CHAPTER 4

Physician and other health professional services

RECOMMENDATION

4 For calendar year 2020, the Congress should increase the calendar year 2019 Medicare payment rates for physician and other health professional services by the amount specified in current law.

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

CHAPTER 4

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 2017, Medicare paid $69.1 billion for physician and other health professional services, accounting for 14 percent of fee-for-service (FFS) Medicare benefit spending. About 985,000 clinicians billed Medicare: roughly 596,000 physicians and 389,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare pays for the services of physicians and other health professionals using a fee schedule. Under current law, there is no update to Medicare's conversion factor for the fee schedule on January 1, 2020.

In this chapter

- Are Medicare fee schedule payments adequate in 2019?
- How should Medicare payments change in 2020?

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 problems obtaining a new specialist.

- ***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 2017, across all services, volume per beneficiary grew by 1.6 percent. Among broad service categories, growth rates were 1.2 percent for evaluation and management services, 1.3 percent for imaging services, 2.1 percent for major procedures, 2.1 percent for other procedures, and 2.4 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. We report three population-based measures: patient experience measures, avoidable hospitalizations for ambulatory care–sensitive conditions, and rates of low-value care in Medicare. Patient experience scores in Medicare FFS remain high, and rates of avoidable hospitalizations for ambulatory care–sensitive conditions continue to decline modestly from prior years, but there is substantial use of low-value care.

***Medicare payments and providers' costs*—**CMS currently projects that the increase in 2020 in the Medicare Economic Index (which measures input prices) will be 2.4 percent. In 2017, Medicare FFS payment rates for physician and other health professional services averaged 75 percent of commercial rates paid by preferred provider organizations, unchanged from 2016. Median compensation in 2017 was much lower for primary care physicians than for physicians in certain specialties, 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 Medicare payments for physicians and other health professionals are adequate. Therefore, the Commission recommends that the 2020 payment rate for physician and other health professional services be updated by the amount specified in current law. ■

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.

The Medicare program paid $69.1 billion for physician and other health professional services in 2017, or 14 percent of benefit spending in Medicare's traditional fee-for-service (FFS) program. In 2017, about 985,000 health professionals billed Medicare through the fee schedule—roughly 596,000 physicians and 389,000 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 will be $36.04 in 2019, up from $36.00 in 2018.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a set of updates for clinicians billing under the Medicare fee schedule and repealed the prior framework that set the conversion factor—the sustainable growth rate (SGR) formula. The SGR was established to limit total fee schedule spending by restraining annual updates when spending exceeded certain parameters. MACRA established two paths for clinicians: one payment path for clinicians who participate in advanced alternative payment models (A–APMs) and, for other clinicians, the Merit-based Incentive Payment System (MIPS) (Table 4-1). In 2020, there is no statutory update for clinicians. Clinicians qualifying for the A–APM incentive payment will receive an incentive payment of 5 percent of their professional services payments in a lump sum. Clinicians remaining in MIPS can receive payment adjustments of –5 percent to +5 percent (or higher) in 2020, based on performance.

TABLE 4–1

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

	2019	2020	2021	2022	2023	2024	2025	2026 and later
A–APM clinicians								
Update	0.25%	0%	0%	0%	0%	0%	0%	0.75%
APM bonus	5%	5%	5%	5%	5%	5%	N/A	N/A
Other clinicians								
Update	0.25%	0%	0%	0%	0%	0%	0%	0.25%
Potential MIPS adjustments	(–4% to +4%)	(–5% to +5%)	(–7% to +7%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)

Note: A–APM (advanced alternative payment model), N/A (not applicable), MIPS (Merit-based Incentive Payment System). Clinicians who are subject to 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 MIPS maximum upward adjustment may exceed these limits or be less than these amounts because of 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 and Bipartisan Budget Act of 2018, www.congress.gov.

TABLE 4–2

Satisfaction with the overall quality of health care received in all settings in the past 12 months, 2018

	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Very satisfied	68%	55%
Somewhat satisfied	20	25
Somewhat dissatisfied	3	5
Very dissatisfied	2	1

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 2018.

Are Medicare fee schedule payments adequate in 2019?

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, Medicare's payment rates relative to commercial rates paid by preferred provider organizations, physician compensation across specialties, and the change in input prices for physician and other health professional services. 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.

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 2018.

The Commission also conducts focus groups in markets 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, and we conducted a primary care physician focus group in each location. In these markets, we also conducted site visits and interviews with various providers.

Overall, findings from our survey and focus groups are consistent with one another and similar to prior years.[2] 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.

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 (80 percent) (Table 4-2).

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

Indicators from our 2018 telephone survey of access are largely comparable with prior years' surveys. In particular, in 2018, 70 percent of Medicare beneficiaries reported that they never had to wait longer than they wanted for routine care, and 79 percent reported the same for illness or injury care (Table 4-3). Medicare beneficiaries were less likely to report trouble obtaining either type of care when needed than privately insured individuals (the rates for privately insured individuals were 64 percent for routine care and 74 percent for illness or injury care).

Rates of access to timely regular or routine care for both Medicare and privately insured individuals were slightly worse in 2018 than in 2017, but Medicare access continued to be slightly better than access for privately insured individuals (Figure 4-1, p. 102).

Medicare beneficiaries were also less likely than privately insured individuals to report that they waited longer than they wanted for care for illness or injury (Figure 4-2, p. 102).

TABLE 4–3

Most aged Medicare beneficiaries and older privately insured individuals had good access to physician care, 2014–2018

Survey question	Medicare (ages 65 and older) 2014	2015	2016	2017	2018	Private insurance (ages 50–64) 2014	2015	2016	2017	2018
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	72%[ab]	72%[a]	68%	73%[ab]	70%[ab]	69%[ab]	69%[ab]	67%[b]	69%[ab]	64%[a]
Sometimes	20[a]	19[a]	22[b]	20	20[a]	23[ab]	23[ab]	23[b]	22[b]	26[a]
Usually	3[b]	4	4	3[b]	5	4	4	5	4	5
Always	3	3	3	3	3[a]	3[b]	3	4	3	4[a]
Don't know/Refused	2[b]	2[b]	2[b]	1[b]	2[a]	1	1	1	1	2[a]
For illness or injury										
Never	83[ab]	82[ab]	79[a]	80[a]	79[a]	79[ab]	77[ab]	75[a]	76[a]	74[a]
Sometimes	12[ab]	13[ab]	16[a]	15	15[a]	16[ab]	17[a]	19[a]	18	19[a]
Usually	2	3	2[ab]	2	2	2[b]	3	3[a]	2[b]	3
Always	1[ab]	2	2[ab]	1[b]	2	2[a]	2	3[a]	2	2
Don't know/Refused	2	1	2	1	1	1[b]	1[b]	1[b]	1	2
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"	10	11	11[a]	11	11[a]	11[b]	12	12[a]	12[b]	14[a]
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")										
Primary care doctor	8	7[ab]	8[ab]	9[a]	10	8[b]	9[a]	10[a]	11[a]	10
Specialist	17[b]	16[b]	18	17[a]	19[a]	17[b]	18[b]	18[b]	20[a]	21[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	67	67	64	69[a]	71	63	63	63	59[ab]	67
Share of total insurance group	*5.5*[b]	*4.7*[b]	*5.1*[b]	*6.2*	*7.1*	*4.9*[b]	*5.7*	*6.1*	*6.5*	*6.7*
Small problem	16	18	15	13	13	16	18	16	18	16
Share of total insurance group	*1.3*	*1.2*	*1.2*	*1.2*[a]	*1.3*	*1.3*	*1.7*	*1.5*	*2.0*[a]	*1.6*
Big problem	15	14	20	14[a]	14	19	17	20	22[a]	16
Share of total insurance group	*1.2*	*1.0*	*1.6*	*1.3*[a]	*1.4*	*1.5*	*1.5*	*1.9*	*2.4*[a]	*1.7*
Specialist										
No problem	85	87[a]	82	83	84	85[b]	82[a]	79	81	80
Share of total insurance group	*14.4*	*14.2*[b]	*14.7*	*14.1*	*16.1*	*14.5*[b]	*14.8*[b]	*14.4*[b]	*16.2*	*17.1*
Small problem	7	7	10	11[b]	7	9	8	9	11	9
Share of total insurance group	*1.2*	*1.1*	*1.8*	*1.9*	*1.4*	*1.4*	*1.5*	*1.6*	*2.2*	*2.0*
Big problem	7	6	8[a]	5[a]	8	6	9	11[a]	8[a]	10
Share of total insurance group	*1.2*	*1.0*[a]	*1.4*	*0.9*[ab]	*1.5*	*1.0*[b]	*1.7*[a]	*2.0*	*1.6*[a]	*2.0*

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

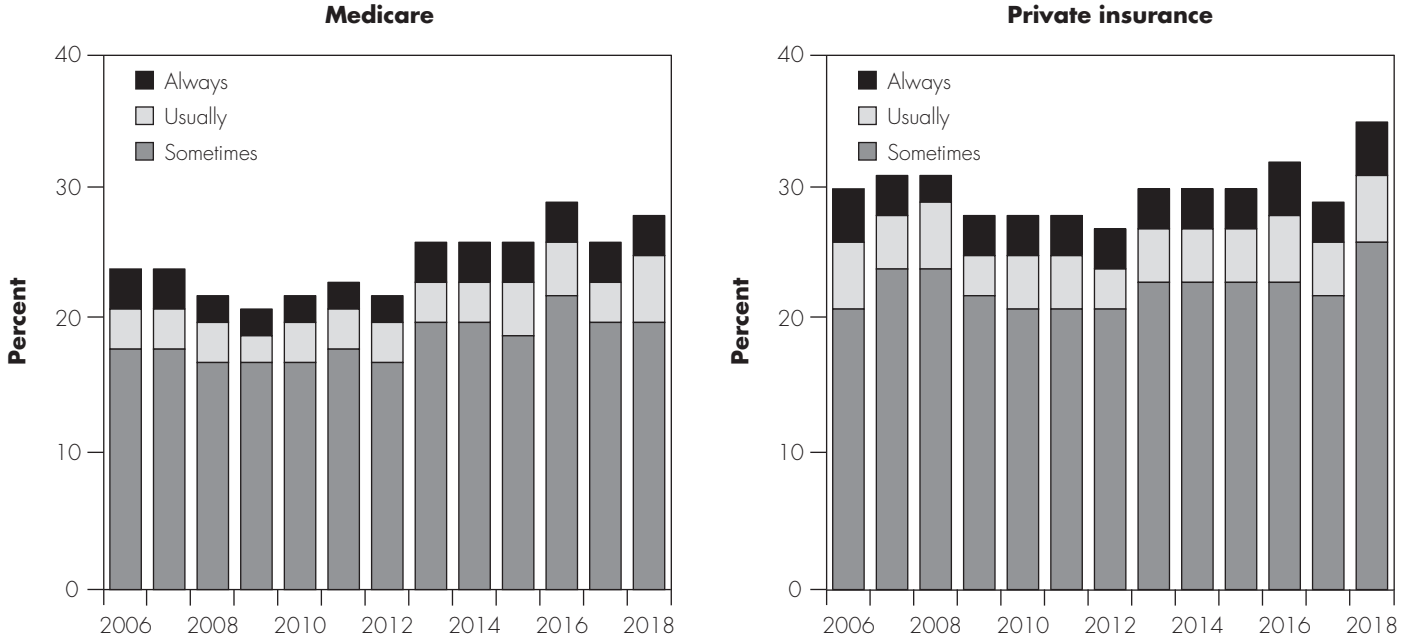
[a] Statistically significant difference between the Medicare and privately insured groups in the given year (at a 95 percent confidence level).

[b] Statistically significant difference from 2018 within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted from 2014 to 2018.

FIGURE 4–1

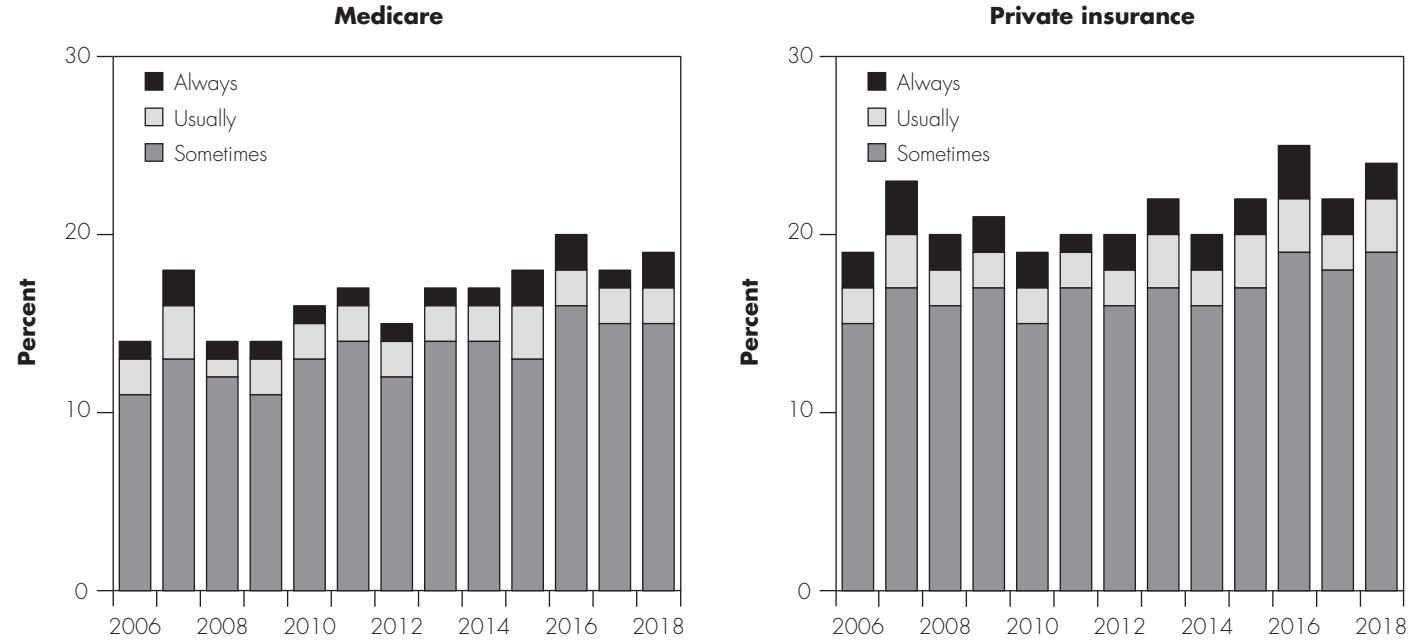
Among patients seeking care, share who ever waited longer than wanted for regular or routine care, Medicare and private insurance



Source: MedPAC-sponsored telephone surveys, 2006–2018.

FIGURE 4–2

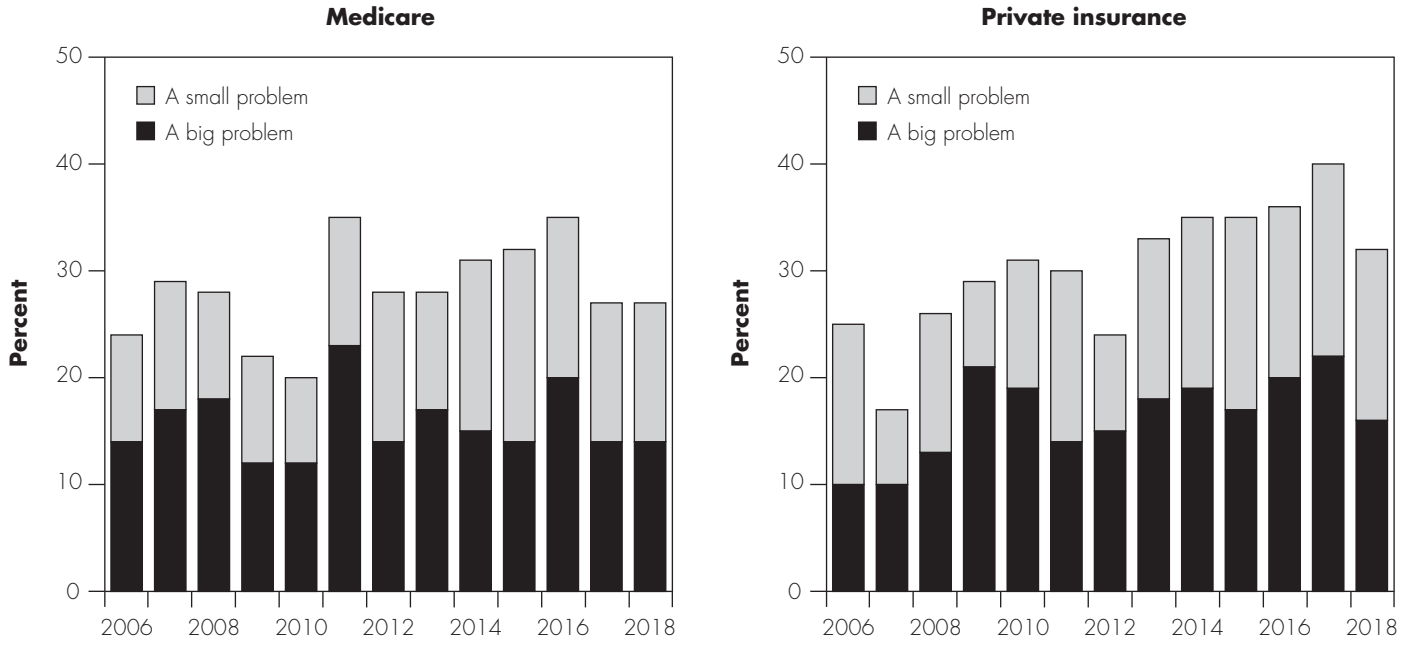
Among patients seeking care, share who ever waited longer than wanted for illness or injury care, Medicare and private insurance



Source: MedPAC-sponsored telephone surveys, 2006–2018.

FIGURE 4–3

Among those looking, share of respondents who indicated trouble finding a new primary care doctor, Medicare and private insurance



Note: The share of respondents looking for a new doctor each year is about 10 percent for primary care. Therefore, the share of Medicare respondents facing a problem (small or big) in obtaining a new primary care doctor was 2.7 percent in 2018, and the share of private insurance respondents facing a problem (small or big) was 4.3 percent in 2018.

Source: MedPAC-sponsored telephone surveys, 2006–2018.

Beneficiaries report more difficulty accessing primary care than specialty care

We also ask respondents whether, when they are looking for a new doctor, they are able to find one without difficulty. Most beneficiaries reported that they were able to find a new doctor without a problem.

Consistent with prior years, beneficiaries looking for a new doctor generally reported more problems finding one when seeking a new primary care doctor than seeking a new specialist (Table 4-3, p. 101). For primary care, 10 percent were looking for a new doctor, and of those looking, 14 percent reported a big problem, meaning that, on net, 1.4 percent of the Medicare population reported a big problem. For specialty care, 19 percent were looking for a new doctor; of those looking, 8 percent reported a big problem, meaning that, on net, 1.5 percent of the total Medicare population reported a big problem.

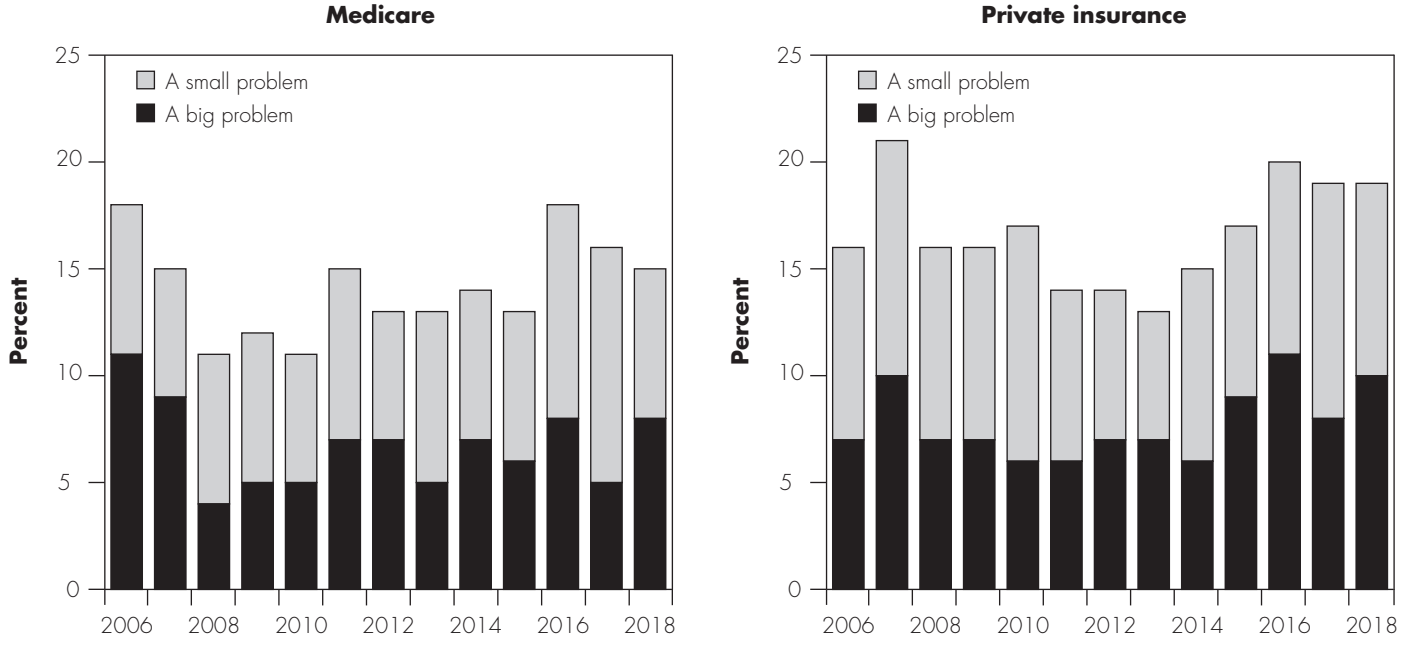
This pattern of greater difficulty for Medicare beneficiaries (among those looking) in finding a new primary care doctor relative to finding a specialist is consistent with prior years, other surveys, and our beneficiary focus groups.

However, overall, Medicare beneficiaries continue to be slightly less likely than individuals with private insurance to report problems obtaining primary and specialty care (Figure 4-3, this page, and Figure 4-4, p. 104).

Beneficiaries in the Commission's telephone survey reported difficulty with certain specialty referrals, namely dermatologists (likely due to specialization in cosmetic dermatology vs. medical dermatology), psychiatrists, and neurologists.

FIGURE 4–4

Among those looking, share of respondents indicating trouble finding a new specialist, Medicare and private insurance



Note: The share of respondents looking for a new doctor each year is about 20 percent for specialty care. Therefore, the share of Medicare respondents facing a problem (small or big) in obtaining a new specialist was 2.8 percent in 2018, and the share of private insurance respondents facing a small or big problem was 4.0 percent in 2018.

Source: MedPAC-sponsored telephone surveys, 2006–2018.

Some groups of beneficiaries report more difficulty obtaining care

In our telephone survey, minority beneficiaries were more likely than (non-Hispanic) White beneficiaries to report that they could not obtain care as quickly as they wanted.

As in prior years, differences in reported access between urban and rural beneficiaries were minimal.

Minority beneficiaries reported more difficulty receiving care as soon as they wanted and higher rates of forgoing care We continue to find through the Commission's telephone survey that Medicare beneficiaries who belong to racial or ethnic minority groups are more likely to report waiting longer than they want for regular or routine care than non-Hispanic White beneficiaries, consistent with general trends in poorer access to health care among racial and ethnic minority groups (Table 4-4).[3]

Specifically, minority Medicare beneficiaries were more likely than non-Hispanic White Medicare beneficiaries to report that they always had to wait longer than they wanted for a routine doctor's appointment (5 percent vs. 2 percent, respectively). Similar to prior years' findings, minority Medicare beneficiaries were also more likely than non-Hispanic White beneficiaries to say that they did not receive care when they thought they should have (15 percent for minority beneficiaries vs. 10 percent for non-Hispanic White beneficiaries).

Minority Medicare beneficiaries also reported higher rates of problems finding a specialist, and a similar pattern exists for privately insured minority individuals. Although the small sample sizes of the Commission's survey generally do not permit us to detect significant differences in reported access among Black (or African American) and Hispanic (or Latinx) beneficiaries separately,

TABLE 4–4

Medicare beneficiaries had similar access to physicians compared with privately insured individuals, but minorities in both groups reported problems more frequently, 2018

	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	**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	70%[a]	71%[ab]	65%[b]	64%[a]	65%[ab]	61%[b]
Sometimes	20[a]	20[a]	21[a]	26[a]	25[a]	29[a]
Usually	5	5	5	5	5	4
Always	3[a]	2[ab]	5[b]	4[a]	4[ab]	6[b]
Don't know/Refused	2[a]	2[ab]	3[ab]	2[a]	*[a]	1[a]
For illness or injury						
Never	79[a]	80[ab]	75[b]	74[a]	75[ab]	71[b]
Sometimes	15[a]	15[a]	15[a]	19[a]	19[a]	22[a]
Usually	2	2	3	3	3	4
Always	2	2	3	2	2[b]	3[b]
Don't know/Refused	1	1[ab]	3[ab]	2	2[a]	2[a]
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Share answering "Yes"	11[a]	10[ab]	15[b]	14[a]	13[a]	16
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care physician	10	10	9	10	9	11
Specialist	19[a]	20[b]	15[b]	21[a]	23[b]	19[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	71	71	69	67	72[b]	59[b]
Share of total insurance group, by race	*7.1*	*7.2*	*6.2*	*6.7*	*6.7*	*6.7*
Small problem	13	14	14	16	15	17
Share of total insurance group, by race	*1.3*	*1.4*	*1.3*	*1.6*	*1.4*	*1.9*
Big problem	14	15	14	16	14[b]	23[b]
Share of total insurance group, by race	*1.4*	*1.5*	*1.3*	*1.7*	*1.3[b]*	*2.5[b]*
Specialist						
No problem	84	86[b]	*77[b]*	80	82[b]	*74[b]*
Share of total insurance group, by race	*16.1*	*17.3[b]*	*11.9[b]*	*17.1*	*18.5[b]*	*14.0[b]*
Small problem	7	7	10	9	9	11
Share of total insurance group, by race	*1.4*	*1.4*	*1.6*	*2.0*	*2.1*	*2.1*
Big problem	8	7[b]	13[b]	10	8[b]	13[b]
Share of total insurance group, by race	*1.5*	*1.4*	*2.0*	*2.0*	*1.8*	*2.5*

Note: Respondents who did not report race or ethnicity were not included in "White" or "Minority" results but were included in "All" results. "White" in the table refers to non-Hispanic White respondents. Numbers may not sum to 100 percent because of rounding. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2018. Sample sizes for individual questions varied.

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

[b] Statistically significant difference by race within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted in 2018.

TABLE 4–5

Access to physician care for Medicare beneficiaries was similar to or slightly better than access for privately insured individuals in urban and rural areas, 2018

	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	**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	70%[a]	70%[a]	68%	64%[a]	63%[ab]	68%[b]
Sometimes	20[a]	20[a]	19[a]	26[a]	26[a]	24[a]
Usually	5	4[b]	6[ab]	5	5	4[a]
Always	3[a]	3[a]	4	4[a]	4[a]	3
Don't know/Refused	2[a]	2	2	2[a]	2	1
For illness or injury						
Never	79[a]	79[a]	78[a]	74[a]	74[a]	73[a]
Sometimes	15[a]	15[a]	15[a]	19[a]	19[a]	21[a]
Usually	2	2[a]	3	3	3[a]	3
Always	2	2	2	2	2	2
Don't know/Refused	1	1	1	2	2	2
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Share answering "Yes")	11[a]	11[a]	11	14[a]	14[a]	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	10	10	9	10	10	9
Specialist	19[a]	19[a]	18	21[a]	22[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	71	72	68	67	68	64
Share of total insurance group, by area	*7.1*	*7.1*	*6.0*	*6.7*	*6.8*	*5.9*
Small problem	13	12	13	16	15	15
Share of total insurance group, by area	*1.3*	*1.2*	*1.2*	*1.6*	*1.6*	*1.4*
Big problem	14	13	18	16	15	21
Share of total insurance group, by area	*1.4*	*1.4*	*1.6*	*1.7*	*1.5*	*1.9*
Specialist						
No problem	84	84	86	80	81	82
Share of total insurance group, by area	*16.1*	*16.1*	*15.7*	*17.1*	*17.6*[b]	*14.0*[b]
Small problem	7	8	5	9	9	8
Share of total insurance group, by area	*1.4*	*1.6*	*0.9*	*2.0*	*2.1*	*1.4*
Big problem	8	7	9	10	9	10
Share of total insurance group, by area	*1.5*	*1.3*[a]	*1.6*	*2.0*	*2.1*[a]	*1.7*

Note: Numbers may not sum to 100 percent because of rounding. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2018. 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).

Source: MedPAC-sponsored telephone survey conducted in 2018.

Hispanic Medicare beneficiaries were more likely to report waiting longer than wanted for regular or routine care than non-Hispanic White beneficiaries. In addition, Black beneficiaries are significantly more likely than non-Hispanic White beneficiaries to report that they should have seen a doctor but did not (15 percent vs. 10 percent for non-Hispanic White beneficiaries) (data not shown).

Few reported differences in access between urban and rural beneficiaries Similar to prior years, the Commission's telephone survey showed no major differences in access between urban and rural 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. Urban beneficiaries reported more timely access to routine care than urban individuals with private insurance. However, differences between rural beneficiaries and rural individuals with private insurance 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 beneficiaries in the Commission's survey reported that they had a regular source of primary care—94 percent in 2018 (data not shown). Beneficiaries in focus groups generally responded that they could access their provider the same day or within a few days.

In the Commission's telephone survey, 16 percent of beneficiaries responded that they saw a nurse practitioner (NP) or physician assistant (PA) for all or most of their primary care, and 29 percent said that they saw an NP or PA for some of their primary care (these numbers have continued to rise gradually over time). 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 (21 percent for rural beneficiaries vs. 14 percent for urban beneficiaries) (data not shown).

Supply of physicians and other health professionals billing Medicare has kept pace with enrollment growth, and most clinicians are in a participating provider arrangement with Medicare

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 are required to 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 2015 to 2017 shows that the number of physicians and other health professionals furnishing services to Medicare beneficiaries is growing and has generally kept pace with enrollment growth in Medicare (Table 4-6, p. 108). Between 2016 and 2017, the number of primary care physicians increased by 1 percent, from almost 185,000 to just over 186,000.[4] Because the number of beneficiaries grew by almost 3 percent between 2016 and 2017 (data not shown), the ratio of primary care physicians to the number of beneficiaries dropped slightly, from 3.6 per 1,000 beneficiaries to 3.5 per 1,000.[5] Similarly, the number of physicians in other specialties grew by 1 percent between 2016 and 2017, from nearly 406,000 to almost 410,000, but the number per 1,000 beneficiaries declined slightly from 7.8 to 7.7. Meanwhile, during the same period, the number of advanced practice registered nurses and PAs billing Medicare grew by 10 percent, and the number per 1,000 beneficiaries rose from 3.9 to 4.2.

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

In 2018, 96 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 (almost all claims are paid on assignment).[6] 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. Clinicians can also opt out of the Medicare program and treat patients entirely outside of the Medicare benefit. Opt-out clinicians are concentrated in the provider specialties of dentistry and behavioral health (including psychiatry). The number of clinicians who opted out of Medicare in 2018 is largely consistent with prior years (data not shown).

TABLE 4–6 **Number of physicians and other health professionals billing Medicare, 2015–2017**

	Physicians				Advanced practice registered nurses and physician assistants		Other practitioners	
	Primary care specialties		Other specialties					
Year	Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries	Number	Number per 1,000 beneficiaries
2015	182,767	3.6	400,303	7.9	182,949	3.6	155,310	3.1
2016	184,905	3.6	405,780	7.8	202,874	3.9	160,661	3.1
2017	186,193	3.5	409,995	7.7	223,567	4.2	165,486	3.1

Note: Specialty is self-reported by physicians and other health professionals when they enroll in the Medicare program. "Primary care specialties" are specialties that were eligible for the Primary Care Incentive Payment program: family medicine, internal medicine, pediatric medicine, and geriatric medicine. In 2017, CMS introduced a new physician specialty code for hospitalists. Most of the physicians who billed Medicare as hospitalists in 2017 billed as a primary care specialty in 2016. To maintain consistency across years, we assigned physicians who billed as hospitalists in 2017 to the "primary care specialties" group. "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 Medicare and Medicare Advantage on the assumption that physicians and other health professionals are furnishing services to beneficiaries in both programs. Figures for 2015 and 2016 may vary from figures that appeared in prior Commission reports due to minor technical changes. Figures exclude nonperson providers such as suppliers or clinical laboratories.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2018 annual report of the Boards of Trustees of the Medicare trust funds.

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 could be related to the movement of services from freestanding offices to hospitals and to general practice pattern changes. For example, the number of echocardiograms per beneficiary administered in freestanding offices declined in 2017 by 0.3 percent, while the number administered in hospital outpatient departments (HOPDs) rose by 2.0 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, technology, and beneficiaries' preferences—can also explain volume increases.

We used claims data from 2012, 2016, and 2017 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 change in service use: units of service per beneficiary and volume of services per beneficiary. Volume is measured as units of service multiplied by each service's relative value units (RVUs) from the fee schedule. Our volume growth measure thus accounts for changes in both the number of services and the complexity, or intensity, of those services. For example, growth in the volume of imaging services would account not just for any change in the number of such services but also for any change in intensity (e.g., if providers substitute computed tomography (CT) scans for less complex X-rays). We used RVUs for 2017 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 includes office/outpatient services, hospital inpatient services, and other subcategories).

Between 2016 and 2017, across all services, volume per beneficiary grew by 1.6 percent (Table 4-7). Among broad service categories, growth rates were 1.2 percent for E&M, 1.3 percent for imaging services, 2.1 percent for major procedures, 2.1 percent for other procedures, and 2.4 percent for tests. The 2017 growth rates for all

TABLE 4–7

Use of clinician services per FFS beneficiary, 2012–2017

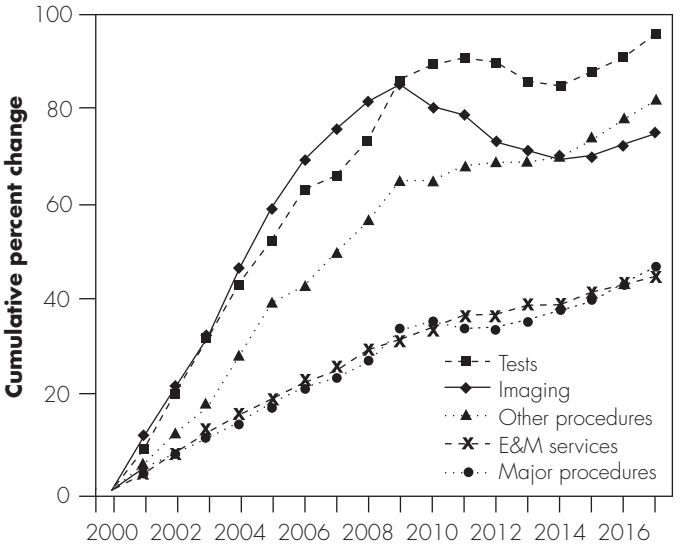
Type of service	Change in units of service per beneficiary		Change in volume per beneficiary		Share of 2017 allowed charges
	Average annual 2012–2016	2016–2017	Average annual 2012–2016	2016–2017	
All services	**0.7%**	**1.3%**	**1.0%**	**1.6%**	**100.0%**
Evaluation and management	**0.2**	**0.6**	**1.0**	**1.2**	**52.8**
Office/outpatient services	1.0	0.5	1.6	1.0	26.9
Hospital inpatient services	–1.8	–1.2	–1.5	–0.5	11.5
Emergency department services	0.4	–0.8	1.2	0.0	3.3
Nursing facility services	1.9	1.0	2.6	2.1	3.0
Ophthalmological services	–0.2	–0.1	0.1	0.2	2.8
Behavioral health services	N/A	3.0	N/A	2.9	1.9
Critical care services	0.9	3.9	0.9	3.8	1.5
Care management/coordination	20.1	31.7	30.3	40.7	0.8
Observation care services	8.2	0.7	7.9	1.1	0.7
Home services	–0.6	–3.6	–0.5	–3.4	0.3
Imaging	**0.2**	**1.4**	**–0.2**	**1.3**	**11.4**
Standard X-ray	–0.8	0.8	–0.3	–0.1	3.0
Ultrasound	–0.1	–0.1	–1.3	–0.1	3.0
CT	3.0	4.8	2.7	4.9	2.1
MRI	1.9	2.4	1.3	2.3	1.3
Nuclear	–3.8	–1.4	–3.8	1.0	1.3
Major procedures	**0.5**	**0.6**	**2.2**	**2.1**	**7.8**
Musculoskeletal	2.4	1.3	3.2	2.2	2.9
Vascular	–1.1	0.0	8.0	9.5	1.3
Cardiovascular	1.5	2.0	1.6	0.5	1.0
Other organ systems	–1.1	0.3	–0.6	0.4	1.0
Digestive/gastrointestinal	–2.7	–1.5	–1.9	–1.4	0.8
Skin	0.4	–0.4	0.1	–0.9	0.5
Eye	–0.5	–1.8	–0.4	–1.7	0.2
Other procedures	**1.8**	**2.4**	**1.4**	**2.1**	**23.1**
Skin	1.6	0.8	1.7	1.3	4.6
Physical, occupational, and speech therapy	5.0	5.8	5.5	6.2	3.9
Musculoskeletal	0.9	0.2	1.3	2.6	2.6
Eye	1.5	2.1	1.0	1.5	2.4
Radiation oncology	–1.8	3.5	–1.4	2.3	2.0
Other organ systems	0.7	1.5	2.4	2.5	1.7
Digestive/gastrointestinal	–0.5	–0.3	0.1	0.0	1.3
Dialysis	–1.4	–1.7	0.2	–0.3	1.2
Vascular	–0.7	–0.5	3.2	2.7	1.1
Chiropractic	–1.9	–2.6	–2.0	–2.7	0.8
Injections and infusions: non-oncologic	–2.5	–0.7	–2.5	–0.8	0.5
Chemotherapy administration	–3.3	–4.9	–3.2	–5.7	0.5
Tests	**0.3**	**1.2**	**–0.2**	**2.4**	**4.6**
Anatomic pathology	–0.2	1.0	–0.4	1.7	1.3
Cardiography	–0.8	1.3	–1.6	4.2	1.3
Neurologic	1.7	0.3	0.7	1.8	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 units (RVUs) from Medicare's fee schedule for physicians and other health professionals. To put service use in each year on a common scale, we used the RVUs for 2017. For billing codes not used in 2017, we imputed RVUs based on the average change in RVUs for each type of service. Use of behavioral health services is not reported for 2012 to 2016 because of a change in billing codes implemented in 2013. Some low-volume categories are not shown but are included in the summary calculations. Totals may not sum due to rounding.

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

FIGURE 4–5

Growth in the volume of clinician services per FFS beneficiary, 2000–2017



Note: FFS (fee-for-service). 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 2017, 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. The type-of-service categories were restructured starting with the growth rates for 2016.

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

services and for broad service categories were higher than the average annual growth rates from 2012 to 2016, except for major procedures (2.1 percent increase in 2017 vs. 2.2 percent average annual growth from 2012 to 2016).

Subcategories of a broad service category sometimes experienced more rapid volume growth in 2017 than the broad service category. For example, volume growth in the other procedures category was 2.1 percent, but volume growth in the subcategory of physical, occupational, and speech therapy was 6.2 percent (physical therapy accounted for most of this growth).

Some service subcategories exhibited large increases in intensity. For example, within major procedures, the vascular procedures subcategory had no change in units of service in 2017 but a 9.5 percent increase in volume. The difference was due to rapid growth of angioplasty and other procedures to treat peripheral artery disease (PAD) in the lower extremities. These procedures have higher RVUs than other procedures in the same subcategory.

Among the service subcategories, care management/coordination had the highest rate of volume growth: 30.3 percent per year from 2012 to 2016 and 40.7 percent in 2017. However, this subcategory had a very low level of volume in 2012 (data not shown). CMS created new billing codes for transitional care management (TCM) in 2013 and chronic care management (CCM) in 2015. In 2016, CMS established a billing code for monthly enhanced oncology services for the Oncology Care Model (OCM). The OCM, CCM, and TCM services account for most of the growth in care management/coordination. In 2017, the volume of OCM services increased by 147.8 percent, CCM increased by 59.9 percent, and TCM increased by 19.4 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 2.8 percent (data not shown). Although care management/coordination experienced high volume growth, it accounts for less than 1 percent of total fee schedule spending.

While volume growth for imaging in 2017 was slightly lower than the average increase for all services and follows a slight decrease from 2012 to 2016, use of imaging services remains much higher than it was in 2000 (Figure 4-5). Cumulative growth in the volume of imaging per beneficiary from 2000 to 2017 totaled 75 percent, which was much higher than cumulative growth during the same period for major procedures and E&M services (47 percent and 45 percent, respectively). In addition, volume increases in 2017 were higher for certain types of imaging than others. For example, in 2017, the volume of CT grew 4.9 percent (Table 4-7, p. 109). By contrast, from 2012 to 2016, average annual volume growth of CT was 2.7 percent. Similarly, in 2017, MRI volume increased 2.3 percent, compared with an average annual increase from 2012 to 2016 of 1.3 percent (Table 4-7, p. 109).

In response to concerns about overuse of imaging, tests, and procedures, the American Board of Internal Medicine (ABIM) Foundation developed the "Choosing Wisely" campaign. As part of this ongoing effort, more than 80 specialty societies have identified over 550 tests and procedures that are often overused (ABIM Foundation 2016). The goal of Choosing Wisely is to promote

and inform conversations between clinicians and their patients about appropriate tests and treatments. As part of Choosing Wisely, the Society for Vascular Medicine has cautioned that patients with PAD usually do not need to have a procedure (ABIM Foundation 2017). Nevertheless, the number of procedures to treat PAD in the lower extremities grew rapidly in 2017.

In addition, CMS is developing the Appropriate Use Criteria (AUC) Program that will require clinicians to use clinical decision support (CDS) software when they order advanced diagnostic imaging services for beneficiaries. Under this program, clinicians who order these services will need to consult with CDS software and obtain feedback on whether the services adhere to AUC 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 as units of service multiplied by each service's RVUs has two advantages. First, volume growth accounts for changes not just in the number of services but also 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 expenses, 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 2018, for example, the most common type of E&M office/outpatient visit for an established patient (Current Procedural Terminology code 99213) had an average nonfacility fee schedule payment of $74.[7] 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. Thus, the shift of E&M office/outpatient visits from freestanding offices to HOPDs reduces volume growth because the RVUs are lower for these services when they are delivered in HOPDs.

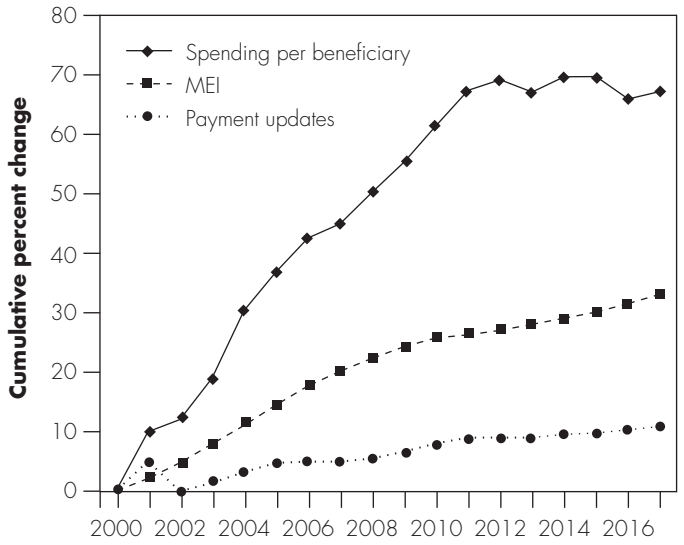
Medicare makes both a fee schedule payment and a facility payment when a service is provided in an HOPD (the facility payment accounts for the cost of the service in an HOPD). However, the program makes only a fee schedule payment when a service is furnished in a freestanding office. For example, in 2018, the total payment for the most common E&M office/outpatient visit for an established patient when provided in an HOPD (other than certain off-campus HOPDs) was $166 ($52 for the fee schedule payment to the clinician plus $114 for the facility payment to the HOPD) compared with $74 (the nonfacility fee schedule payment) for this visit when provided in a freestanding office.

In recent years, there has been a trend toward billing for some services in hospitals instead of freestanding offices. From 2013 to 2017, for example, the number of outpatient hospital–based E&M visits per beneficiary grew by 19.4 percent, compared with a 3.5 percent decline in physician office–based E&M visits. During the same period, the number of chemotherapy administration services per beneficiary delivered in HOPDs grew 28.7 percent, while the number provided in physician offices declined 13.1 percent. This change in the billed setting increases overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in HOPDs than in freestanding offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012). For example, we estimate that the Medicare program spent $1.9 billion more in 2017 than it would have if payment rates for E&M office/outpatient visits in HOPDs were the same as freestanding office rates. In addition, beneficiaries' cost sharing for E&M office/outpatient visits in HOPDs was $480 million higher in 2017 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/outpatient visits in freestanding physician offices and HOPDs (Medicare Payment Advisory Commission 2012). As of 2019, Medicare pays a comparable amount for E&M office/outpatient visits in freestanding physician offices and off-campus HOPDs; however, Medicare continues to pay a higher amount for these visits when provided in on-campus HOPDs.[8] The Commission also recommended adjusting OPPS rates for services in ambulatory payment classification (APC) groups that meet certain criteria so that payment rates are equal or more closely aligned between HOPDs and freestanding offices (Medicare Payment Advisory Commission 2014).[9]

FIGURE 4–6

Growth in the volume of clinician services caused fee schedule spending to increase faster than input prices and payment updates, 2000–2017



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: 2018 annual report of the Boards of Trustees of the Medicare trust funds; Centers for Medicare & Medicaid Services 2017; Clemens 2014.

APCs that meet these criteria are those that are unlikely to have costs associated with operating an emergency department; do not have extra costs associated with higher patient complexity in HOPDs; and include services that are frequently performed in physicians' offices (which indicates that these services are likely safe and appropriate to provide in a physician's office).

Volume growth has contributed to an increase in spending, 2000 to 2017

The growth in service volume has contributed significantly to an increase in spending for fee schedule services (Figure 4-6). From 2000 to 2017, payment updates for these services did not keep pace with growth in input prices. Payment updates increased cumulatively by 11 percent—less than the 33 percent cumulative increase in the Medicare Economic Index (MEI), which measures changes in input prices. However, spending per beneficiary for these services grew at a cumulative rate of 67 percent.

Volume growth, which accounts for most of the difference between the payment updates and spending growth, is influenced, among other things, by changes in clinical practice, such as the diffusion of new technologies. It may also be related to an increase in the treated prevalence (the share of the population receiving treatment) of many chronic conditions. For example, rapid growth in the proportion of beneficiaries treated for five or more chronic conditions between 1987 and 2002 fueled an increase in Medicare spending during this period (Thorpe and Howard 2006). Reasons for growth in the treated prevalence of chronic conditions included higher rates of obesity, advances in technology for diagnosing and treating conditions, and changes in the definition of some diseases (Medicare Payment Advisory Commission 2007). Volume growth could also reflect changes in the demographic status of beneficiaries, although the effect of changes in age and sex on Medicare spending for physician and other health professional services has generally been small in the recent past, and spending on physician services varies less by age than spending for other services, such as inpatient hospital and post-acute care.

In 2017, per beneficiary spending for fee schedule services increased slightly, by 0.8 percent.[10] Several factors influenced this increase: 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 meet the electronic health record (EHR) meaningful use requirement, and smaller incentive payments for clinicians who met the EHR meaningful use requirement.[11]

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 and clinician attestation of participation in certain activities. In 2019, CMS is implementing the Merit-based Incentive Payment System (MIPS), which entails clinician-level payment adjustments based on these clinician-reported and -attested quality measures and participation activities (see text box for first year results, pp. 114–115).

The Commission has established a set of principles for quality measurement in Medicare; we believe that the MIPS measures are neither effective in assessing true clinician quality nor appropriate for Medicare's value-based purchasing programs. Specifically, quality

TABLE 4–8 **Medicare FFS CAHPS® performance rates, 2013–2017**

CAHPS composite measure	2013	2014	2015	2016	2017
Getting needed care and seeing specialists	87%	86%	85%	84%	84%
Getting appointments and care quickly	75	76	75	77	77
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical records, helps with managing care)	86	86	85	86	86
Rating of health plan (FFS Medicare)	85	84	82	84	83
Rating of health care quality	86	86	86	85	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). "Plan" in the fourth row refers to the Medicare FFS program.

Source: FFS CAHPS mean scores provided by CMS.

measurement should be patient oriented, encourage coordination across providers and time, and promote change in the delivery system. Medicare quality programs should include population-based measures such as outcomes, patient experience, and value. Along these lines, this chapter reports three measures assessing the ambulatory care environment for Medicare FFS beneficiaries: patient experience (measured using the Consumer Assessment of Health Providers and Systems® (CAHPS®)), population-based measures assessing avoidable hospitalizations for ambulatory care–sensitive conditions, and rates of low-value care in Medicare.

Patient experience measures

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

Overall, how Medicare FFS beneficiaries rated their health care quality and reported their ability to get care quickly was generally stable between 2013 and 2017, although there was a slight decline in reporting that they could get needed care and see specialists (Table 4-8). There was also a slight decline in beneficiaries' ratings of their health plans and health care quality.

Avoidable hospitalizations

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 can be one indication of higher quality. However, this measure is also sensitive to secular trends over time in the site of care.

Figure 4-8 (p. 116) presents results for three common conditions among the Medicare population—diabetes, congestive heart failure, and bacterial pneumonia. Consistent with prior years, the rates show general declines across all three conditions and the age categories, likely due to continuing declines in inpatient admissions. The modest increase for heart failure may be the result of CMS dramatically reducing its frequency of challenges to the medical necessity of short-stay cases.

The Commission plans to continue to refine a set of population-based outcome measures that Medicare can calculate using claims data.

Low-value care

Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm

The Merit-based Incentive Payment System year 1 results

As of 2019, the Merit-based Incentive Payment System (MIPS) adjusts payments in fee-for-service (FFS) Medicare at the individual clinician level based on performance in four areas: quality; resource use; clinical practice improvement activities; and advancing care information (formerly meaningful use of electronic health records) (Centers for Medicare & Medicaid Services 2016).

The payment changes that take place in 2019 are based on clinician performance in 2017. On November 8, 2018, CMS released the initial summary of MIPS performance data that will underlie the payment adjustments in 2019.

For the first year of the program, CMS made a number of discrete policy decisions to reflect a phased approach to implementation, which CMS refers to as "Pick Your Pace." Specifically, CMS used its regulatory authority to:

- Set the MIPS performance threshold at 3 points (out of 100). Clinicians with a score above 3 are to receive a neutral or positive payment adjustment, and clinicians with a score of 3 or below are to receive a negative payment adjustment.
- Set the MIPS exceptional performance bonus threshold at 70 points (out of 100).
- Permit clinicians to meet the 3-point MIPS performance threshold by reporting minimal information on one quality measure (or attesting to one performance activity).
- Weight the cost component at 0 points.

Because the basic MIPS payment adjustments must be weighted to be budget neutral, the decision to set the performance threshold very low means that the payment increases will be very small (because there will be many clinicians meeting or exceeding the thresholds). The exceptional performance bonus is not budget neutral and will linearly increase for clinicians at a certain threshold above the MIPS threshold.

In the first year of the program, just over 1 million MIPS-eligible clinicians (including physicians, nurse practitioners, physician assistants, group practices, and certain other nonphysician practitioners) reported MIPS information (Table 4-9). Most clinicians—over 700,000—reported sufficient information with sufficiently high scores to receive both a positive MIPS adjustment and qualify for the MIPS exceptional performance bonus.

Figure 4-7 illustrates how the MIPS incentive payment works for the first year. In concept, the

TABLE 4–9 **MIPS performance information for eligible clinicians, 2017**

		Number of clinicians	Payment adjustment
Did not report		51,500	–4%
Reported	Minimum required	20,100	0%
	Sufficient data to gain a positive update	221,400	Between 0% and 0.22%
	Sufficient data to gain a positive update and exceptional performance bonus	714,500	Between 0.28% and 1.88%

Note: MIPS (Merit-based Incentive Payment System). This table includes all clinicians who reported MIPS information, even those who may qualify as "low volume" for MIPS purposes or are excluded from Table 4-6 (p. 108).

Source: CMS. http://qpp.cms.gov.

(continued next page)

The Merit-based Incentive Payment System year 1 results (cont.)

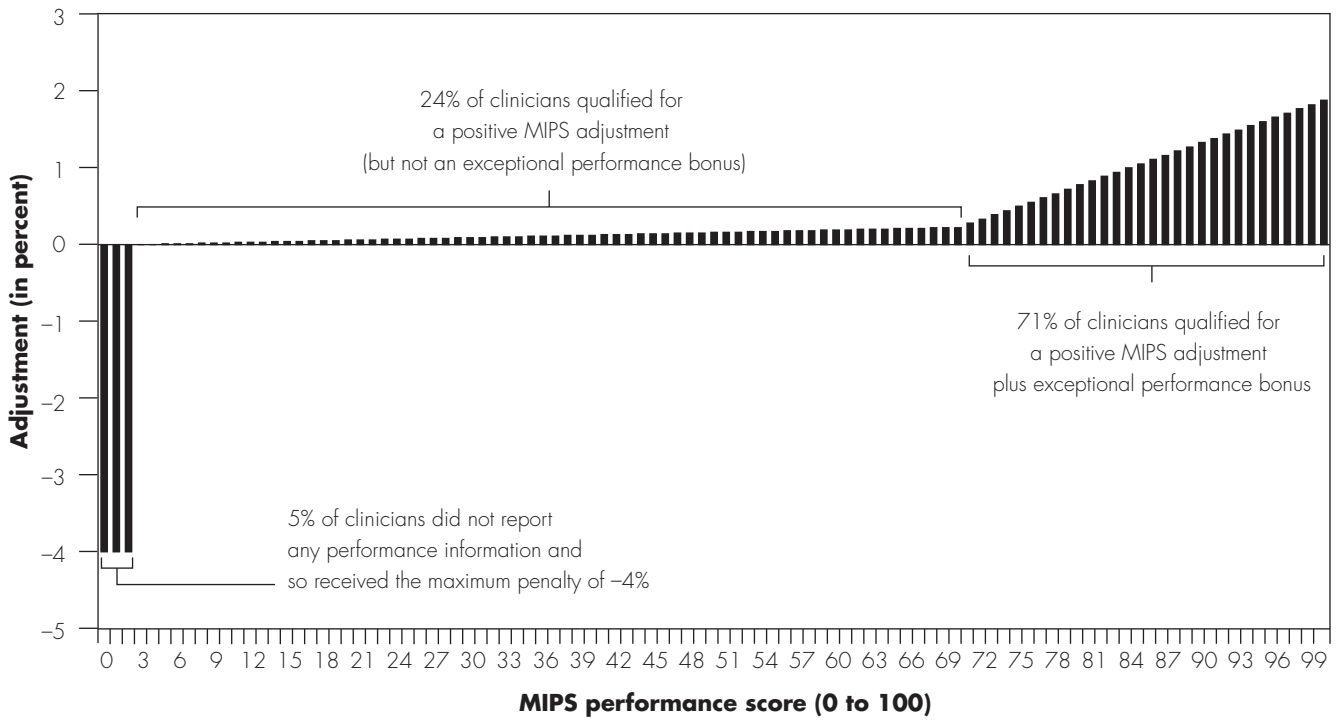
negative payment adjustment applied to clinicians below the MIPS performance threshold must fund the bonuses applied to clinicians above the MIPS performance threshold. Under these circumstances, performance bonuses this year were predictably small: The maximum MIPS bonus was 0.22 percent. When the exceptional performance bonus was added, the maximum total bonus was 1.88 percent.

Despite the low performance threshold, because clinicians could choose which measures to report, most clinicians had very high performance scores overall in the first year of the program. Specifically, the mean performance score was 74 points, and the median performance score was 89 points, well in excess of the 3-point threshold for a positive adjustment and the 70-point threshold for the exceptional performance bonus.

CMS is moving toward meeting an eventual statutory deadline in 2022 to set the MIPS performance score at the mean or median of clinician performance, which will compress the range of positive payment adjustments such that small changes in MIPS performance scores will result in large swings in payment adjustments. In other words, because most clinicians have sufficiently high scores in the first year of the program (with 71 percent qualifying for both a positive payment adjustment and the exceptional performance bonus), the mean or median MIPS performance scores will be very high. ■

FIGURE 4–7

The Merit-based Incentive Payment System adjustments, 2017

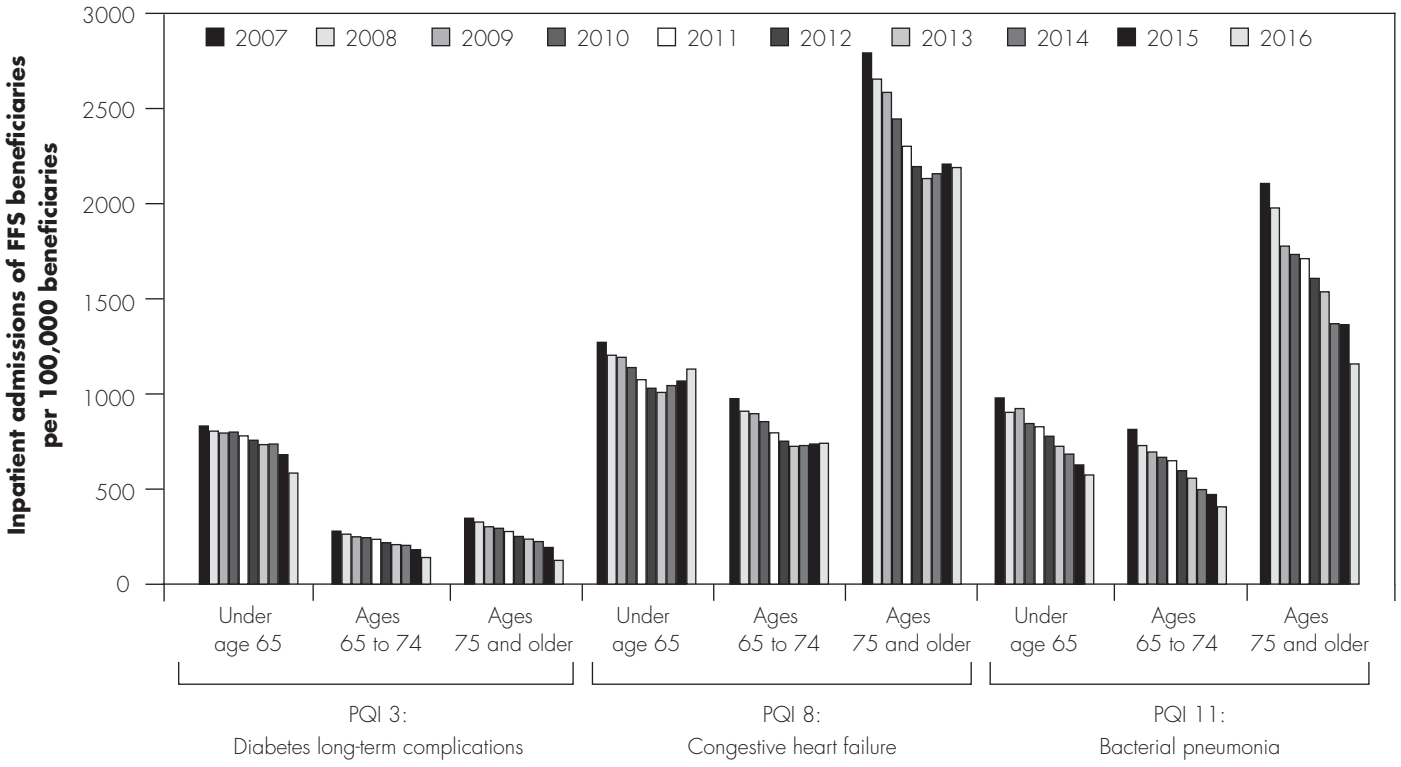


Note: MIPS (Merit-based Incentive Payment System).

Source: MedPAC analysis based on data from CMS.

FIGURE 4–8

Trends in selected PQIs for inpatient admissions of FFS beneficiaries for ambulatory care–sensitive conditions, 2007–2016



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.

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). Because the current MIPS measure set has few measures assessing low-value care and few clinicians report these measures, the Commission previously used a set of 31 claims-based measures to assess low-value care in Medicare in 2014. Our analysis demonstrated that low-value care was a significant issue in Medicare that year: We found between 34 and 72 instances of low-value care per 100 beneficiaries, depending on whether we used a narrow or broad version of each measure. Between 23 percent and 37 percent of beneficiaries received at least one low-value service, and annual Medicare spending for these services ranged from $2.4 billion to $6.5 billion. The spending estimates are conservative because they do not reflect the downstream cost of low-value services (e.g., follow-up tests and procedures). For more information on this analysis, see the Commission's June 2018 report to the Congress (Medicare Payment Advisory Commission 2018).

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 fee schedule contributes to an income disparity between primary care clinicians and other specialties. The third measure assesses the change in input prices for physician and other health professional services—the MEI.

Ratio of Medicare payments to commercial PPO payments

In 2017, Medicare's payment rates for physician and other health professional services (including cost sharing) were 75 percent of commercial rates paid by PPOs, unchanged from 2016. The ratio has declined from 81 percent in 2010. The ratio in 2017 varied by type of service. For example, Medicare rates were 80 percent of commercial rates for E&M office visits for established patients but 59 percent of commercial rates for coronary artery bypass graft surgery. This analysis uses data on paid claims for PPO members of a large national insurer that covers a wide geographic area across the United States. The payments reflect the insurer's allowed amount with allowed cost sharing. The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments.

The ratio of Medicare rates to commercial rates has declined in recent years as 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, which gives physicians greater leverage to negotiate higher prices with commercial plans. In recent years, an increasing number of physicians have joined larger groups, hospitals, and health systems. For example, between 2009 and 2014, the share of physicians working in practices with more than 50 physicians grew 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 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 varies by practice size within the same market because larger practices can obtain higher prices from commercial payers than smaller practices. In addition to varying within markets, evidence suggests that commercial prices for physician services vary widely across markets. A study by the Congressional Budget Office found that the average ratio of commercial prices to Medicare prices for 20 common services was at least 70 percent higher in the most costly market than in the least costly market (Congressional Budget Office 2018).

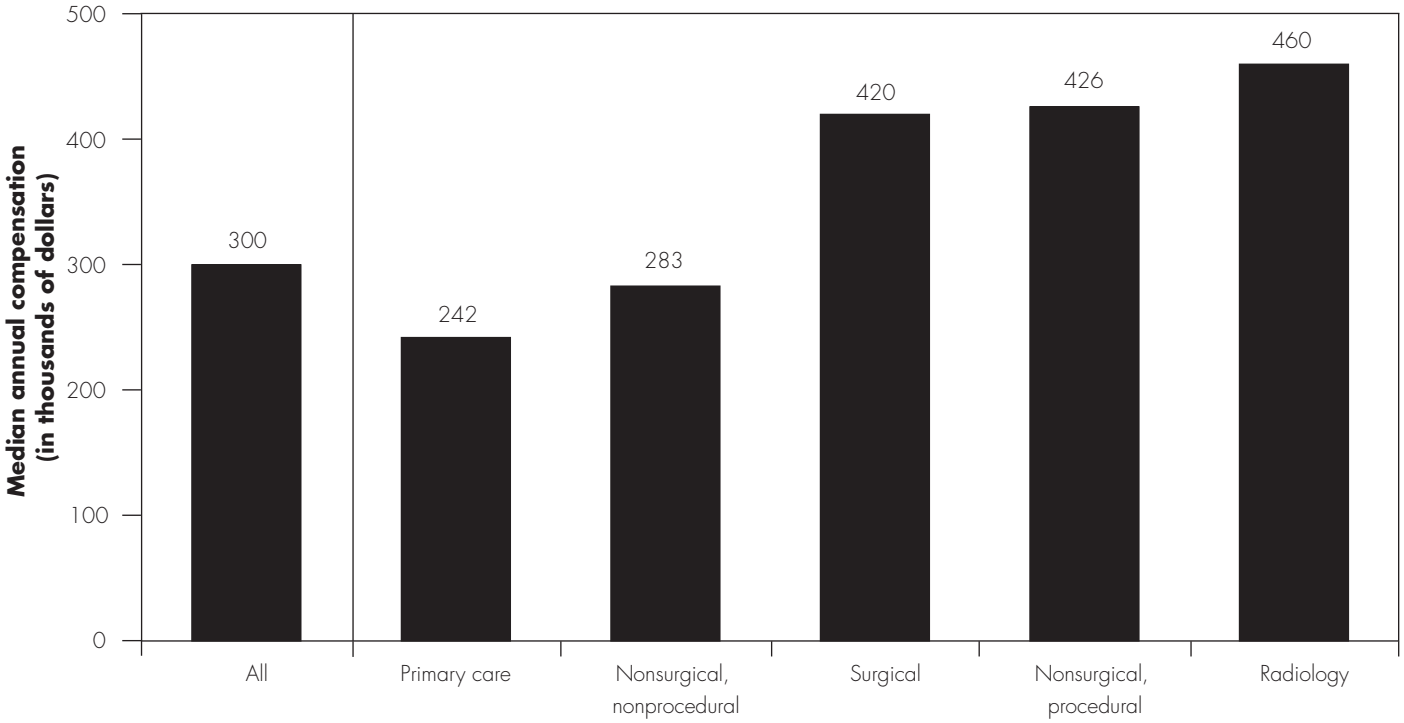
Compensation is much higher for certain specialties than for primary care

The Commission remains concerned that ambulatory E&M 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 (Medicare Payment Advisory Commission 2018).[12] This factor contributes 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—the Commission contracted with the Urban Institute, working in collaboration with SullivanCotter. The contractor calculated median compensation based on 2017 data from SullivanCotter's Physician Compensation and Productivity Survey. Median compensation across all specialties was $300,000 in 2017. Compensation was much higher for some specialties than others. The specialty groups with the highest median compensation were radiology ($460,000); the nonsurgical, procedural group ($426,000); and surgical specialties ($420,000) (Figure 4-9, p. 118).[13] Median compensation for radiology was 90 percent higher than median compensation for primary care ($242,000), and median compensation for nonsurgical, procedural specialties was 76 percent higher than that of primary care. Psychiatry—which is in the nonsurgical, nonprocedural group—had median compensation of $241,000, slightly lower than primary care physicians (data not shown).[14] Previous Commission work using data from the Medical Group Management Association (MGMA) showed that such disparities also existed when compensation was observed on an hourly

FIGURE 4–9

Disparities in physician compensation are widest when primary care physicians are compared with radiologists, nonsurgical proceduralists, and surgeons, 2017



Note: Figure includes all physicians who reported their annual compensation in the survey (76,336).

Source: Urban Institute 2018.

basis, thus accounting for variations in hours worked per week.[15] From 2013 to 2017, median compensation for primary care physicians and surgeons increased at a cumulative rate of 15.4 percent, slower than nonsurgical, procedural specialties (17.9 percent) and nonsurgical, nonprocedural specialties (16.2 percent) but faster than radiology (9.6 percent) (data not shown).[16] Across all specialty groups, median compensation grew 15.9 percent during this period.

Three of the four specialty groups with higher annual compensation than primary care also generated more work RVUs per year.[17] For example, in 2017, median compensation for radiology was nearly double the median compensation for primary care, and radiology had the highest median number of cumulative work RVUs per physician (8,862)—83 percent higher than the median number of work RVUs per physician generated by primary care (4,833) (Table 4-10). Median compensation for surgical specialties was 76 percent higher than median compensation for primary care, and their median number of work RVUs was 46 percent higher than primary care. Because primary care physicians are more likely to focus on ambulatory E&M services than the other specialty groups and because these services tend to have lower work RVUs than other services, the fee schedule's RVUs for ambulatory E&M services may be an important source of the disparities in compensation between primary care and other specialty groups.

The fee schedule's work RVUs, which account for the amount of work required to provide a service, are based on an assessment of how much time and intensity (e.g., mental effort and technical skill) services require relative

TABLE 4–10

Most specialty groups with higher median annual compensation than primary care generate a higher median number of work RVUs than primary care, 2017

Specialty group	Median number of annual work RVUs per physician	Ratio of median annual compensation for specialty group to median compensation for primary care
Radiology	8,862	1.99
Surgical	7,070	1.76
Nonsurgical, procedural	6,395	1.80
Primary care	4,833	1.00
Nonsurgical, nonprocedural	4,554	1.19

Note: RVU (relative value unit). The table includes only physicians who reported both their annual compensation and their annual number of work RVUs in the survey (44,605).

Source: Urban Institute 2018.

to one another. If estimates of time and intensity are not kept up to date, especially for services that experience efficiency improvements, the work RVUs become inaccurate. Because of advances in technology, technique, and clinical practice, efficiency improves more easily for procedures, imaging, and tests than for ambulatory E&M services, which are composed largely of activities that require the clinician's time and so do not lend themselves to efficiency gains. When efficiency gains reduce the amount of work needed for a service, the work RVUs for the affected services should decline accordingly. Under the budget-neutral fee schedule, a reduction in the RVUs of these services would raise the RVUs for all other services, such as ambulatory E&M services. Because of problems with the process of reviewing overpriced services and the data used to set prices, such as the lack of current and objective data on clinician work time and practice expenses, this two-step sequence tends not to occur (Medicare Payment Advisory Commission 2018). Therefore, ambulatory E&M services become passively devalued over time.

The Commission is concerned that this mispricing could lead to problems with beneficiary access to E&M services and, over the longer term, could even influence the pipeline of physicians in specialties that tend to provide a large share of these services. The Commission has made previous recommendations to improve the accuracy of the data used to set RVUs and to rebalance the fee schedule toward primary care by establishing a per beneficiary payment for primary care practitioners (see text box, pp. 120–121).

Input costs for physicians and other health professionals are projected to increase from 2019 to 2020

The MEI measures the change in the market basket of input prices for physician and other health professional services and is adjusted for economy-wide productivity.[18] As of the third quarter of 2018, CMS's forecast is that the MEI will increase by 2.4 percent in 2020. This projection is subject to change.

How should Medicare payments change in 2020?

The Commission's deliberations on payment adequacy for physician and other health professional services are informed by beneficiary access to services, volume growth, quality, and input prices for clinician services. We find that, on the basis of these indicators, payments appear adequate.

On measures of access to the services of physicians and other health professionals, the Commission continues to find that 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

Previous Commission recommendations to improve the accuracy of data for setting relative value units and establish a per beneficiary payment for primary care clinicians

The Commission has a long-standing concern that ambulatory evaluation and management (E&M) services, 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 for physician and other health professional services compared with other services, such as procedures (Medicare Payment Advisory Commission 2018). Validation of the relative value units (RVUs) in the fee schedule could help correct the fee schedule's inaccuracies and ensure that ambulatory E&M visits—such as office visits, hospital outpatient department visits, nursing facility visits, and home visits—are not underpriced. Addressing this mispricing could also reduce disparities in compensation among specialties.

In 2011, the Commission recommended that CMS use a streamlined method to regularly collect data from a cohort of efficient clinician practices—including service volume and work time—to establish more accurate work and practice expense RVUs (Medicare Payment Advisory Commission 2011a, Medicare Payment Advisory Commission 2011b). These data should be used to calculate the amount of time that a clinician worked over the course of a week or month and compare it with the time estimates in the fee schedule for all of the services that the clinician billed over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates—and, hence, the work RVUs—are too high. CMS could use this approach to identify groups of services that are likely overpriced, carefully review those services, and adjust the work RVUs accordingly.

Practice expense RVUs—which account for the cost of operating a practice—are based on data from a survey of total practice costs incurred by nearly all specialty groups. Because this survey was conducted in 2007 and 2008, practice expense RVUs are not likely to reflect current practice costs. CMS has not developed a strategy for updating practice cost data. However, CMS could regularly collect data on total practice costs along with data on service volume and work time from a cohort of efficient practices, as the Commission recommended in 2011 (Medicare Payment Advisory Commission 2011a).

(continued next page)

registered nurses and physician assistants per beneficiary, and the share of providers enrolled in Medicare's participating provider program remains high.

In 2017, across all services, volume per beneficiary grew 1.6 percent. Among broad service categories, growth rates were 1.2 percent for E&M, 1.3 percent for imaging services, 2.1 percent for major procedures, 2.1 percent for other procedures, and 2.4 percent for tests.

As of the third quarter of 2018, input prices for physicians and other health professionals were projected to increase by 2.4 percent in 2020. In 2017, compensation was much lower for primary care physicians than for physicians in certain specialties, which raises 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:

- maintaining beneficiary access to physician and other health professional services;
- minimizing the burden on taxpayers and beneficiaries, who finance the Medicare program; and
- ensuring 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 2020 consistent with current law.

Previous Commission recommendations to improve the accuracy of data for setting relative value units and establish a per beneficiary payment for primary care clinicians (cont.)

In addition to concern about the mispricing of ambulatory E&M services, the Commission is also 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. Consequently, in 2015, the Commission recommended that the Congress establish a per beneficiary payment for primary care clinicians 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 initially amount to about $2.35. The Commission recommended that the additional payments to primary care clinicians be in the form of a per beneficiary payment to move away from the approach of paying separately for each discrete service. The payment would provide funds to support the investment in infrastructure and staff that facilitate care management and care coordination. Funding for the per beneficiary payment would come from reducing payment rates for all services in the fee schedule other than ambulatory E&M visits provided by any clinician. This method of funding would be budget neutral and would help rebalance the fee schedule toward primary care clinicians.

In the Commission's June 2018 report, we described another budget-neutral approach to rebalance the fee schedule that would increase payment rates for ambulatory E&M services while reducing payment rates for other services (e.g., procedures, imaging, and tests) (Medicare Payment Advisory Commission 2018). Under this approach, the increased payment rates would apply to ambulatory E&M services provided by all clinicians, regardless of specialty, and would not change the current fee-for-service system. This change would be a one-time price adjustment to the fee schedule to address several years of passive devaluation of ambulatory E&M services. We modeled the impact of a 10 percent payment rate increase for ambulatory E&M services, although a higher or lower increase could be considered. A 10 percent increase would raise annual spending for ambulatory E&M services by $2.4 billion. To maintain budget neutrality, payment rates for all other fee schedule services would be reduced by 3.8 percent. These payment changes could be implemented in one year or phased in gradually over multiple years. ■

RECOMMENDATION 4

For calendar year 2020, the Congress should increase the calendar year 2019 Medicare 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 no statutory update for calendar year 2020. 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 policy of no update for 2020.

IMPLICATIONS 4

Spending

- No change as compared with current law.

Beneficiary and provider

- The Commission's recommendation of the current-law update should not affect beneficiaries' access to care or 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://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_physician_final_sec.pdf?sfvrsn=0.

2 This year's survey results continue to be largely consistent with other surveys of Medicare beneficiaries and privately insured individuals.

3 In this section, the category *White* refers to those not of Hispanic origin. See the U.S. Census Bureau's "Explanation of Race and Hispanic Origin Categories" at https://www.census.gov/population/estimates/rho.txt.

4 Primary care physicians include specialties that were eligible for the Primary Care Incentive Payment Program: family medicine, internal medicine, pediatric medicine, and geriatric medicine. In 2017, CMS introduced a new physician specialty code for hospitalists. Most of the physicians who billed Medicare as hospitalists in 2017 billed as a primary care specialty in 2016. Therefore, to maintain consistency across years, we assigned physicians who billed as hospitalists in 2017 to the primary care physicians group for this analysis.

5 The number of beneficiaries used to calculate the ratio of physicians and other health professionals per 1,000 beneficiaries includes those in FFS Medicare and Medicare Advantage because we assume that clinicians are furnishing services to beneficiaries covered under either program.

6 Services that are less likely to be assigned include osteopath services and chiropractor services (although the assignment rates are still about 90 percent for both service types).

7 When this type of visit is provided in an HOPD, it is billed as Healthcare Common Procedure Coding System code G0463.

8 Section 603 of the Bipartisan Budget Act of 2015 prohibits HOPDs that began billing under the OPPS on or after November 2, 2015, and are located off a hospital campus from billing under the OPPS after January 1, 2017. In 2018, the facility payment rate for services provided at these off-campus HOPDs was equal to 40 percent of the rate under the OPPS. 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. However, as of 2019, Medicare pays all off-campus HOPDs (regardless of when they began billing under the OPPS) an amount equal to 40 percent of the OPPS rate for office/outpatient E&M visits.

9 For the OPPS, CMS classifies services into APC groups on the basis of clinical and cost similarity; all services within an APC group have the same payment rate.

10 This figure is based on incurred spending, rather than cash spending, for fee schedule services. Cash spending for fee schedule services declined slightly between 2016 and 2017 because of a lag between incurred and cash spending.

11 Between 2016 and 2017, the penalty for clinicians who did not meet the EHR meaningful use requirement grew from 2 percent of payments to 3 percent of payments, and the total amount of incentive payments for clinicians who met the EHR meaningful use requirement dropped from $932 million to $437 million. The penalties and incentive payments under the EHR program are mandated by statute.

12 Ambulatory E&M services include visits in offices, hospital outpatient departments, certain other settings such as nursing facilities, and patients' homes.

13 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.

14 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hospital medicine, 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.

15 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.

16 To control for annual changes in survey respondents, the percentage changes are based on a cohort analysis in which the sample was restricted to physicians who were present in both the 2013 and 2017 data.

17 The exception was nonsurgical, nonprocedural specialties, which had median annual compensation that was 19 percent higher than primary care but generated 6 percent fewer work RVUs per year than primary care.

18 The MEI measures the weighted average annual price change for various inputs used by physicians and other health professionals to furnish services.

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