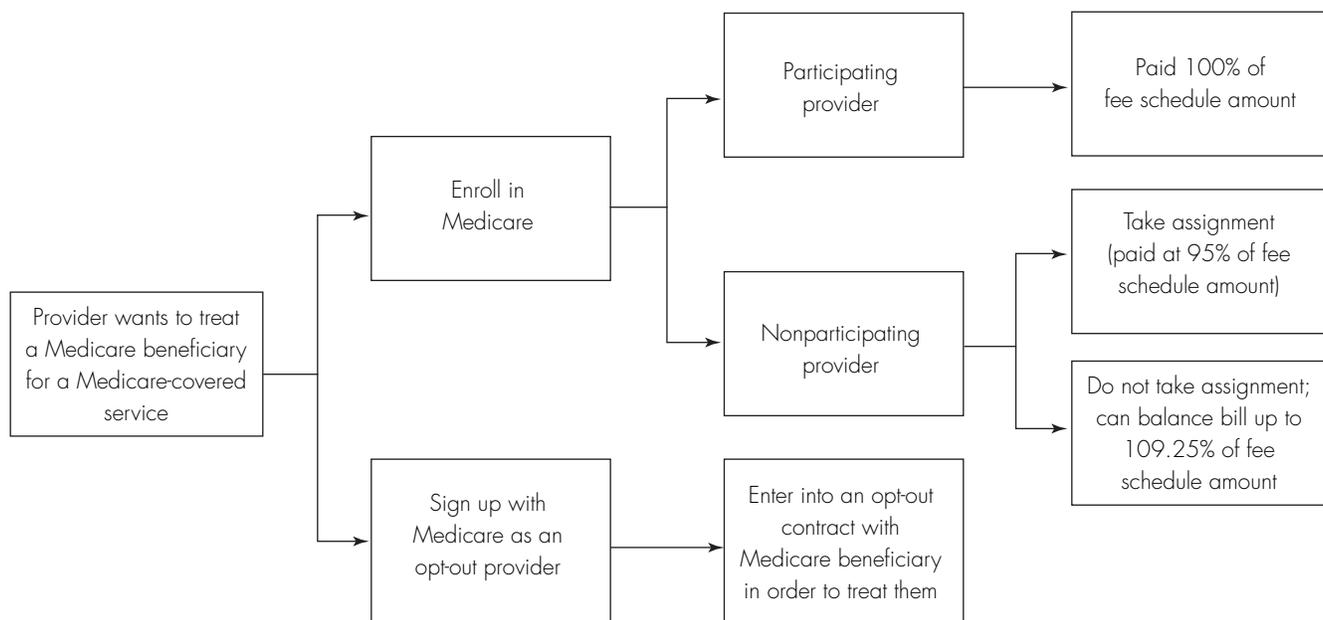
Psychiatrists also opt out in large numbers, even though most psychiatry services are covered by Medicare.

The Medicare statute requires that, to deliver a covered service to a Medicare beneficiary, the provider must either enroll in Medicare (as a participating or nonparticipating provider) or opt out of the program entirely (Figure 4-2). There is no analogue in Medicare to out-of-network benefits in preferred provider organization products in the commercial insurance market.

Mental health providers in general are much less likely to accept all types of insurance than any other specialty. Only about half of psychiatrists take any insurance at all, and their rates of accepting Medicare are comparable with rates for accepting private insurance (Medicaid acceptance is lower still) (Bishop et al. 2014). Several reasons account for low acceptance rates: high coinsurance (including, until 2014, a mental health limitation in Medicare), concern about stigma by patients, and utilization management tools by plans.

FIGURE 4-2

Options for providers to deliver Medicare-covered services to beneficiaries



Note: There is no option for a provider to deliver a Medicare-covered service to a Medicare patient outside of these arrangements.

(continued next page)

Why providers who opt out of Medicare are concentrated in certain specialties (cont.)

To the extent that psychiatrists and other mental health providers wish to treat Medicare patients, they need to enroll either as a Medicare provider (participating or nonparticipating) or as an opt-out provider. If mental health providers and beneficiaries wish to enter into an arrangement outside of the Medicare benefit (for example, if beneficiaries feel stigma about using their

insurance benefit and wish to pay for services out of pocket), the opt-out arrangement allows them to do so.

In both cases—that of dentists and of mental health providers—factors outside of Medicare’s payment rates contribute to the high number of clinicians opting out of the program. ■

years. Such growth was more than double the cumulative growth rates during the same period for E&M services and major procedures, which were 32 percent and 34 percent, respectively. In addition, volume increases in 2016 were higher for certain types of imaging than for others. For example, in 2016, CT volume grew by 3.6 percent. By contrast, from 2011 to 2015, average annual volume growth of CT was 1.4 percent. Similarly, in 2016, MRI volume increased by 2.6 percent, after falling by 0.2 percent per year from 2011 to 2015.

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. In the latest iteration of this ongoing effort, more than 80 specialty societies have identified 520 tests and procedures that are often overused (ABIM Foundation 2017). The goal of Choosing Wisely is to promote conversations between clinicians and their patients to help patients choose care that is supported by evidence, free from harm, truly necessary, and not duplicative of other tests or procedures. 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 developing this program, which is scheduled to begin on January 1, 2020.

Volume changes reflect shift in billing from freestanding offices to hospitals

Measuring volume growth has two advantages. First, volume growth accounts for changes not just in the number of services but also any changes in the intensity of services (e.g., substitution of CT scans for X-rays). Second, volume growth is important because it has a significant impact on spending growth, along with changes in payment rates.

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 2017, for example, the most common type of E&M office visit (Current Procedural Terminology code 99213) had an average nonfacility fee schedule payment of \$74. 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 office. For example, in 2017, the total payment for the most common E&M office visit when provided in an HOPD (other than certain off-campus HOPDs) was \$158 (\$52 for the fee schedule payment to the clinician plus \$107 for the HOPD facility payment) compared with \$74 (the nonfacility fee schedule payment) for this visit when provided in a freestanding office.⁵

In recent years, there has been a trend toward billing for some services in hospitals instead of freestanding offices.

**TABLE
4-10**

Use of clinician services per FFS beneficiary

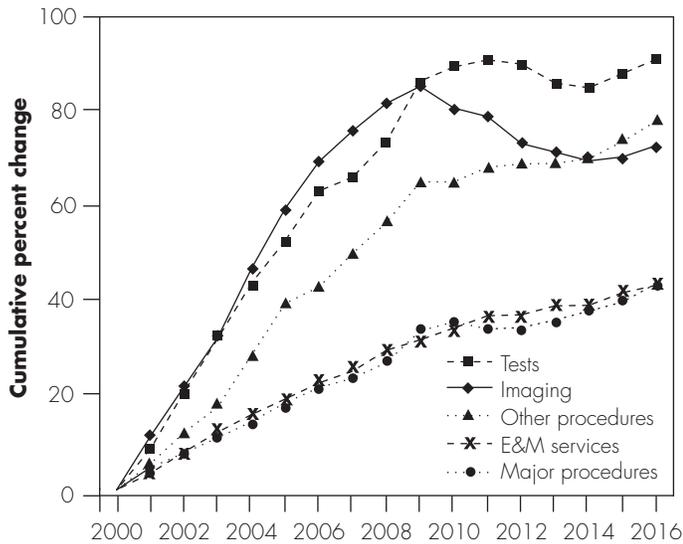
Type of service	Change in units of service per beneficiary		Change in volume per beneficiary		Share of 2016 allowed charges
	Average annual 2011-2015	2015-2016	Average annual 2011-2015	2015-2016	
All services	0.1%	1.4%	0.5%	1.6%	100.0%
Evaluation and management	-0.1	0.6	0.6	1.1	52.6
Office/outpatient services	0.7	1.1	1.3	1.8	26.9
Hospital inpatient services	-2.2	-2.1	-1.9	-1.7	11.6
Emergency department services	0.8	0.0	1.6	0.8	3.3
Nursing facility services	2.7	-0.9	3.3	-0.1	3.0
Ophthalmological services	-0.3	0.3	0.0	0.5	2.9
Behavioral health services	N/A	3.4	N/A	3.8	1.9
Critical care services	0.9	1.7	0.9	1.5	1.5
Observation care services	11.2	6.6	10.7	6.1	0.7
Care management/coordination	7.8	33.9	15.8	27.3	0.5
Home services	-0.7	0.4	-0.4	-0.1	0.4
Imaging	-0.3	0.4	-1.2	1.4	11.5
Standard X-ray	-1.2	-0.7	-1.0	1.2	3.3
Ultrasound	-0.6	0.5	-2.1	0.1	3.0
CT	2.1	3.5	1.4	3.6	1.9
Nuclear	-5.2	-0.9	-8.5	-2.0	1.3
MRI	1.0	2.6	-0.2	2.6	1.3
Major procedures	-0.4	1.6	1.7	2.8	8.0
Musculoskeletal	1.8	3.7	2.6	4.4	3.0
Vascular	-1.1	-2.2	8.7	5.9	1.4
Other organ systems	-2.1	0.7	-1.5	0.6	1.0
Cardiovascular	-0.6	2.9	0.2	1.5	1.0
Digestive/gastrointestinal	-2.8	-1.6	-2.1	-1.4	0.9
Skin	-2.6	1.0	-1.0	0.8	0.5
Eye	0.1	-1.1	0.2	-0.8	0.2
Other procedures	0.8	3.3	0.7	2.5	23.0
Skin	1.4	2.0	1.5	2.5	4.5
Physical, occupational, and speech therapy	2.9	7.4	3.5	7.8	3.7
Musculoskeletal	0.0	1.9	1.4	2.8	2.6
Eye	1.6	3.4	0.7	2.9	2.4
Radiation oncology	-2.2	-2.4	-2.8	-3.0	2.0
Other organ systems	0.2	2.8	2.0	2.5	1.7
Digestive/gastrointestinal	-1.0	1.0	-0.6	2.8	1.4
Vascular	-2.5	0.3	2.6	3.9	1.1
Dialysis	-0.9	-2.5	0.4	-0.2	1.2
Chiropractic	-2.4	-1.6	-2.6	-2.2	0.8
Injections and infusions: non-oncologic	-3.1	0.0	-3.3	-0.1	0.5
Chemotherapy administration	-4.1	-0.8	-4.1	-0.8	0.5
Tests	-0.1	1.6	-2.0	1.7	4.6
Anatomic pathology	-0.2	1.4	-0.4	1.4	1.4
Cardiography	-1.8	1.7	-4.5	2.8	1.2
Neurologic	1.3	1.3	-3.7	0.5	0.9

Note: FFS (fee-for-service), CT (computed tomography), MRI (magnetic resonance imaging), N/A (not available). 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 2016. For billing codes not used in 2016, we imputed RVUs based on the average change in RVUs for each type of service. Use of behavioral health services is not reported for 2011 to 2015 because of a change in billing codes implemented in 2013. Some low-volume categories are not shown but are included in the summary calculations. The type-of-service categories and subcategories that we used in prior years were restructured for this table.

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

FIGURE 4-3

Growth in the volume of clinician services per fee-for-service beneficiary, 2000-2016



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 2016, 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.

From 2012 to 2016, for example, HOPD-based E&M visits per beneficiary grew by 29 percent, compared with a 1.6 percent decline in physician office-based visits. Echocardiography and nuclear cardiology services have also shifted from freestanding offices to HOPDs. From 2015 to 2016, the number of echocardiograms per beneficiary delivered in HOPDs rose by 5.4 percent, compared with a 1.1 percent decline in freestanding offices (Table 4-11). Similarly, the number of nuclear cardiology studies per beneficiary provided in HOPDs increased by 0.3 percent, compared with a 4.2 percent decline in freestanding offices.

This change in setting raises overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in HOPDs (other than certain off-campus 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 \$1.8 billion more in 2016 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 \$460 million higher in 2016 than it would have been had payment rates been the same in both settings.

To address the increased spending that results when services shift from freestanding offices to HOPDs, the Commission recommended adjusting payment rates in the outpatient prospective payment system (OPPS) so that Medicare pays the same amount for E&M office visits in freestanding physician offices and HOPDs (Medicare Payment Advisory Commission 2012). The Commission also recommended adjusting OPPS rates for a set of other services so that rates are equal or more closely aligned across these two settings (Medicare Payment Advisory Commission 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 4-4, p. 112). From 2000 to 2016, payment updates for these services did not keep pace with growth in input prices. Payment updates increased cumulatively by 10 percent—less than the 32 percent cumulative increase in the Medicare Economic Index (MEI), which measures changes in input prices. However, spending per beneficiary

TABLE 4-11

Cardiovascular imaging services continue to shift from freestanding physicians' offices to HOPDs, 2015-2016

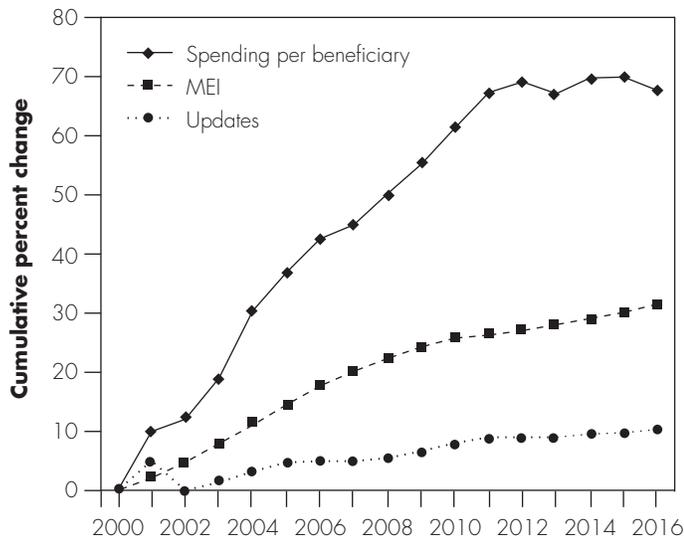
	Share of services performed in HOPDs, 2016	Per beneficiary change in units of service	
		HOPD	Freestanding office
Echocardiography	44.4%	5.4%	-1.1%
Nuclear cardiology	47.7	0.3	-4.2

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.

**FIGURE
4-4**

Growth in the volume of clinician services caused fee schedule spending to increase faster than input prices and updates, 2000–2016



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: 2017 annual report of the Boards of Trustees of the Medicare trust funds; Centers for Medicare & Medicaid Services 2017b; Clemens 2014.

for these services grew at a cumulative rate of 68 percent. Volume growth, which accounts for most of the difference between the payment updates and spending growth, likely reflects changes in clinical practice, such as the diffusion of new technologies, as well as changes in the demographic and health status of beneficiaries.⁶

In 2016, per beneficiary spending for fee schedule services decreased slightly, by 1.3 percent. Several factors influenced this decline: the small increase in volume (1.6 percent), the small increase in the fee schedule conversion factor (0.5 percent), a larger penalty for clinicians who did not submit data under the Physician Quality Reporting System (PQRS), a larger penalty for clinicians who did not meet the electronic health record (EHR) meaningful use requirement, smaller incentive payments for clinicians who met the EHR meaningful use requirement, and the expiration of the Primary Care Incentive Payment (PCIP) program in 2015.⁷

Quality of care

For the past decade, CMS has assessed the quality of Medicare-billing physicians and other health professionals based largely on clinician-reported individual quality measures. Starting in 2007, clinicians began reporting quality measures through the voluntary Physician Quality Reporting Incentive and they qualified for a payment incentive for such reporting. The program was rebranded as the PQRS in 2010 and began imposing a payment penalty for nonreporting in 2015.

There are currently about 300 measures in the PQRS measure set (and over 600 reporting method combinations). In 2015, CMS began adjusting payments in FFS Medicare based on these clinician-reported measures (plus other claims-calculated measures) through the value-based payment modifier, which will be used through 2018. Starting in 2019, CMS will implement the Merit-based Incentive Payment System (MIPS). MIPS is an individual clinician-level payment adjustment that will adjust Medicare FFS payments based on performance in four areas: quality, resource use, clinical practice improvement activities, and advancing care information (formerly “meaningful use of EHRs”) (Centers for Medicare & Medicaid Services 2016). (See Chapter 15 for a full discussion of MIPS). It generally repurposes many of the measures and processes used in the value-based payment modifier (see text box for the results from the value-based payment modifier, pp. 114–115).

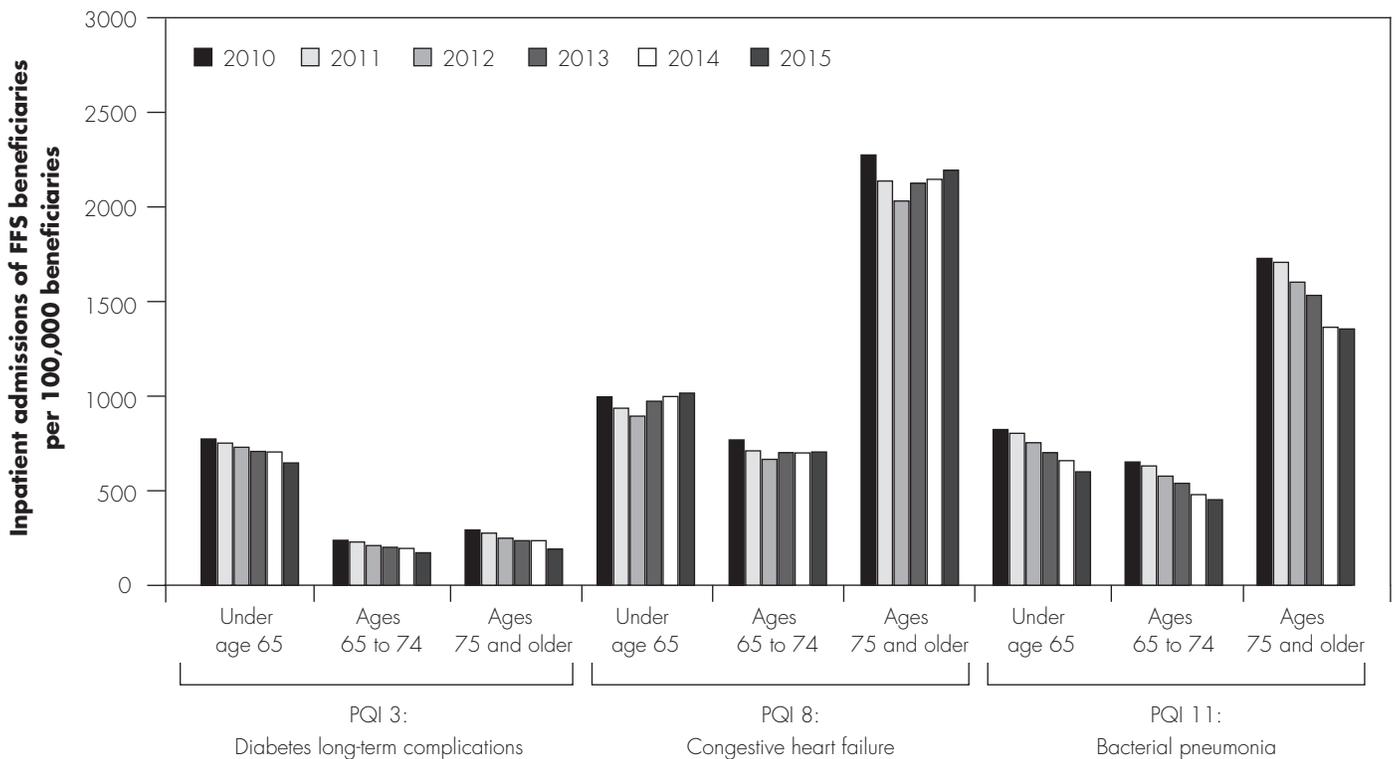
Overall, we do not believe the PQRS measures help the Medicare program assess high-quality clinician services, and we do not believe that they are appropriate for use in a value-based purchasing program. Instead, we review a population-based measure assessing avoidable hospitalizations for ambulatory care-sensitive conditions and rates of low-value care in Medicare.

To assess rates of avoidable hospitalizations for ambulatory care-sensitive conditions, we use the Prevention Quality Indicators (PQIs), a set of population-based measures of potentially avoidable hospital admissions developed by the Agency for Healthcare Research and Quality. The PQIs, which are based on national data, can help gauge the quality of a community’s ambulatory care environment. Lower rates indicate higher quality.

Figure 4-5 presents results for three common conditions among the Medicare population—long-term diabetes complications, congestive heart failure, and bacterial pneumonia. The trends show largely falling rates of

**FIGURE
4-5**

Trends in selected PQIs for inpatient admissions of FFS beneficiaries for ambulatory care-sensitive conditions, 2010-2015



Note: PQI (Prevention Quality Indicator), FFS (fee-for-service). 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.

avoidable hospitalizations across all three conditions and age categories; the modest increase for heart failure across all age categories may be the result of continuing changes in hospital behavior related to enforcement of the two-midnight rule (a CMS policy instructing auditors to approve inpatient stays only if the duration of the stay covers two midnights).

The Commission plans to continue refining a set of population-based outcome measures, such as hospitalizations for potentially preventable complications (HPCs) and potentially preventable emergency department (ED) visits, that CMS can calculate using claims data.⁸

We also calculated rates of low-value care in Medicare, which is another indicator of quality. Because the current PQRS measure set has few measures assessing low-value care, and few clinicians report these measures, we used a set of 31 claims-based measures to assess low-value

care. We found that low-value care is a significant issue in Medicare: Between 23 percent and 37 percent of beneficiaries received at least one low-value service in 2014 (see text box on low-value care, pp. 116–117).

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 compares physician compensation across specialties and evaluates whether Medicare's payment policies contribute to an income disparity between primary care clinicians and other specialties. The third measure—the MEI—assesses the change in input prices for physicians and other health professionals.

The first three years of the value-based payment modifier

The Patient Protection and Affordable Care Act of 2010 created a value-based payment modifier (value modifier, or VM) for clinicians participating in Medicare fee-for-service (FFS). Starting with groups of 100 or more clinicians in 2015, and phasing in to apply to all clinicians by 2017, clinicians had their Medicare FFS payments adjusted by a composite VM that assessed the quality and cost of the services they delivered in the two years prior

(e.g., 2013 performance would determine a clinician's value modifier for the purpose of adjusting payment in 2015).

Quality was assessed using six measures that each clinician reported from the set of Physician Quality Reporting System (PQRS) measures, plus up to three claims-calculated measures: hospital admissions for ambulatory care-sensitive conditions (acute), hospital

**TABLE
4-12**

Most clinician groups subject to the value-based payment modifier in 2015 either received no adjustment or did not participate

	Payment adjustment	Number of clinician groups (reporting under the same TIN)
Penalty	-1%	322
	-0.5	8
Neutral	0	853
Increase	+4.89	14

Note: TIN (taxpayer identification number). Value modifier applied in 2015 to TINs of 100 clinicians or more. "Neutral" included TINs with insufficient data, TINs that did not elect quality tiering, and TINs that were not subject to the value modifier because they were in an accountable care organization model or the Comprehensive Primary Care Initiative.

Source: Centers for Medicare & Medicaid Services.

**TABLE
4-13**

In 2016, 40 percent of clinicians did not participate in the value modifier (receiving a penalty), nearly 60 percent received no adjustment, but a few received large bonuses

	Payment adjustment	Number of clinician groups (reporting under the same TIN)
Penalty	-2%	5,418
	-1	57
Neutral	0	8,208
Increase	+15.92	70
	+31.84	58

Note: TIN (taxpayer identification number). Value modifier applied in 2016 to TINs of 10 clinicians or more. "Neutral" included TINs with insufficient data, TINs that did not elect quality tiering, and TINs that were not subject to the value modifier because they were in an accountable care organization model or the Comprehensive Primary Care Initiative.

Source: Centers for Medicare & Medicaid Services.

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The first three years of the value-based payment modifier (cont.)

admissions for ambulatory care–sensitive conditions (chronic), and readmissions. Cost was assessed using six measures: the Medicare spending per beneficiary measure, a total per capita cost measure, and per capita cost measures for four chronic conditions.

CMS used a statistical significance threshold to determine whether each clinician or group of clinicians was average, high, or low for both cost and quality. In each year of the program, CMS determined whether each clinician or group of clinicians was eligible for a payment adjustment based on the groupings and the cost and quality composite scores.

For example, clinicians who were average on both cost and quality would not receive a payment adjustment. Those who were high cost and low quality received a 1 percent or 2 percent penalty (depending on the year of the program). Those who were low cost and high

quality could qualify for a positive adjustment (the amount was determined at the end of the year based on the budget-neutrality calculation). The VM was budget neutral. In part because of this budget neutrality, the resulting positive updates were very large, even in the first two years of the program (Table 4-12, Table 4-13).

By 2017, the resulting positive payment increases were so large that 69 practices received an incentive payment of 77 percent of their fee schedule revenue, over 5,000 practices received an incentive payment of 46 percent of their fee schedule revenue, and nearly 7,000 practices received an incentive payment of 15 percent or 31 percent of their fee schedule revenue (Table 4-14). The experience with the value modifier underscores the importance of capping the upward adjustments in any value-based purchasing program that is designed to be budget neutral. ■

**TABLE
4-14**

Most clinicians (and clinician groups) still received no payment adjustment in 2017, but a few received very large increases

	Payment adjustment	Number of clinician groups (reporting under the same TIN)
Penalty	-4%	3,605
	-2	23,368
Neutral	0	445,674
Increase	+15.48	2,618
	+30.95	4,113
	+46.43	5,376
	+77.38	69

Note: TIN (taxpayer identification number). Value modifier applied in 2017 to TINs of two or more, plus solo clinicians. "Neutral" included TINs with insufficient data, TINs that did not elect quality tiering, and TINs that were not subject to the value modifier because they were in an accountable care organization model or the Comprehensive Primary Care Initiative.

Source: Centers for Medicare & Medicaid Services.

Ratio of Medicare payments to commercial PPO payments

In 2016, Medicare's payment rates for physician and other health professional services (including cost sharing) were 75 percent of commercial rates for PPOs, compared with 78 percent in 2015 and 81 percent in 2010. The ratio in

2016 varied by type of service. For example, Medicare rates were 80 percent of commercial rates for E&M office visits for established patients, but 70 percent of commercial rates for cataract surgery. This analysis uses data on paid claims for PPO members of a large national insurer that covers a wide geographic area across the

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

Low-value care is either 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, more than 80 specialty societies have identified 520 tests and procedures that are often overused (ABIM Foundation 2017).

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 to 2012 (Schwartz et al. 2015, Schwartz et al. 2014). It is challenging to reliably identify low-value care with claims data because they may not have enough clinical detail to distinguish appropriate use from inappropriate use. Thus, a key feature of these measures is that they are designed to allow for explicit trade-offs between the sensitivity and specificity of each measure. 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’ algorithms, which we applied to Medicare claims data from 2012 to 2014. We used 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 fee-for-service (FFS) beneficiaries, the share of FFS beneficiaries who received at least one low-value service, and total spending across all FFS beneficiaries for each service.

Our results show substantial use of low-value care in FFS Medicare in 2014. Based on the broader versions of the measures, our analysis found 72 instances of low-value care per 100 beneficiaries, and 37 percent of beneficiaries received at least one low-value service. Medicare spending for these services was \$6.5 billion, or 2.0 percent of FFS Medicare spending for the beneficiaries in our sample. Based on the narrower versions of the measures, our analysis showed 34 instances of low-value care per 100 beneficiaries, and 23 percent of beneficiaries received at least one low-value service. Medicare spending for these services totaled \$2.4 billion, or 0.7 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. Between 2012 and 2014, there was a modest decline in the volume and spending on low-value services.

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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.

The ratio of Medicare rates to commercial rates has declined in recent years because commercial rates have risen while Medicare rates have remained relatively stable. The growth of commercial prices could be a consequence of greater consolidation of physician practices. In recent years, an increasing number of physicians have joined

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

The measures we used excluded many low-value services (e.g., imaging for pulmonary embolism without moderate or high pretest probability) because it was difficult to distinguish with claims data inappropriate use of these services from appropriate use (Schwartz et al. 2014). Therefore, our analysis likely represents a conservative estimate of the number of low-value services in Medicare. In addition, we did not estimate the downstream cost of low-value services because it is difficult to determine using claims data whether a specific low-value service led directly to a downstream service (e.g., a follow-up test or procedure). Consequently, our spending estimates probably understate actual spending on low-value care.

Among the measures' broader versions, measures with the highest volume in 2014 were imaging for low back pain (12.0 per 100 beneficiaries), prostate-specific antigen (PSA) screening for men age 75 and over (9.0), and colon cancer screening for older adults (8.0). Those with the highest Medicare spending were percutaneous coronary intervention with balloon angioplasty or stent placement for stable coronary disease (\$1.3 billion), spinal injection for low back pain (\$1.3 billion), and stress testing for stable coronary disease (\$1.2 billion).

Among the measures' narrower versions, measures with the highest volume in 2014 were PSA screening for men age 75 and over (5.1 per 100 beneficiaries), screening for carotid artery disease in asymptomatic adults (4.2), and parathyroid hormone measurement for patients with early chronic kidney disease (3.9). Those with the highest Medicare spending were spinal injection for low back pain (\$643 million), vertebroplasty or kyphoplasty for osteoporotic vertebral fractures (\$327 million), and screening for carotid artery disease in asymptomatic adults (\$221 million).

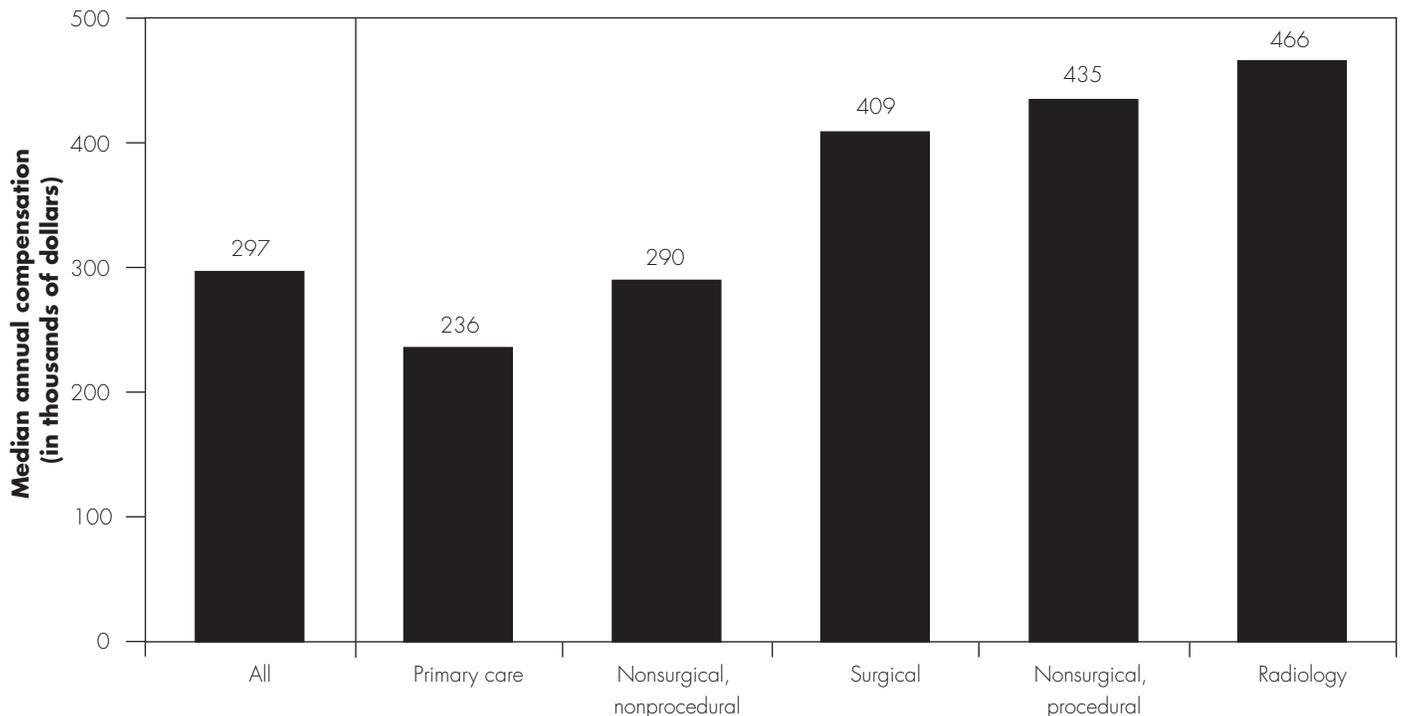
For more details on the volume and spending for individual measures, see the Commission's June 2017 data book (http://www.medpac.gov/docs/default-source/data-book/jun17_databooksec5_sec.pdf?sfvrsn=0).

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 in 2014. However, cardiovascular testing and procedures and other surgical procedures constituted over 71 percent of the spending. Among the measures' narrower versions, imaging and diagnostic and preventive testing accounted for 61 percent of the volume of low-value care, while other surgical procedures and imaging made up two-thirds of the spending.

We also examined geographic variation in the use of low-value services, using a model that adjusted for geographic differences in demographic characteristics and comorbidities that could affect the use of low-value services.⁹ Even after adjusting for these factors, we found substantial variation in the use of low-value services. For example, the adjusted number of low-value services per 100 beneficiaries was 61 percent higher in the geographic area at the 90th percentile compared with the area at the 10th percentile. Because we adjusted for differences in beneficiaries' demographic characteristics and chronic conditions, the variation in the use of low-value care could reflect factors such as geographic differences in physician practice patterns, entrepreneurial behavior, and beneficiaries' preferences for care. ■

larger groups, hospitals, and health systems. For example, the share of physicians working in practices with more than 50 physicians grew between 2009 and 2014 from 16 percent to 22 percent (Medicare Payment Advisory Commission 2017). Recent studies show that commercial prices for physician services are higher in markets with

larger physician practices and in markets with greater physician-hospital consolidation (Baker et al. 2014, Clemens and Gottlieb 2017, Neprash et al. 2015). Our own research found that independent practices with larger market shares and hospital-owned practices received higher commercial prices for E&M visits than other

**FIGURE
4-6****Disparities in physician compensation are widest when primary care physicians are compared with nonsurgical proceduralists and radiologists, 2016**

Source: MedPAC analysis of data from SullivanCotter's Physician Compensation and Productivity Survey, 2016.

practices in their market (Medicare Payment Advisory Commission 2017). For example, independent practices with a large market share of E&M visits received an average commercial price for an E&M visit that was 41 percent higher than the Medicare rate. By contrast, the average commercial price received by the smallest independent practices for an E&M visit was about equal to Medicare's rate. These findings indicate that the ratio of Medicare rates to commercial rates for physician services can vary by practice size within the same market. There is also evidence that commercial prices for physician services vary widely across markets. In 2011, we reported that average prices paid by commercial insurers were more than 50 percent above Medicare rates in some markets but were below Medicare rates in other markets (Medicare Payment Advisory Commission 2011).

Compensation is much higher for certain specialties than for primary care

The Commission remains concerned that E&M office visits, which make up a large share of the services

provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology), are underpriced in the fee schedule relative to other services, such as procedures. In addition, the nature of FFS payment allows some specialties to more easily increase the volume of services they provide (and therefore their revenue from Medicare). Such increases are less likely for other specialties, particularly those that spend most of their time providing labor-intensive E&M services. These factors contribute to an income disparity between primary care physicians and certain specialists.

For an analysis of the compensation received from all payers by physicians—the largest subset of practitioners—we examined 2016 data from SullivanCotter's Physician Compensation and Productivity Survey. Median compensation across all specialties was about \$297,000 in 2016. Compensation was much higher for some specialties than others. The specialty groups with the highest median compensation were radiology (\$466,000); the nonsurgical, procedural group (\$435,000); and surgical specialties

Commission recommendation for a per beneficiary payment for primary care

The Commission has a long-standing concern that evaluation and management (E&M) office visits, which make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology), are underpriced by the Medicare fee schedule for physicians and other health professionals compared with other services such as procedures. The Commission has also become concerned that the fee schedule—with its orientation toward discrete services that have a definite beginning and end—is not well designed to support primary care, which requires ongoing care coordination for a panel of patients. The Commission, in its March 2015 report, recommended that the Congress establish a per beneficiary payment for primary care practitioners to replace the expired Primary Care Incentive Payment (PCIP) program,

which provided a 10 percent bonus payment on fee schedule payments for certain E&M visits provided by primary care clinicians (Medicare Payment Advisory Commission 2015). A monthly per beneficiary payment based on the total amount of PCIP payments in 2015 would have amounted to about \$2.35.

The Commission recommended that the additional payments to primary care practitioners be in the form of a per beneficiary payment to move away from the service-oriented fee-for-service payment approach. Funding for the per beneficiary payment would come from reducing payment rates for all services in the fee schedule other than certain E&M visits provided by any practitioner. This method of funding would be budget neutral and would help rebalance the fee schedule toward primary care clinicians. ■

(\$409,000) (Figure 4-6).¹⁰ Median compensation for radiology was almost double the median compensation for primary care physicians (\$236,000), and median compensation for nonsurgical, procedural physicians was 84 percent higher than that of primary care physicians. Psychiatry—which is in the nonsurgical, nonprocedural group—had median compensation of \$234,000, slightly lower than primary care physicians (data not shown).¹¹ Our analysis of compensation data from the Medical Group Management Association (MGMA) from prior years showed similar differences between specialties.

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.¹² 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. 2010). This finding suggests that the fee schedule is an important source of the disparities in compensation among specialties.

Validation of the fee schedule's RVUs could help correct price inaccuracies and ensure that E&M office visits are not underpriced relative to other services. 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, in 2015, the Commission recommended a per beneficiary payment for primary care that could also help rebalance the fee schedule toward primary care services (see text box on the Commission's recommendation).

Input costs for physicians and other health professionals are projected to increase from 2018 to 2019

The MEI measures the annual change in the market basket of input prices for physician and other health professional services and is adjusted for economy-wide productivity. As of the fourth quarter of 2017, CMS's forecast is that the MEI will increase by 1.8 percent in 2019. This projection is subject to change.

How should Medicare payments change in 2019?

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.

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 beneficiaries' access to care appears generally stable. Overall, Medicare beneficiaries generally have comparable or slightly better access to clinician services than privately insured individuals ages 50 to 64. A slight decline in the number of physicians per beneficiary was offset by an increase in the number of advanced practice registered nurses and physician assistants per beneficiary, and the share of providers accepting assignment and enrolled in Medicare's participating provider program remains high.

In 2016, across all services, volume per beneficiary grew by 1.6 percent. Among broad service categories, growth rates were 1.1 percent for E&M, 1.4 percent for imaging services, 2.8 percent for major procedures, 2.5 percent for other procedures, and 1.7 percent for tests (Table 4-10, p. 110).

As of the fourth quarter of 2017, input prices for physicians and other health professionals were projected to increase by 1.8 percent in 2019. We note that this projection is subject to change. In 2016, 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 findings that payments appear adequate, the Commission recommends an update for 2019 consistent with current law.

RECOMMENDATION 4

For calendar year 2019, the Congress should increase the calendar year 2018 payment rates for physician and other health professional services by the amount specified in current law.

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 on January 1, 2019. 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 2019. (Subsequent to the Commission's vote on this update recommendation, the Bipartisan Budget Act of 2018 changed the 2019 update to the fee schedule to 0.25 percent.)

IMPLICATIONS 4

Spending

- No change as compared with current law at the time the Commission voted on this recommendation.

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. ■

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_17_physician_final9da411adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.
- 2 CMS is required by statute to ensure that changes to RVUs do not change aggregate fee schedule spending by more than \$20 million. In addition, from 2016 through 2018, CMS was required by statute to meet an annual target for reduced fee schedule spending resulting from adjustments to the prices of misvalued services. The target was 1.0 percent of fee schedule spending in 2016, 0.5 percent of fee schedule spending in 2017, and 0.5 percent of fee schedule spending in 2018. Because CMS did not meet any of these annual targets, the conversion factor in each year was reduced by the difference between the target amount and the reduction in fee schedule spending that resulted from adjustments to the prices of misvalued services, also known as the target recapture amount. In 2018, the target recapture amount was 0.09 percent. The misvalued-services target is scheduled to expire after 2018.
- 3 Services that are less likely to be assigned include osteopath services and chiropractor services (although the assignment rates are still around 90 percent for both service types).
- 4 Under prior law, opt-out agreements were effective for two years, and clinicians had to affirmatively renew them every two years.
- 5 The total payment sums to \$158 instead of \$159 due to rounding. Section 603 of the Bipartisan Budget Act of 2015 prohibits HOPDs that began billing under the outpatient prospective payment system (OPPS) on or after November 2, 2015, and are located off a hospital campus from billing under the OPPS after January 1, 2017. In 2017, CMS paid 50 percent of the OPPS rate for services provided at these off-campus HOPDs (this was a proxy for the facility payment rate under the fee schedule for physicians and other health professionals). On-campus HOPDs, off-campus HOPDs that began billing before November 2, 2015, and dedicated emergency departments are permitted to continue billing under the OPPS.
- 6 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.
- 7 The penalty for clinicians who did not submit data under the PQRS increased from 1.5 percent of payments in 2015 to 2.0 percent of payments in 2016. The penalty for clinicians who did not meet the EHR meaningful use requirement grew from 1.0 percent of payments in 2015 to 2.0 percent of payments in 2016. Between 2015 and 2016, the total amount of incentive payments for clinicians who met the EHR meaningful use requirement dropped from \$1.4 billion to \$0.9 billion. The PCIP program provided \$686 million to eligible primary care clinicians in 2015, the final year of the program. The penalties and incentive payments under PQRS, the EHR program, and the PCIP program were mandated by statute.
- 8 HPCs are hospital discharges that can be managed or treated in an outpatient setting and may have resulted from the lack of adequate ambulatory care access and coordination. The HPCs are based on the premise that, while not every complication can be averted, comparatively high risk-adjusted ratios of these events can identify opportunities for improvement in an area's ambulatory care systems. The measure includes both inpatient admission and observation stay discharges. The measure specification is developed by the Agency for Healthcare Research and Quality and adapted by the National Committee for Quality Assurance with permission.
- 9 Our model included demographic variables (e.g., age, race, sex, and Medicaid enrollment), clinical variables (e.g., the presence of specific chronic conditions and the total number of conditions), and a dummy variable for each geographic area.
- 10 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.
- 11 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hematology/oncology, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.
- 12 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. Hourly compensation for nonsurgical, procedural specialties and radiology was more than double the hourly compensation rate for primary care.

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