CHAPTER 4

Physician and other health professional services

RECOMMENDATIONS

4 The Congress should establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. The per beneficiary payment should equal the average per beneficiary payment under the PCIP and should be exempt from beneficiary cost sharing. Funding for the per beneficiary payment should protect PCIP-defined primary care services regardless of the practitioners furnishing the services and should come from reduced fees for all other services in the fee schedule.

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

(Additionally, the Commission reiterates its 2011 recommendations on moving forward from the sustainable growth rate system. See text box, p. 104.)

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 2013, Medicare paid $68.6 billion for physician and other health professional services, accounting for 16 percent of fee-for-service (FFS) Medicare spending. About 876,000 clinicians billed Medicare—573,000 physicians and 303,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare pays for the services of physicians and other health professionals using a fee schedule, and total payments in a year are limited in principle by the sustainable growth rate (SGR) formula. Because of years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, an estimated fee reduction of 21.2 percent is scheduled to take effect on April 1, 2015. Except for a 4.8 percent reduction in 2002, such reductions—called for in previous years by the SGR formula's spending limits—have never been implemented.

Assessment of payment adequacy

We use the following factors to assess payment adequacy for physicians and other health professionals: beneficiary access to care, volume growth, quality, changes in input costs, and differences in compensation across specialties.

In this chapter

***Beneficiaries' access to care*—**Overall, beneficiary access to physician and other health professional services is adequate and largely unchanged from last year. Most beneficiaries report they are able to obtain timely appointments for routine care, illness, or injury, and most beneficiaries are able to find a new doctor without a problem. However, beneficiaries seeking a specialist were more likely to report that they had no problem finding a doctor than beneficiaries seeking a primary care doctor.

- ***Capacity and supply of providers*—**The number of physicians and other health professionals providing services to Medicare beneficiaries from 2011 to 2013 grew at rates similar to growth in the beneficiary population.
- ***Volume of services*—**Across all services, volume per beneficiary grew by 0.5 percent in 2013. Among broad categories of service, evaluation and management grew by 1.4 percent, major procedures by 1.2 percent, and other procedures by 0.1 percent, while imaging declined by 1.0 percent and tests by 2.1 percent. The decline in imaging and tests do not raise concerns about access because they follow large increases in the use of these services since 2000. Specific to imaging, the decrease in volume includes a shift in billing for cardiovascular imaging from professionals' offices to hospitals.

***Quality of care*—**In prior years' reports, the Commission has assessed quality in ambulatory care settings by reporting trends in a set of ambulatory care process measures. The Commission has been increasingly concerned that Medicare's approach to quality measurement is flawed because it relies on too many clinical process measures. Many current process measures are weakly correlated with outcomes such as mortality and readmissions, and most process measures focus on addressing the underuse of services, while the Commission believes that overuse and inappropriate use are also concerns. Therefore, we are not reporting on the process measures that we have used in the past. We have begun exploring the use of a small set of population-based outcome measures to assess and compare performance of FFS Medicare, Medicare Advantage, and Medicare accountable care organizations in the same locality. We are also assessing whether provider-based quality measures will still be needed to make FFS payment adjustments.

***Medicare payments and providers' costs*—**Medicare's payments relative to private insurer payments have remained relatively steady at around 79 percent. CMS currently projects that the percentage increase in 2016 in the Medicare Economic Index will be 2.2 percent. In 2012, compensation was lower for primary care physicians than for physicians in specialty groups such as radiology and nonsurgical, procedural physicians. The disparity is large enough to raise significant concerns about fee schedule pricing.

Repeal of the SGR

The Commission previously made a multicomponent recommendation to repeal the SGR formula. The Commission's long-standing SGR repeal recommendation is based on these principles: Repeal of the SGR is urgent because it stands in the way of more constructive reforms; beneficiary access must be preserved; payments should be rebalanced between primary care and other specialties; and the Medicare program should encourage movement toward reformed delivery systems.

Because this year's payment adequacy findings are largely similar to the findings in prior years, the Commission continues to reiterate its position on the SGR. The budgetary cost of SGR repeal remains near its historic low, providing clear opportunity for repeal. The Commission urges the Congress to take advantage of this opportunity to repeal the SGR so that policymakers and clinicians can pursue in earnest the kinds of delivery system reforms that can provide improved care for beneficiaries at high value to the Medicare program.

Per beneficiary payment for primary care

Medicare's Primary Care Incentive Payment program (PCIP) expires at the end of 2015. The PCIP provides a 10 percent bonus payment on fee schedule payments for PCIP-defined primary care services furnished by eligible primary care practitioners. The Commission believes that the additional payments to primary care practitioners should continue. Allowing the PCIP to expire without a replacement sends a poor signal to primary care practitioners. While Medicare beneficiaries generally have good access to care now, in the future, the aging of the population and health care workforce and the increased use of services by the newly insured may expose beneficiaries to an increasing risk of impaired access to primary care.

The Commission has become increasingly concerned that the fee schedule—oriented toward discrete services and procedures—is an ill-suited payment mechanism for the ongoing, coordinated care of a panel of patients. Therefore, the Commission recommends that the additional payments to primary care practitioners be in the form of a per beneficiary payment as a step away from the service-oriented FFS payment approach and toward beneficiary-centered payments that encourage care coordination. The Commission recommends funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services provided by any practitioner, regardless of the practitioner's specialty designation or whether PCIP-defined primary care services accounted for at least 60 percent of the practitioner's allowed charges. Beneficiaries would not pay cost sharing, just as beneficiaries do not pay cost sharing to fund the

PCIP. This method of funding would be budget neutral and would help rebalance the fee schedule to achieve greater equity of payments between primary care and other services. ■

Background

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

In 2013, the Medicare program paid $68.6 billion for physician and other health professional services, or 16 percent of benefit spending in Medicare's traditional fee-for-service (FFS) program. This spending covered 1.1 billion services for 32 million FFS beneficiaries: 98 percent of Part B FFS enrollees had at least one service. Program payments per person served were just over $3,000 (Centers for Medicare & Medicaid Services 2014c). In 2013, 876,000 professionals billed Medicare through the fee schedule—573,000 physicians and 303,000 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 work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. These three factors are then adjusted by variation in the input prices in different markets, and the sum is then multiplied by the fee schedule's conversion factor to produce a total payment amount.[1]

The conversion factor, which is $35.75 for 2015, is updated by a formula known as the sustainable growth rate (SGR). The SGR was established to limit total fee schedule spending by restraining annual updates when spending exceeded certain parameters. Under the SGR formula, fee schedule spending is permitted to increase by growth in input costs, FFS enrollment, and gross domestic product (GDP).[2]

If volume growth exceeds this target growth rate, the SGR mechanism reduces the yearly update of the conversion factor to a level that would bring spending in line with the target. The SGR was scheduled to produce negative updates beginning in 2002. However, the Congress has not permitted negative updates to go into effect, except for the first year they occurred (2002). There is now a large negative reduction called for under current law, which, absent legislative action, will reduce the payment rate for physician and other health professional services by 21.2 percent on April 1, 2015 (Congressional Budget Office 2014).

In 2011, the Commission laid out its recommendations regarding repeal of the SGR (Medicare Payment Advisory Commission 2011). The recommendation is based on these principles: repeal of the SGR is urgent, beneficiary access must be preserved, payments should be rebalanced between primary care and other specialties, and the Medicare program should encourage movement toward reformed delivery systems.

In addition to the administrative burden that short-term SGR overrides impose on both clinicians and CMS (by sometimes requiring delayed claims processing), the process of short-term overrides (and the search for budgetary offsets) often monopolizes the Medicare policy development process. In other words, constant action on short-term legislative patches means that there is often little time to pursue more meaningful policies to improve the Medicare program and how it pays for physician and other health professional services. At this time, the budgetary cost of SGR repeal remains at historic lows (less than half the cost it was two years ago). Because the measures of payment adequacy are generally similar to last year, the Commission continues to reiterate its recommendations and urges the Congress to repeal the SGR.

Are Medicare fee schedule payments adequate in 2015?

We assess payment adequacy by reviewing beneficiary access to care provided by physicians and other health professionals, volume growth, quality of care, and Medicare's payment rates relative to those in the private sector. 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 practitioners; and site visits conducted yearly. Supplementing these primary sources, we also review (1) other surveys of patient access and satisfaction among Medicare beneficiaries and those with private insurance and (2) physician and provider surveys on their willingness to accept Medicare beneficiaries.

Each year, the Commission sponsors a telephone survey of 4,000 Medicare beneficiaries age 65 and over and 4,000

TABLE 4–1

Satisfaction with the overall quality of health care received in all settings in the past 12 months, 2014

	Medicare (age 65 or older)	Private insurance (age 50–64)
Very satisfied	68%	59%
Somewhat satisfied	20	23
Somewhat dissatisfied	3	4
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 2014.

privately insured individuals ages 50 to 64.[3] 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 2014.

The Commission also conducts focus groups in markets around the country to provide a qualitative description of beneficiary and physician experiences with the Medicare program. We conduct these groups in markets where Medicare beneficiaries have reported experiencing relatively less access to routine, specialty, and urgent care through the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey.[4] In each market, the focus groups consisted of Medicare beneficiaries, non-Medicare-eligible individuals between the ages of 55 and 64, primary care physicians, and nurse practitioners.

Overall, findings from our survey and focus groups and other external sources are very consistent. Medicare beneficiaries have generally stable access to ambulatory care services, and their reported access is either as good as or better than access among privately insured individuals. The share of beneficiaries waiting longer than they wanted for an appointment is largely unchanged from prior years.

Beneficiaries seeking a new primary care doctor are more likely to report difficulty doing so than are beneficiaries seeking a specialist, although the share of beneficiaries experiencing any problem continues to be quite small. Physicians and other types of clinicians appear willing to treat Medicare beneficiaries, although primary care physicians are less likely than specialty physicians to accept new Medicare patients.

It is worth noting that while overall access to ambulatory care is good, this situation could change in the future. The balance between supply and demand will be affected by aging of the population, aging of the health care workforce, and increased use of services by newly insured people. And in some markets, an imbalance in supply and demand could come more quickly than in others. The Commission is concerned in particular about access to primary care services, given the higher reported difficulty accessing care and the important role primary care will play in delivery system reform.

Medicare beneficiaries' overall satisfaction with care is comparable with privately insured patients

Medicare beneficiaries report high levels of satisfaction with their care and are slightly more likely to report being satisfied than near-beneficiaries with private health insurance. From our telephone survey, higher shares of Medicare beneficiaries report that they are very or somewhat satisfied with their care (88 percent) compared with those who have private insurance (82 percent) (Table 4-1).

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

From our telephone survey, the share of Medicare beneficiaries reporting that they never had to wait longer than they wanted for routine care (72 percent) or illness or injury care (83 percent) was consistent with prior years and slightly better than the rates reported by the privately insured—69 percent for routine care and 79 percent for illness or injury care (Table 4-2).

Beneficiaries report more difficulty accessing primary care than specialty care Most beneficiaries report they are able to obtain timely appointments for routine care, illness, or injury, and most beneficiaries are able to find a new doctor without a problem. However, 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 4-2). Overall, 1.2 percent of all Medicare beneficiaries reported that they had a big problem finding a new primary care doctor, and 1.2 percent said they had a big problem finding a new specialist, but among those looking for a new doctor, the share of those reporting a big problem was different for primary care doctors and specialists. For primary care, 8 percent were looking for a new doctor, and of those looking, 15 percent reported a big

TABLE 4–2

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2010–2014

	Medicare (age 65 or older)					Private insurance (age 50–64)				
Survey question	**2010**	**2011**	**2012**	**2013**	**2014**	**2010**	**2011**	**2012**	**2013**	**2014**
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	75%	74%	77%[b]	73%	72%[a]	72%	71%	72%	69%	69%[a]
Sometimes	17[b]	18	17[b]	20	20[a]	21[b]	21	21[b]	23	23[a]
Usually	3	3	3	3	3	4	4	3	4	4
Always	2	2[b]	2[b]	3	3	3	3	3	3	3
For illness or injury										
Never	83	82	84	82	83[a]	80	79	80	77	79[a]
Sometimes	13	14	12	14	12[a]	15	17	16	17	16[a]
Usually	2	2	2	2	2	2	2	2	3	2
Always	1	1	1	1	1[a]	2	1[b]	2	2	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?"										
Percent answering "Yes"	8[b]	8[b]	8[b]	8[b]	10	12	11	11	11	11
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")										
Primary care doctor	7[b]	6[b]	7[b]	7	8	7	7	7	8	8
Specialist	13[b]	14[b]	13[b]	14[b]	17	15	16	18	16	17
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	79[b]	65	72	70	67	69	68	75	67	63
Percent of total insurance group	*5.2*	*3.6*	*4.7*	*5.2*	*5.5*	*4.8*	*4.5*	*5.0*	*5.2*	*4.9*
Small problem	8[b]	12	14	11	16	12	16	9	15	16
Percent of total insurance group	*0.5*	*0.7*	*0.9*	*0.8*	*1.3*	*0.8*	*1.1*	*0.6*	*1.2*	*1.3*
Big problem	12	23[b]	14	17	15	19	14	15	18	19
Percent of total insurance group	*0.8*	*1.3*	*0.9*	*1.3*	*1.2*	*1.3*	*0.9*	*1.0*	*1.4*	*1.5*
Specialist										
No problem	87	84	87	86	85	82	86	86[b]	87	85
Percent of total insurance group	*11.0*	*12.1*	*11.7*	*12.4*	*14.4*	*12.6*	*13.9*	*15.6*	*13.9*	*14.5*
Small problem	6	8	6	8	7	11	8	7[b]	6	9
Percent of total insurance group	*0.8*	*1.1*	*0.7*	*1.2*	*1.2*	*1.8*	*1.3*	*1.2*	*0.9*	*1.4*
Big problem	5	7	7	5	7	6	6	7	7	6
Percent of total insurance group	*0.7*	*1.0*	*0.9*	*0.7*	*1.2*	*1.0*	*1.0*	*1.2*	*1.1*	*1.0*

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not included. Sample sizes for each group (Medicare and privately insured) are 4,000. Sample sizes for individual questions varied.

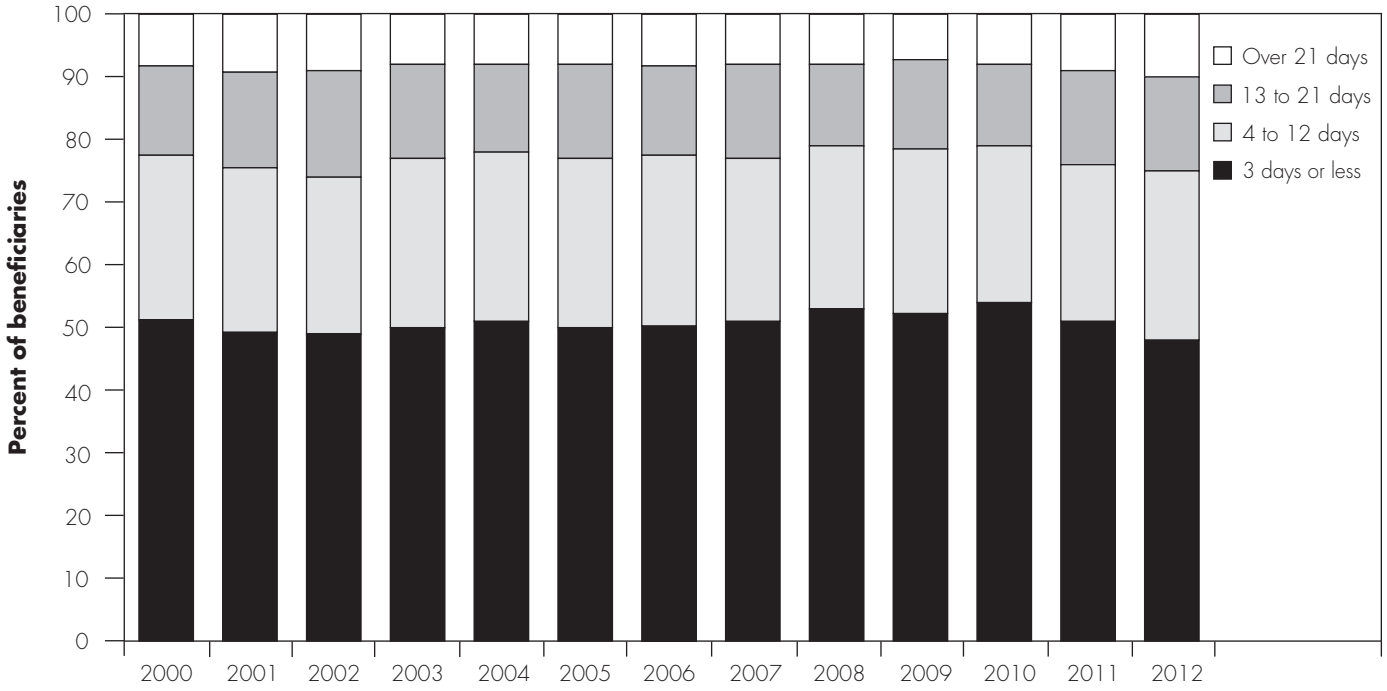
[a] Statistically significant difference between the Medicare and privately insured groups in the given year (at a 95 percent confidence level).

[b] Statistically significant difference from 2014 within the same insurance coverage category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted from 2010 to 2014.

FIGURE 4–1

Just less than half of beneficiaries can see their doctor within three days, and this share is slightly lower in 2012 than in the past few years



Note: Data include noninstitutionalized beneficiaries only.

Source: Medicare Current Beneficiary Survey, 2000–2012.

problem (8 percent × 15 percent = 1.2 percent). Among those looking for a new specialist, 17 percent were looking for a new doctor, and of those looking, 7 percent reported a big problem (17 percent × 7 percent = 1.2 percent).

Medicare beneficiaries overall were slightly less likely than privately insured individuals to report a big problem finding either a new primary care doctor or a new specialist, although the same pattern of greater difficulty finding a primary care doctor than a specialist exists among respondents with private insurance.

Some of the beneficiaries in the focus groups reported difficulty accessing timely appointments with certain types of specialists (specifically, dermatology and neurology). The primary care physicians and nurse practitioners in the focus groups reported difficulty securing referrals to certain types of specialists, in particular dermatology and psychiatry. In one market, some of the primary care physicians said that dermatology is difficult to access because of a shortage of doctors practicing medical dermatology in the area. For psychiatric services, primary care physicians and nurse practitioners generally attributed the access problems for psychiatric services to a shortage of psychiatrists in the area and to the fact that some psychiatrists do not accept insurance at all (including Medicare).

Some beneficiaries may be seeking a new doctor because they temporarily move to another area (e.g., "snowbirds"). However, these beneficiaries likely have access to physicians and other providers in their resident state who can help them find services in their temporary residence. In addition, snowbirds on average have higher incomes and are in better health than the average beneficiary (Smith and House 2006).

Wait times for appointments The Medicare Current Beneficiary Survey (MCBS), a panel survey of Medicare beneficiaries, includes a question assessing wait times—how long, specifically, respondents waited for their last physician appointment. Over the past decade, about half of beneficiaries reported that they were able to see a doctor within three days. In 2012, these figures declined slightly, to 48 percent (Figure 4-1).

In our focus groups, the reported wait times for routine and urgent care varied, but in general, beneficiaries said they could get an appointment the same day, the next day, or within a week. Some beneficiaries noted that they could get an earlier appointment if they were willing to see another practitioner in their primary care provider's practice. The beneficiaries who had looked for new primary care practitioners recently were generally able to find one who was accepting new patients, although some said the search was time consuming. The near-beneficiaries in our focus groups reported similar experiences with respect to accessing primary care.

Medicare beneficiaries were about as likely to report delaying medical care as privately insured individuals In our telephone survey, a similar percentage of Medicare beneficiaries (10 percent) and privately insured individuals (11 percent) reported that they had a health problem for which they should have seen, but did not see, a doctor (Table 4-2, p. 85). The rate for Medicare beneficiaries in 2014 (10 percent) is statistically higher than in previous years (8 percent from 2010 to 2013).

The 2012 Medical Expenditure Panel Survey (MEPS) found the rate of Medicare beneficiaries reporting difficulty receiving needed medical care, dental care, or prescription medications at about 9.5 percent, slightly higher than the rate reported for those under age 65 with private insurance (8.4 percent). But the rates of those reporting that they could not obtain needed care because of either cost or insurance-related issues was significantly lower for Medicare beneficiaries than privately insured individuals under age 65 (Agency for Healthcare Research and Quality 2014).

Some groups of beneficiaries report more difficulty obtaining care, although most differences are not large

Among Medicare beneficiaries, a greater share of minority beneficiaries than nonminority beneficiaries reported that they always had to wait longer than they wanted for an illness or injury appointment, but the percentage of both groups was very small (2 percent and 1 percent, respectively). However, minority individuals who had Medicare reported better access than minority individuals with private insurance: 65 percent of Medicare beneficiaries reported they never had to wait for a routine appointment compared with 58 percent for privately insured individuals. Most other differences by race were not significant (Table 4-3, p. 88).

Few reported differences in access between urban and rural beneficiaries The Commission's telephone survey shows no major differences in access between urban and rural beneficiaries (Table 4-4, p. 89). There was no significant difference between the share of urban and rural beneficiaries experiencing an unwanted delay in getting an appointment, although rural beneficiaries seeking an illness or injury appointment were more likely than urban beneficiaries to report sometimes waiting longer than they wanted. In contrast to earlier years, beneficiaries seeking a specialist were more likely to report a big problem in urban areas (1.4 percent) than in rural areas (0.4 percent), whereas last year the difference was small and not significant.

Differences in access by basis of Medicare eligibility In the MCBS, most beneficiaries did not report significant barriers to care, but they reported access is worse for beneficiaries who are entitled to Medicare on the basis of disability. Of the overall population, 6 percent of beneficiaries reported that they had difficulty obtaining care, and 11 percent of beneficiaries reported that they delayed care because of cost. Among beneficiaries entitled on the basis of disability, the rates were 17 percent and 28 percent, respectively (Centers for Medicare & Medicaid Services 2014a). Beneficiaries entitled on the basis of disability were also about twice as likely as the total Medicare population to report dissatisfaction with overall care, availability of their doctor, and ease of access to their doctor. Some of these differences may be due in part to other differences between disabled and aged beneficiaries: disease burden, type of additional coverage (e.g., Medicaid), and overall resources (e.g., income, social supports).

Difference in access among beneficiaries with different types of coverage In the MCBS, beneficiaries with supplemental private insurance reported slightly more satisfaction with the ease of access to their doctor and were less likely to report being very unsatisfied (Table 4-5, p. 90). As with other surveys and beneficiary focus groups, the MCBS information on access also shows that beneficiaries who were dually eligible for Medicaid were more likely to report that they were unsatisfied with the ease of access to their doctor than other beneficiaries.

An analysis by the Kaiser Family Foundation of the 2012 CAHPS reported that beneficiaries in FFS Medicare were generally able to get an appointment for routine care as soon as needed at the same rates as beneficiaries in Medicare Advantage (MA)—62 percent (Boccuti et al. 2013).

TABLE 4–3

Medicare beneficiaries have better or similar access to physicians compared with privately insured individuals, but minorities in both groups report problems more frequently, 2014

	Medicare (age 65 or older)			Private insurance (age 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	72%[a]	73%[a]	72%[a]	69%[a]	70%[a]	66%[a]
Sometimes	20[a]	20[a]	19[a]	23[a]	23[a]	24[a]
Usually	3	3	3	4	4	4
Always	3	2	3	3	2[b]	5[b]
For illness or injury						
Never	83[a]	84[ab]	80[a]	79[a]	80[ab]	73[ab]
Sometimes	12[a]	12[a]	14[a]	16[a]	16[ab]	19[ab]
Usually	2	2	2	2	2	3
Always	1[a]	1	2[a]	2[a]	2[b]	4[ab]
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Percent answering "Yes"	10	10	9	11	11	11
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")						
Primary care physician	8	8	8	8	7	9
Specialist	17	18[b]	14[b]	17	18[b]	14[b]
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor / specialist who would treat you? Was it..."						
Primary care physician						
No problem	67	67	69	63	60	72
Percent of total insurance group, by race	*5.5*	*5.6*	*5.3*	*4.9*	*4.4*	*6.2*
Small problem	16	16	16	16	17	14
Percent of total insurance group, by race	*1.3*	*1.4*	*1.3*	*1.3*	*1.3*	*1.2*
Big problem	15	15	13	19	22	13
Percent of total insurance group, by race	*1.2*	*1.2*	*1.0*	*1.5*	*1.6*	*1.1*
Specialist						
No problem	85	85	83	85	86	84
Percent of total insurance group, by race	*14.4*	*15.2[b]*	*11.9[b]*	*14.5*	*15.3[b]*	*11.8[b]*
Small problem	7	7	5	9	8	10
Percent of total insurance group, by race	*1.2*	*1.3*	*0.8*	*1.4*	*1.5*	*1.3*
Big problem	7	7	8	6	6	7
Percent of total insurance group, by race	*1.2*	*1.2*	*1.1*	*1.0*	*1.1*	*0.9*

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 missing responses ("Don't know" or "Refused") are not included. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2014. 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 2014.

TABLE 4–4

Access to physician care for Medicare beneficiaries is similar to that for privately insured individuals in urban and rural areas, 2014

Survey question	Medicare (age 65 or older) All	Medicare (age 65 or older) Urban	Medicare (age 65 or older) Rural	Private insurance (age 50–64) All	Private insurance (age 50–64) Urban	Private insurance (age 50–64) 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	72%[a]	72%[a]	75%	69%[a]	68%[a]	75%[b]
Sometimes	20[a]	20[a]	18	23	24[ab]	19[b]
Usually	3	3	4	4	4	4
Always	3	3	2	3	3	2
For illness or injury						
Never	83[a]	84[a]	80	79[a]	78[a]	81
Sometimes	12[a]	11[ab]	16[b]	16[a]	17[a]	16
Usually	2	2	1	2	2	2
Always	1[a]	1[a]	2	2[a]	3[a]	1
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
(Percent answering "Yes")	10	10	11	11	11	12
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")						
Primary care physician	8	8	10	8	8	7
Specialist	17	18	15	17	18[b]	14[b]
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor/specialist who would treat you? Was it..."						
Primary care physician						
No problem	67	68	64	63	61	74
Percent of total insurance group, by area	*5.5*	*5.3*	*6.3*	*4.9*	*4.4*	*6.2*
Small problem	16	14	23	16	17	12
Percent of total insurance group, by area	*1.3*	*1.1[b]*	*2.2[b]*	*1.3*	*1.3*	*1.2*
Big problem	15	16	11	19	20	14
Percent of total insurance group, by area	*1.2*	*1.1*	*2.0*	*1.4*	*1.3*	*1.1*
Specialist						
No problem	85	84	90	85	85	85
Percent of total insurance group, by area	*14.4*	*14.8*	*12.9*	*14.5*	*15.0*	*12.4*
Small problem	7	7	6	9	9	8
Percent of total insurance group, by area	*1.2*	*1.3*	*0.9*	*1.4*	*1.5*	*1.3*
Big problem	7	8	3	6	6	7
Percent of total insurance group, by area	*1.2*	*1.4[b]*	*0.4[b]*	*1.0*	*1.0*	*1.1*

Note: Numbers may not sum to 100 percent because missing responses ("Don't Know" or "Refused") are not included. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2014. Sample sizes for individual questions varied.
MedPAC uses the Census Bureau definitions of urban and rural. The Census Bureau classifies as urban all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census-block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. In addition, under certain conditions, less densely settled territory may be part of each UA or UC. The Census Bureau's classification of rural consists of all territory, population, and housing units located outside of UAs and UCs.
[a] Statistically significant difference between the Medicare and privately insured populations in a given year (at a 95 percent confidence level).
[b] Statistically significant difference by area type within the same insurance category in a given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2014.

TABLE 4–5

Satisfaction with ease of access to doctor, 2012

			Medicare and supplemental coverage			
	All Medicare respondents	Medicare HMO	Medicaid	Individually purchased private insurance	Employer-sponsored private insurance	Medicare FFS only
Very satisfied	30%	30%	17%	34%	36%	25%
Very unsatisfied	5	4	10	4	3	7

Note: FFS (fee-for-service).

Source: CMS analysis of the Medicare Current Beneficiary Survey Access to Care file 2012.

Comparisons of access between MA and FFS, however, should be viewed with some caution. Differences in the patient populations in MA and FFS may be responsible for any reported differences in access to care. The Commission has made recommendations that would facilitate comparisons between FFS and MA plans on quality of and access to care (Medicare Payment Advisory Commission 2010).

Beneficiaries receive care from many types of clinicians in a variety of locations

Nearly all beneficiaries in our focus groups reported that they had a regular source of primary care. In the 2012 MCBS, 95 percent of Medicare beneficiaries reported that they had a usual source of medical care (Centers for Medicare & Medicaid Services 2014a).

In our telephone survey in 2014, 11 percent of beneficiaries responded that they saw a nurse practitioner (NP) or physician assistant (PA) for all or most of their primary care, and 26 percent said that they saw an NP or PA for some of their primary care. Rural beneficiaries were more likely than urban beneficiaries to report that they saw an NP or PA for all or most of their care (18 percent for rural beneficiaries vs. 10 percent for urban beneficiaries).

Many beneficiaries and near-beneficiaries in the focus groups said that they were able to access routine or urgent primary care faster, including same-day appointments, by seeing a nurse practitioner in their primary care physician's practice. Nurse practitioners were also described as filling a need for access to care in rural areas, particularly in states with less restrictive scope of practice requirements (see text box). Although many physicians in the focus groups had only positive things to say about nurse practitioners, some thought their roles should be limited.

More so than in past years, the beneficiaries in this round of focus groups discussed using urgent care centers for routine and urgent primary care. Beneficiaries stated that they generally make this choice when they cannot get appointments with their usual primary care providers right away, or when they think it will be less expensive or more convenient to visit the urgent care center.

Clinician acceptance of Medicare beneficiaries

We also look at the trends regarding providers' willingness to take new Medicare patients. Two analyses of the National Ambulatory Medical Care Survey (NAMCS), a survey of physicians who practice in office settings, find that physician acceptance of new Medicare patients is similar to prior years, with a little less than 90 percent of physicians accepting new patients: 85 percent of primary care physicians (when pediatricians are excluded) and 90 percent of specialist physicians (Boccuti et al. 2013, Shartzer et al. 2013).

These measures should be interpreted with some caution, however. Physicians reporting willingness to take new Medicare patients is not the same as Medicare beneficiaries being able to access care. For example, providers are generally much less willing to accept Medicaid than private insurance (about 50 percent of physician offices said they would take Medicaid, as compared with 90 percent for commercial insurance). However, Medicaid and private enrollees were equally likely to report that they have a usual source of care (Frakt 2014, Kenney et al. 2014). The American Medical Association 2013 National Health Insurer Report Card finds that Medicare is comparable with other large payers

Developments regarding scope of practice for advanced practice registered nurses and physician assistants

As noted in previous Commission work, many of the restrictions on the scope of practice for advanced practice registered nurses (APRNs) (for example, nurse practitioners) and physician assistants (PAs) result from state laws that are more restrictive than the Medicare statute. Recent federal activities that affect practice authority for APRNs and PAs include the following:

- recommendations by the Federal Trade Commission to expand scope of practice to increase competition between providers (March 2014);
- proposed changes to the Veterans Administration nursing handbook to treat advanced practice nurses on staff as independent practitioners authorized to treat patients without supervision (2013, not finalized); and
- a Supreme Court case regarding a Board of Dental Examiners' regulation of teeth-whitening services and specifically whether the Board is exempt from antitrust law by acting as a state entity (October 2014). This case may have implications for professional boards in which there is a question of whether the board is unduly restricting behavior for anticompetitive reasons.

Policy changes for APRNs and PAs at the state level include:

- Connecticut and Minnesota's adoption of a Full Practice Authority law;[5]
- enactment in Utah of a bill easing the practice hour requirements before full licensure for psychiatric advanced practice nurses, as well as expanded recognition under Utah's Medicaid program;
- a bill enacted into law in Ohio that would permit limited medication dispensing during a public health emergency; and
- Expansion of authority for APRNs and PAs to conduct prescreening exams for patients requiring involuntary admission (e.g., for psychiatric or safety reasons) in Mississippi. ■

in terms of payment accuracy, timeliness, and transparency (American Medical Association 2013).

The vast majority of primary care physicians and nurse practitioners in our focus groups said that they accept Medicare. Some, however, limit the number of new patients; others limit their panels to patients with certain types of insurance. For example, some of the primary care physicians said they accept Medicare FFS patients but will not accept Medicare Advantage patients because of reimbursement rates and prior authorization requirements.

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 providers billing Medicare, whether physicians and other health professionals are participating providers, and whether these providers take assignment (which means that they accept Medicare's payment as payment in full). A small number of providers opt out of the Medicare program—less than 1 percent.

Supply of physicians and other health professionals billing Medicare has grown at rates similar to enrollment growth

Our analysis of Medicare FFS claims data for 2011 to 2013 shows that the number of physicians and other health professionals furnishing services to Medicare beneficiaries grew at rates similar to growth in the beneficiary population (Table 4-6, p. 92). In 2013, the ratio of physicians in primary care specialties to the number of beneficiaries was 3.7 per 1,000, slightly below the 2011 and 2012 ratios of 3.8 per 1,000. Similarly, in 2013, the ratio of physicians in other specialties fell slightly to 8.2 per 1,000 from the 2011 and 2012 ratios of 8.4 per 1,000. Meanwhile, the number of APRNs and PAs billing Medicare grew each year between 2011 and 2013, from 2.8 per 1,000 to 3.0 per 1,000 to 3.2 per 1,000.

TABLE 4–6 **Physicians and other health professionals billing Medicare, 2011–2013**

	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
2011	169,640	3.8	379,411	8.4	123,959	2.8	140,436	3.1
2012	174,848	3.8	388,237	8.4	138,184	3.0	146,396	3.2
2013	178,404	3.7	394,103	8.2	152,612	3.2	150,466	3.1

Note: Primary care specialties are specialties eligible for the Primary Care Incentive Payment Program: family medicine, internal medicine, pediatric medicine, and geriatric medicine. 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 lab facilities.

Source: MedPAC analysis of claims data for 100 percent of beneficiaries and the 2014 annual report of the Boards of Trustees of the Medicare trust funds.

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

About 96 percent of physicians and other health professionals billing Medicare sign an agreement with Medicare to be part of the participating provider program (Centers for Medicare & Medicaid Services 2012a). 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 2013). In return, participating providers receive the full fee schedule amount, can receive payments directly from Medicare (rather than billing the beneficiary for the full amount of the service), have their name and address listed on Medicare's website, and can electronically search a beneficiary's supplemental insurance status.

Providers who do not elect to participate receive a 5 percent lower payment amount and can choose whether to take assignment for their claims. If they do not assign a claim, providers may "balance bill" up to 109.25 percent of the fee schedule amount (the limiting charge), with the beneficiary paying the difference between that limiting charge and Medicare's payment.

Balance billing and nonparticipating providers are relatively rare in Medicare, and the total amount of balance billing has been declining over time (Centers for Medicare & Medicaid Services 2012b).

Practitioners who opt out of Medicare are rare, but may be increasing

Physicians and other health professionals opt out of the Medicare program by signing an affidavit with Medicare agreeing that they cannot receive any reimbursement from Medicare, directly or indirectly, for any Medicare patient they see. They must enter into a private contract with Medicare beneficiaries to deliver care to them, and the contract must state that no payment will be made from Medicare either to the beneficiary or to the provider for services delivered by the opt-out physician. Opt-out agreements are in place for two years and can be renewed. Based on data from CMS, as of September 30, 2013, just over 6,600 providers had opted out of the Medicare program, accounting for less than 1 percent of all providers billing under the fee schedule. The largest share of these opt-out providers were psychiatrists and oral surgeons (dentists only), and these two specialties accounted for over half of the opt-out providers.

News reports have highlighted trends in the use of retainer-based medical models, which charge a flat fee for enhanced access to services such as same-day appointments or longer appointments (Gunderman 2014, Wieczner 2013). However, some retainer-based practices also accept insurance, so it is unclear what effect this trend will have on the rate of physicians opting out of Medicare.[6]

Small increase in volume growth

We analyze annual changes in use of services as another indicator of payment adequacy but recommend caution

in interpreting such data because factors unrelated to Medicare's payment adequacy can influence service volume. Our analysis indicates that volume decreases are more likely to be due to factors unrelated to payment, such as general practice pattern changes or concerns about overuse of imaging. For example, the volume of coronary artery bypass grafting has been declining as other interventions substitute for this procedure. Increases in volume may signal overpricing if physicians favor certain services because they are relatively profitable, but other factors—including population changes, disease prevalence, changes in Medicare benefits, shifts in the site of care, technology, and beneficiaries' preferences—can also explain volume increases.

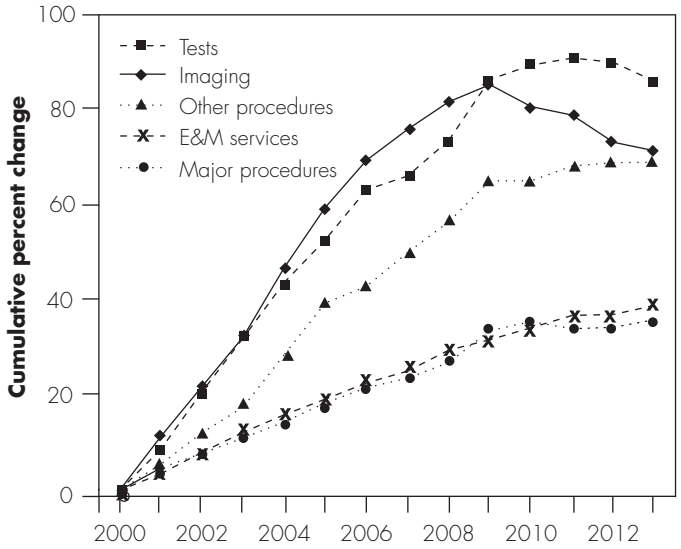
For this year's analysis of volume changes, we used claims data for 2008, 2012, and 2013. We identified the services furnished by physicians and other professionals billing under Medicare's fee schedule and calculated two measures of changes in service use: units of service per beneficiary and volume of services per beneficiary. Volume is measured as units of service multiplied by each service's relative value units (RVUs) from the fee schedule. Our volume growth measure thus accounts for changes in both the number of services and the complexity, or intensity, of those services. For example, growth in the volume of imaging services would account not just for any change in the number of such services but also for any change in intensity as providers substitute computed tomography (CT) scans for X-rays, which are less complex. We used RVUs for 2013 to put service volume for all years on a common scale.

Our volume analysis also accounts for the policy changes that have occurred in payments for office and inpatient consultations. As of 2010, CMS stopped recognizing the billing codes for consultations.[7] Physicians and other health professionals now use office visit codes and codes for hospital and nursing facility visits instead of consultation codes. If we ignored this change in policy, the volume analysis would show a change in intensity of services—use of lower payment rate visits in place of higher payment rate consultations. To avoid this skewing, we focus the discussion of changes in service use before 2010 on the change in units of service and limit discussion of changes in volume growth to those services not affected by the change in payments for consultations.

In 2013, across all services, volume per beneficiary grew by 0.5 percent (Table 4-7, p. 94). Among broad categories of service, growth rates were 1.4 percent for evaluation and management (E&M), −1.0 percent for imaging services, 1.2 percent for major procedures, 0.1 percent for other procedures, and −2.1 percent for tests.

FIGURE 4–2

Growth in the volume of fee schedule services, 2000–2013



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 2013, we used a growth rate for 2009 to 2010 of 1.9 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.

While imaging continues the downward trend we have seen since 2009, use of imaging services remains much higher than it was a decade ago (Figure 4-2). Cumulative growth in the volume of imaging from 2000 to 2009 totaled 85 percent compared with a cumulative decrease 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—such as allergy tests—during those 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.

The growth in 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

TABLE 4–7

Use of services provided by physicians and other health professionals, per FFS beneficiary

Type of service	Change in units of service per beneficiary: Average annual 2008–2012	Change in units of service per beneficiary: 2012–2013	Change in volume per beneficiary: Average annual 2008–2012	Change in volume per beneficiary: 2012–2013	Percent of 2013 allowed charges
All services	**0.6%**	**–0.2%**	**N/A**	**0.5%**	**100.0%**
Evaluation and management	**0.2**	**1.4**	**N/A**	**1.4**	**47.3**
Office visit—new and established	0.5	2.8	N/A	2.8	26.8
Inpatient visit—hospital and nursing facility	–0.6	–0.5	N/A	–0.6	15.6
Emergency room visit	2.2	–1.1	3.5%	–0.1	3.1
Hospital visit—critical care	4.7	0.6	4.8	0.5	1.4
Home visit	3.8	1.0	4.3	1.1	0.4
Imaging	**–0.5**	**–0.6**	**–1.4**	**–1.0**	**11.5**
Advanced—CT: other	1.8	2.2	0.6	0.9	1.6
Advanced—MRI: other	0.0	1.6	–2.3	0.4	1.1
Echography—other	4.5	4.1	6.7	6.8	1.1
Echography—heart	–0.8	–1.2	–2.1	–7.3	1.0
Standard—nuclear medicine	–6.8	–7.9	–10.1	–10.2	0.9
Standard—musculoskeletal	0.0	0.5	–0.6	0.3	0.9
Standard—breast	1.4	0.9	1.1	0.1	0.7
Imaging/procedure—other	–3.5	–2.0	0.4	5.3	0.7
Advanced—MRI: brain	–1.3	–0.3	–4.4	–1.8	0.5
Advanced—CT: head	1.2	–0.3	–0.6	–0.8	0.4
Standard—chest	–2.1	–3.5	–2.7	–3.6	0.4
Echography—abdomen and pelvis	1.5	0.0	1.8	0.4	0.4
Major procedures	**0.3**	**–1.1**	**1.2**	**1.2**	**7.4**
Cardiovascular—other	–1.4	–7.6	0.4	–2.9	1.7
Orthopedic—other	1.6	2.5	3.1	3.6	1.1
Knee replacement	0.9	3.2	1.3	4.4	0.6
Hip replacement	3.2	4.1	3.7	5.2	0.3
Explore, decompress, or excise disc	2.6	0.3	4.7	2.7	0.3
Hip fracture repair	–2.3	0.3	–2.2	0.8	0.3
Coronary angioplasty	–3.3	7.2	–3.2	6.8	0.2
Coronary artery bypass graft	–7.0	–2.8	–7.0	–2.0	0.2
Other procedures	**1.9**	**–0.9**	**1.9**	**0.1**	**22.2**
Skin—minor and ambulatory	0.7	1.4	2.3	1.0	4.8
Outpatient rehabilitation	3.9	–2.4	4.7	–1.9	3.3
Radiation therapy	–2.7	–2.5	–1.1	–2.4	1.9
Minor—other	0.6	–1.4	1.2	–0.8	2.0
Cataract removal/lens insertion	–0.4	1.2	–0.2	1.2	1.4
Minor—musculoskeletal	1.8	0.0	2.5	0.6	1.4
Eye—other	10.1	4.8	4.8	2.5	1.1
Colonoscopy	–2.0	0.4	–1.9	0.7	0.9
Upper gastrointestinal endoscopy	0.5	–1.1	1.0	–0.6	0.5
Cystoscopy	0.1	0.1	–0.3	0.2	0.4
Tests	**0.8**	**0.5**	**2.0**	**–2.1**	**4.6**
Other tests	1.2	4.9	1.1	0.5	1.7
Laboratory tests—other	3.7	0.7	5.0	0.0	1.6
Electrocardiograms	–0.4	–2.5	–0.2	–3.2	0.5

Note: FFS (fee-for-service), N/A (not available), CT (computed tomography), MRI (magnetic resonance imaging). 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 2013. For billing codes not used in 2013, we imputed RVUs based on the average change in RVUs for each type of service. Some low-volume categories are not shown but are included in the summary calculations. Evaluation and management service volume is not reported for some types of service because a change in payment policy for consultations prevented assignment of RVUs to those services. For 2008, "units of service" for office visits and inpatient visits includes, respectively, office and inpatient consultations. "Laboratory tests" includes tests billable under the fee schedule for physicians and other health professionals and excludes services billable under the laboratory fee schedule.

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

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 services, even though standards for doing so are lacking (Welch et al. 2012). One response to such findings is that the American Board of Internal Medicine Foundation has a Choosing Wisely initiative underway to help physicians and patients have conversations about the overuse of imaging and other services (ABIM Foundation 2014, ABIM Foundation 2012).

Volume growth as a measure of change in service use includes shift in billing from professionals' offices to hospitals

As a measure of growth in service use, volume growth has two advantages. First, it accounts for not just changes in the number of services but also any changes in the intensity of services (e.g., substitution of advanced imaging for X-rays). Second, together with changes in fees, volume growth determines growth in spending.

Volume growth, however, is sensitive to shifts in the site of care. The RVUs in the calculation of volume include practice expense RVUs, which are lower for services provided in a facility setting, such as a hospital, compared with services in a nonfacility setting, such as a professional office.[8] For example, in 2014, the sleep study—a type of neurological test—most frequently used by Medicare beneficiaries had an average nonfacility fee of $652.[9] By contrast, when the test is administered in a facility setting, the practice expense RVU is lower, making the average fee $129.

In recent years, there been a trend toward billing for some services in hospitals instead of professionals' offices. This shift in billing patterns explains at least some of the drop in volume we see for imaging and tests. Indeed, the change in imaging volume would be an increase instead of a decrease if one type of imaging—cardiovascular imaging—were excluded from the calculation.

Decrease in imaging volume includes shift in billing for cardiovascular imaging

The decrease in use of imaging services includes a shift in billing for cardiovascular imaging from professionals' offices to hospitals (Table 4-8). From 2012 to 2013, the number of echocardiograms per beneficiary administered in hospital outpatient departments rose by 7.4 percent, but the number provided in professional offices declined by 8 percent. Similarly, during that period, the number of cardiac nuclear medicine studies per beneficiary administered in hospital outpatient departments increased slightly, by 0.4 percent, but the number in professional offices went down by 12.1 percent. These changes in billing patterns are consistent with reports of an increase in hospital-owned cardiologist practices (American College of Cardiology 2012).

TABLE 4–8 **Billing for cardiovascular imaging has shifted from professionals' offices to hospitals, 2012–2013**

	Share of services performed in HOPDs, 2013	Per beneficiary growth in units of service	
		HOPD	Professional office
Echocardiography	38.0%	7.4%	–8.0%
Nuclear cardiology	42.2	0.4	–12.1

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.

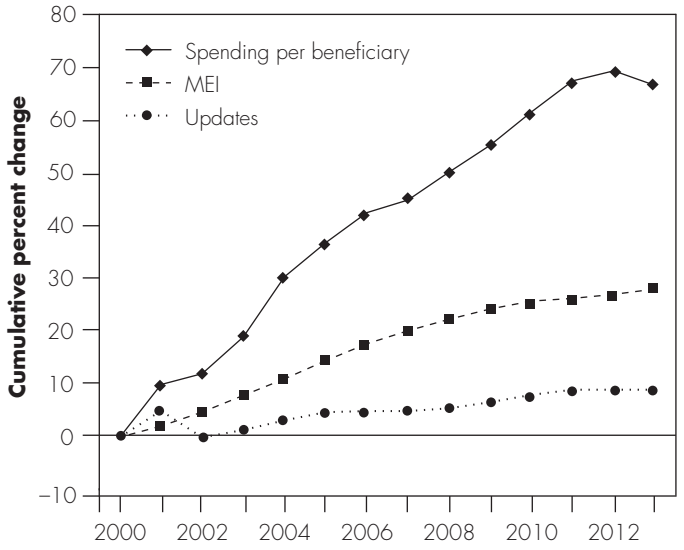
Source: MedPAC analysis of outpatient claims data for 5 percent of Medicare beneficiaries and carrier claims data for 100 percent of Medicare beneficiaries.

Some of the 1 percent decrease in the volume of imaging services is due to decreases in units of service for nuclear medicine and echocardiography. However, billing for many of these services has simply shifted from the nonfacility setting to the facility setting. If these two services were excluded from the calculations, the volume of all other imaging services from 2012 to 2013 would show a 0.8 percent increase (instead of the 1 percent decrease).

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

The growth in service volume has contributed to an increase in spending for fee schedule services (Figure 4-3, p. 96). From 2000 to 2013, payment updates for these services increased cumulatively by 9 percent—less than the 28 percent cumulative increase in the Medicare Economic Index. However, spending per beneficiary for the services went up at a cumulative rate of 67 percent. Volume growth, which accounts for most of the difference between the payment updates and spending growth, may include factors other than change in clinical practice, for example, changes in the demographic and health status of beneficiaries.[10] However, most of the volume growth is in the use of more intensive services and more services

FIGURE 4–3 **Volume growth has caused spending to increase faster than input prices and updates, 2000–2013**



Note: MEI (Medicare Economic Index).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and Office of the Actuary 2014.

for an average beneficiary population with little change in clinical and demographic characteristics over time.

From 2012 to 2013, per beneficiary spending for fee schedule services declined by 1.6 percent. With the small increase in volume growth and no change in the fee schedule conversion factor, the sequester—in effect for three-quarters of the year—would account for most of the spending decrease.

The 2013 decrease in spending per beneficiary is small when compared with the increase in spending that occurred from 2000 to 2012, when spending increased at an average annual rate of 4.5 percent. In addition, payment adjustments outside of the update process also affect spending for fee schedule services. Indeed, some of the adjustments—such as those in the $2.6 billion electronic health records (EHR) program—are not included in the published estimates of fee schedule spending.

Payment adjustments outside of the update process

While volume growth for many categories of services and the conversion factor updates have been low or near zero in recent years, Medicare spending for fee schedule services is also affected by bonuses, penalties, and other types of payment adjustments. The net effect of these adjustments in recent years has been to increase the effective payment rate to physicians and other health professionals by more than the update of the conversion factor.

The adjustments can be grouped into three categories (Table 4-9). The first category includes payment adjustments made to claims billing for fee schedule services. One example of adjustments in this category is the work geographic practice cost index (GPCI) floor, a legislated policy that raises the work GPCI up to 1 in areas where it otherwise would be below 1. Because the work GPCI is designed to be budget neutral, imposing a floor on the work GPCI increases spending. Another example is the 2 percent reduction in Medicare program payments to all providers imposed by the sequester.

The second category of payment adjustments includes adjustments that were not made to providers' individual claims for services, but were included in Medicare spending totals. These adjustments include the Primary Care Incentive Payment program and health professional shortage area incentive payments. This category also includes three incentive programs: the Physician Quality Reporting System (PQRS) bonus and penalty, the EHR "meaningful use" incentive payments and subsequent penalties for nonusers, and the electronic prescribing (eRx) bonus and penalty.

The third category includes payments to practitioners participating in models run by the Center for Medicare & Medicaid Innovation (CMMI). Currently, three such models make available additional funds for clinicians billing under the fee schedule: two medical home models (the Comprehensive Primary Care Initiative and the Multi-payer Advanced Primary Care Practice demonstration) and the recently announced Transforming Clinical Practices Initiative. The first two models are for practices to test the medical home concept and are available to practices that were approved for the model and comply with model requirements; the third model is in the application review process.

We would note that some of the adjustments are presently positive payment adjustments but will change to negative payment adjustments over the next few years. Specifically, the eRx payment adjustment began to include penalties for nonparticipation between 2012 and 2014, and the EHR Incentive Program and the PQRS payment adjustment will include penalties starting in 2015. In addition, the value

TABLE 4–9

CMS payment adjustments for eligible physicians and other health professionals billing under the Medicare fee schedule

Category	Adjustment	Total amount of adjustment in most recent available year (in millions)	Year of estimate and source
Adjustments to fee schedule claims	Work GPCI floor	$300	2014: CBO estimate of H.R. 4302, one-year extension
	Sequester	–1,200	2013: Estimate from 2014 Medicare trustees report
Adjustments outside fee schedule claims but included in Medicare spending figures	Primary care incentive payment	650	2012: Estimate from claims
	HPSA bonuses, including mental health and surgical bonuses	37	Average of 2011 and 2012: CMS
	EHR Incentive Program	2,563	2013: CMS payment summary
	PQRS	168	2012: CMS experience report
	eRx upward adjustment*	335	2012: CMS experience report
Adjustments outside of Medicare spending figures	CMMI—Comprehensive Primary Care Initiative	172	2014: CMMI Report to Congress
	CMMI—Multi-payer Advanced Primary Care Practice	N/A	CMMI has not released a spending figure for this initiative
	CMMI—Transforming Clinical Practices Initiative	210	$840 million for the next four years: CMS

Note: GPCI (geographic practice cost index), CBO (Congressional Budget Office), HPSA (health professional shortage area), EHR (electronic health record), PQRS (Physician Quality Reporting System), eRx (electronic prescribing), CMMI (Center for Medicare & Medicaid Innovation), N/A (not available).
*An eRx penalty also applied in 2012 to 59,955 eligible professionals, but CMS did not publish the total reduction in payments.

Sources: CMS/CMMI; CMS, Office of the Actuary; CMS press releases; and CBO.

modifier (not discussed) could result in both upward and downward payment adjustments for clinicians starting in 2015.

Quality of care

In prior years' reports, the Commission has assessed quality in ambulatory care settings by reporting trends in the Medical Ambulatory Care Indicators for the Elderly (MACIEs), a set of claims-based quality measures developed by the Commission. The MACIEs assess under-provision of clinically indicated care. Most MACIEs are process measures—for example, (1) checking whether certain kinds of routine diagnostic tests were performed for beneficiaries diagnosed with diabetes and heart failure and (2) six potentially avoidable hospitalization measures.

In recent years, the Commission has become concerned that Medicare's predominant approach to quality measurement is flawed. First, it includes too many clinical process measures, which are weakly correlated with such outcomes as mortality and readmissions, outcomes that patients care about most. Second, clinical process measures have focused almost exclusively on the underuse of services, while the Commission believes that overuse

TABLE 4–10

Trends in selected Prevention Quality Indicators (inpatient admissions of FFS beneficiaries for ambulatory care–sensitive conditions), 2008–2012

	Inpatient admissions per 100,000 FFS beneficiaries in age group								
	PQI 3: Diabetes long-term complications			PQI 8: Congestive heart failure			PQI 11: Bacterial pneumonia		
Year	Under 65	65–74	Over 75	Under 65	65–74	Over 75	Under 65	65–74	Over 75
2008	781	257	325	1,056	823	2,474	881	716	1,972
2009	774	243	301	1,047	809	2,408	901	682	1,776
2010	775	238	293	994	767	2,276	822	651	1,730
2011	751	229	275	935	710	2,139	804	631	1,708
2012	728	209	249	892	664	2,033	753	576	1,603

Note: FFS (fee-for-service), PQI (Prevention Quality Indicators). 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 enrolled in Part A and Part B are included. Beneficiaries who were enrolled in a Medicare Advantage plan at any point during the year are excluded. 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.

and inappropriate use are also significant concerns. Third, it is administratively burdensome for providers to report on clinical process measures that require data extracted from patient medical records (claims-based process measures may avoid these costs, but questions remain about their meaningfulness and possible incentive for overuse). Last, using process measures creates an incentive for providers to focus their resources and attention on the care processes being measured, not on the overall quality of care provided to their patient population.

For these reasons, the Commission supports the use of a small set of population-based outcome measures such as rates of potentially avoidable hospitalizations and readmissions, mortality, and patient experience. One approach, discussed in our June 2014 report to the Congress, is to assess and compare performance of FFS Medicare, Medicare Advantage (MA), and Medicare accountable care organizations (ACOs) within a locality, such as a metropolitan statistical area (MSA) or Dartmouth Atlas Health Service Area (HSA), on the basis of a few key outcome measures (Medicare Payment Advisory

TABLE 4–11

Variation in Prevention Quality Indicators (inpatient admissions of FFS beneficiaries for ambulatory care–sensitive conditions) among hospital referral regions, 2012

	Inpatient admissions per 100,000 FFS beneficiaries in age group								
	PQI 3: Diabetes long-term complications			PQI 8: Congestive heart failure			PQI 11: Bacterial pneumonia		
	Under 65	65–74	Over 75	Under 65	65–74	Over 75	Under 65	65–74	Over 75
Minimum	214	64	68	215	180	820	237	199	723
Median	683	193	223	801	651	2,037	736	563	1,606
Maximum	1,611	679	715	1,900	1,334	3,515	1,459	1,340	3,405

Note: FFS (fee-for-service), PQI (Prevention Quality Indicators). Figures represent the number of hospital admissions for the identified condition for Medicare beneficiaries in each age range per 100,000 beneficiaries. Only Part A and Part B FFS beneficiaries are included. Beneficiaries who were enrolled at any point during the year in a Medicare Advantage plan are excluded. Beneficiaries who died during the year are included.

Source: CMS, Data on Geographic Variation. Figures calculated by CMS from the Chronic Conditions Data Warehouse of 100 percent of claims.

TABLE 4–12

Variation in potentially preventable admission and potentially preventable emergency department visit rates for FFS Medicare enrollees across metropolitan statistical areas and health service areas, 2011

	MSAs		HSAs	
Summary statistic	**PPA rate**	**PPV rate**	**PPA rate**	**PPV rate**
Mean (population weighted)	1.00	1.00	1.00	1.00
10th percentile	0.80	0.82	0.47	0.20
25th percentile	0.91	0.94	0.72	0.42
Median (50th percentile)	1.00	1.06	0.96	0.95
75th percentile	1.10	1.19	1.13	1.19
90th percentile	1.21	1.31	1.29	1.39

Note: FFS (fee-for-service), MSA (metropolitan statistical area), HSA (health service area), PPA (potentially preventable admission), PPV (potentially preventable emergency department visit). Rates were calculated using 3M™ PPA/PPV software. Health service areas with small numbers of enrollees may show extreme (statistically unreliable) high or low values. There are 411 metropolitan statistical areas and 3,340 health service areas.

Source: MedPAC contractor analysis of 2010 and 2011 100 percent Part A and Part B claims data.

Commission 2014). We acknowledge that this approach may not be appropriate for adjusting FFS Medicare payments to individual providers in an area because, unlike an ACO or MA plan, providers operating in FFS Medicare do not explicitly accept responsibility for the care of a population of beneficiaries. Also, for physicians and other health care professionals, it may be difficult to define clinically meaningful and statistically reliable quality measures for some specialties (for example, certain surgical subspecialties and hospital-based specialties such as radiologists, anesthesiologists, and pathologists).

Population-based outcome measures can gauge the quality of a community's ambulatory care environment. Rates of potentially avoidable hospitalizations are one such measure. For example, some patients with worsening conditions need to be hospitalized, but of these patients, some might have avoided hospitalization had they been treated earlier in an ambulatory setting. CMS publishes data on one set of potentially avoidable hospitalization measures for the Medicare population—the Prevention Quality Indicators (PQIs), developed by the Agency for Healthcare Research and Quality. Table 4-10 presents national results for three prevalent and costly conditions among the Medicare population—diabetes, congestive heart failure, and bacterial pneumonia. The PQIs measure the rate of hospital admissions for the selected condition by age category, expressed as a number per 100,000 beneficiaries.

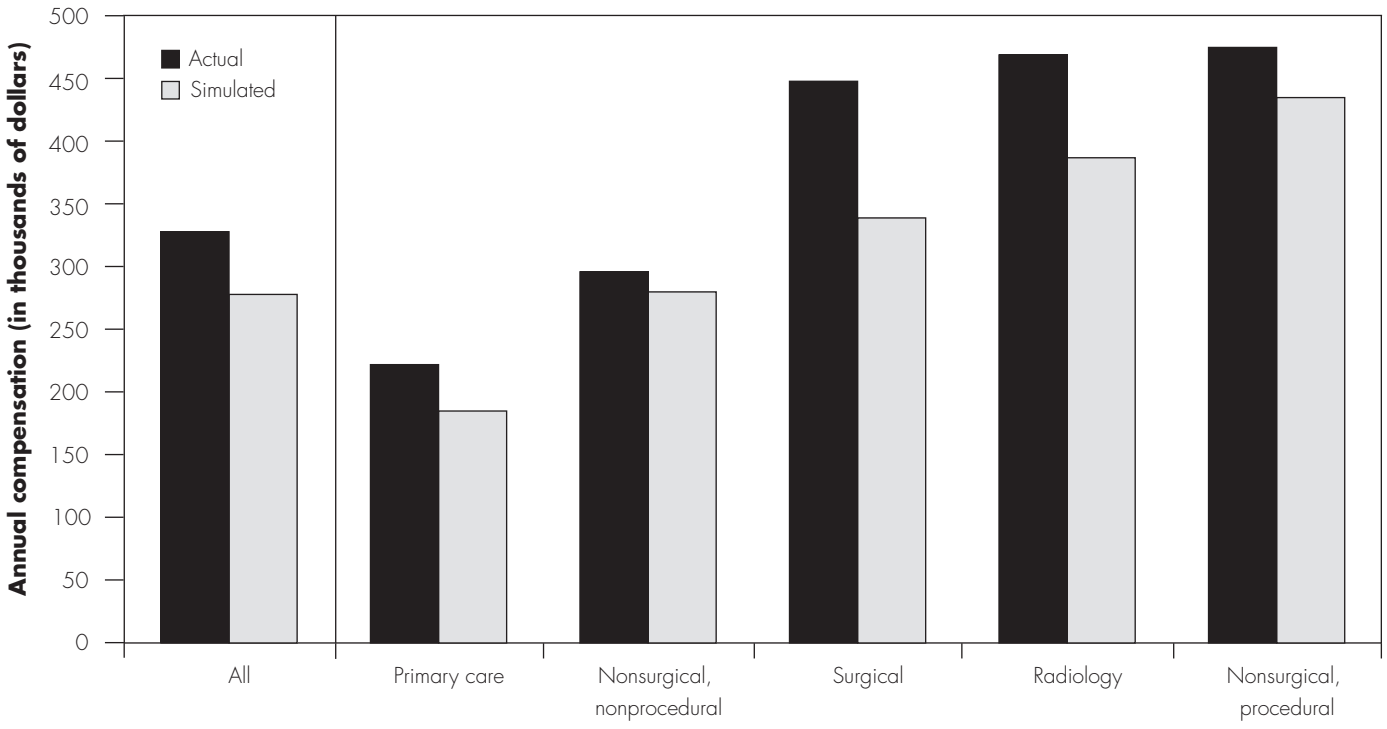
Most of the rates show improvements over time, but these overall patterns mask wide variation across the United States when these rates are assessed within hospital referral regions. For example, in 2012, avoidable hospitalizations for congestive heart failure varied five-fold on average between the area with the lowest rate and the area with the highest rate (Table 4-11).

The Commission has also explored the feasibility of calculating population-based outcome measures for FFS Medicare in localities across the country using two such measures developed by 3M™ Health Information Systems: potentially preventable admissions (PPAs) and potentially preventable emergency department visits (PPVs). Similar to the PQIs, these measures are designed to assess the effectiveness of ambulatory care delivery within a geographic area. The PPAs and PPVs are based on the premise that, while not every PPA or PPV can be averted, comparatively high rates of these events (when appropriately risk adjusted for variation and severity in the local population's existing clinical conditions) can identify opportunities for improvement in an area's ambulatory care systems.

The Commission's preliminary analyses of PPA and PPV rates using 100 percent Medicare claims data for 2011 revealed two important findings (Table 4-12).[11] First, PPA and PPV rates vary significantly across the nation's localities, whether the areas measured are larger, such as

FIGURE 4–4

Disparities in physician compensation are widest when primary care physicians are compared with radiologists and nonsurgical proceduralists, 2012



Note: Simulated compensation is compensation as if all services were paid under the Medicare physician fee schedule.

Source: Urban Institute analysis of physician compensation data for MedPAC 2014.

MSAs, or smaller, such as HSAs. For example, MSAs at the 75th percentile of PPA rates had 10 percent more PPAs than the national average, which indicates potential savings for Medicare and its beneficiaries if those areas could be brought down to the average. MSAs at the 25th percentile had PPA rates almost 20 percentage points lower than those at the 75th percentile. The distribution of PPV rates showed similar variation. The second finding is that using smaller areas, such as HSAs instead of MSAs, introduces more variation in the PPA and PPV rates, which could be useful for understanding finer distinctions in outcome differences across localities. For example, the interquartile range (i.e., difference between 25th and 75th percentiles) for PPA rates using HSAs is over 40 percentage points compared with about 20 points for MSAs. In general, larger areas have less variation. The trade-off in using smaller areas is that it may introduce more statistical "noise" (i.e., random variation) in the results, which can be seen in Table 4-12 (p. 99) in the minimum and maximum PPA and PPV values for HSAs. In practice, this statistical phenomenon could be addressed by imposing a minimum population threshold or other technique to increase the statistical reliability of the results to an acceptable level.

The Commission plans to continue to refine its current position on quality measurement for clinicians, including whether a system that assesses local population-level performance on the basis of a few key outcome measures will still require other, provider-based quality measures to make FFS payment adjustments.

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 fees paid by private

insurers for covered services. The second measure is whether Medicare's fee schedule contributes to differences in physician compensation across specialties—even after accounting for the cost of running a practice. The third measure assesses input prices for physicians and other health professionals—the Medicare Economic Index (MEI).

Ratio of Medicare payments to private insurer payments is steady

Since 1999, Medicare's physician and other health professional fees (including cost sharing) have been about 80 percent of private insurer fees. In 2013, Medicare's payments for physician and other health professional services were 79 percent of commercial rates for preferred provider organizations (PPOs). This analysis uses a data set of paid claims for PPO members of a large national insurer.

Compensation differences between primary and specialty care

The Commission remains concerned that the fee schedule and the nature of FFS payment lead to an undervaluing of primary care and overvaluing of specialty care. First, the Commission has concerns that the resource-based relative value scale, which forms the basis for the fee schedule, includes mispriced services and that these mispriced services cause an income disparity between primary care and specialty physicians. Second, FFS payment allows some specialties to more easily increase the volume of services they provide (and therefore their revenue from Medicare), while other specialties, particularly those that spend most of their time providing E&M services, have limited ability to increase their volume.

For an analysis of the compensation received by physicians—the largest subset of practitioners—the Commission contracted with the Urban Institute, working in collaboration with the Medical Group Management Association (MGMA) (Berenson et al. 2010). The contractor developed a method for analysis of two measures of compensation: "actual compensation," or actual revenues received by a physician from all payers, and "simulated compensation," or payments a physician would receive if all the services the physician provided were paid under Medicare's fee schedule.[12] Private payers often use a conversion factor—or multiple conversion factors, depending on the type of service—that differs from Medicare's.

In an update of the initial analysis, the contractor used data from MGMA's Physician Compensation and Production Survey to analyze physician compensation in 2012. The analysis showed that—averaged across all specialties—actual physician compensation was about $328,000 per year. Simulated annual compensation for all specialties was about $277,000—roughly 15 percent lower.[13]

Within these averages, compensation was much higher for some specialties than others. The specialty groups with the highest compensation were the nonsurgical, procedural group and radiology (Figure 4-4).[14] Their actual compensations were on average $475,000 and $469,000, respectively. Compensation at these levels was more than double that of the $222,000 average for primary care specialties.[15] Previous Commission work using MGMA data showed that such disparities also existed when compensation was observed on an hourly basis.[16]

Use of simulated annual compensation instead of actual annual compensation resulted in minimal narrowing of the disparities between primary care physicians and specialists. Simulated, radiologists' average annual compensation was about $387,000, or 2.1 times the $185,000 compensation for primary care physicians. For nonsurgical, procedural physicians, the average simulated compensation was about $435,000, or 2.3 times the $185,000 compensation for primary care physicians.

The fee schedule's RVUs have changed since 2012. The disparities in compensation between primary care physicians and specialists may be affected also by the payments for transitional care management and chronic care management instituted in 2013 and 2015, respectively. Nonetheless, the disparities are large enough to remain a concern. In addition, their persistence—under both actual compensation and simulated compensation—shows that the fee schedule is an important source of the disparities. Validation of the fee schedule's RVUs can help correct the fee schedule's inaccuracies and ensure that physicians at the high end of compensation scale are not overcompensated (see text box, pp. 102–103).

Input costs for physicians and other health professionals are projected to increase from 2015 to 2016

The MEI measures the changes in the market basket of input prices for physician and other health professional services and is adjusted for economy-wide productivity.[17] CMS's current forecast for 2016 is that the change in the MEI will be 2.2 percent (Centers for Medicare & Medicaid Services 2014b).

Validating the fee schedule's relative value units

In 2011, as part of its sustainable growth rate reform package, the Commission recommended that CMS undertake a data collection effort to help identify mispriced services in the fee schedule. CMS now has a statutory mandate and resources to examine and address inaccuracies in the fee schedule. The agency currently has two contracts under way, both of which have taken a "bottom up" approach, meaning they attempt to validate the time estimates for services one by one. This process may require direct observation or time-and-motion studies, or detailed data from electronic health records. This type of study is likely to be burdensome for providers and CMS, biased if the practitioners observed change their behavior because they are observed, and very costly. Because of the burden and cost, it is unlikely that the approach could be repeated regularly to maintain accuracy over the long term.

The Commission is exploring a different approach. Instead of looking at each individual service "bottom-up," the "top-down" approach looks at the amount of time that a physician worked over the course of a day/week/month and compares it with the time estimates inherent in all the services that the physician billed over that same period. If a physician worked 10 hours, but the fee-schedule assumed that the services provided required 15 hours, the difference might mean that the time estimates in the fee schedule are overstated. Statistical analysis of the data would then provide direction for further investigation by CMS.

A contractor for the Commission explored the feasibility of this approach by collecting data from a small set of physician practices on (1) the services that its practitioners billed (by Current Procedural Terminology code) and (2) the practitioners' actual hours worked (Zismer et al. 2014). Complete practitioner-level data were available from four practices—cardiology, family medicine, orthopedics, and urology.

Computing averages for each of the practices, the contractor found that, for physicians in all of the practices, the time assumed in the fee schedule exceeded actual hours worked (Figure 4-5). For the physicians in the family medicine practice, the difference was smallest, with fee schedule time averaging 8.8 hours per day, but hours worked per day averaging 7.1 hours, a difference of 24 percent. For the physicians in the orthopedics practice, the difference was the largest among the four practices, with fee

(continued next page)

How should Medicare payments change in 2016?

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 are adequate.

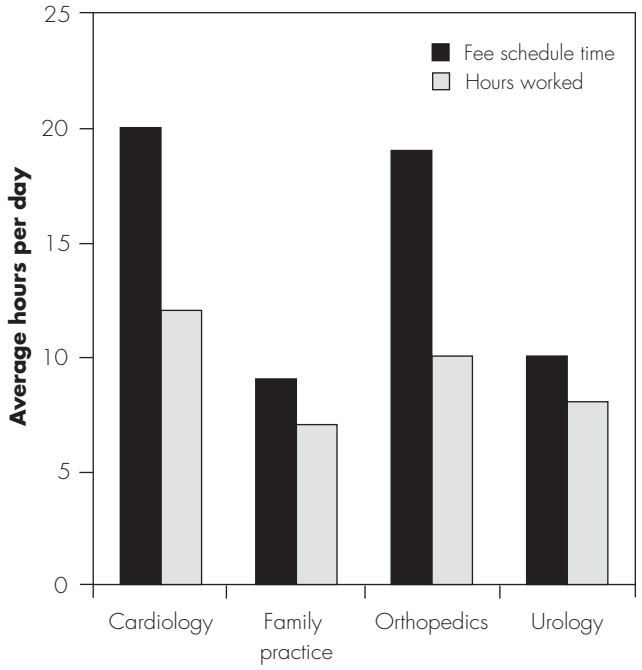
On measures of access to the services of physicians and other health professionals, the Commission continues to find—consistent with our findings over many years—that beneficiary access to care is stable. Medicare beneficiaries generally have better overall access than privately insured individuals ages 50 to 64. Other beneficiary access surveys have consistent findings. The number of physicians per beneficiary has remained relatively constant, the number of other health professionals per beneficiary has grown, and the share of providers accepting assignment and enrolled in Medicare's participating provider program remains high. However, more beneficiaries seeking a primary care doctor report a big problem than beneficiaries seeking a specialist, which continues to be of concern to the Commission.

The volume of physician and other health professional services per beneficiary grew by 0.5 percent in 2013. Growth rates varied across services: 1.4 percent for evaluation and management, −1 percent for imaging services, 1.2 percent for major procedures, 0.1 percent for other procedures, and −2.1 percent for tests. The decline in imaging and tests does not raise concerns about access since they follow large increases in the use of these services since 2000. Specific to imaging, the decrease in volume includes a shift in billing for cardiovascular imaging from professionals' offices to hospitals.

Validating the fee schedule's relative value units (cont.)

FIGURE 4–5

On average, fee schedule time exceeded physician hours worked, 2012 or 2013



Source: Zismer et al. 2014.

schedule time averaging 19.2 hours per day but hours worked averaging 10 hours per day, a difference of 92 percent. This difference suggests that services provided by the orthopedic practice may be based on inflated time estimates and that further investigation of the relative values for these services is needed.

These data represent a small number of practices and physicians and are not definitive. The task of collecting enough data to reliably conduct this analysis has its challenges. However, these preliminary findings are consistent with the Commission's concerns—that primary care services are undervalued in the fee schedule and the time estimates underlying procedural and testing services are overstated. The vast majority of fee schedule time for the physicians in the family medicine practice is time providing office visits. By contrast, the physicians in the other three practices—where the differences between fee schedule time and hours worked are larger—provide more imaging, procedural, and testing services. This approach could be a desirable method for ensuring the accuracy of the fee schedule going forward and is more efficient than trying to validate the relative value units for each individual service. ■

Input prices for physicians and other health professionals are projected to increase by 2.2 percent in 2016 (including a productivity adjustment).

SGR repeal remains the highest priority

The Commission's highest policy priority with respect to Medicare's payments to physicians and other health professionals is repeal of the SGR. Given that this year's payment adequacy findings are largely similar to the findings from prior years, the Commission continues to reiterate its previous recommendations on the SGR as its position with respect to the 2016 fee schedule payment update (see text box, p. 104). The Commission's principles for addressing the SGR are the following:

- ***Repeal of the SGR is urgent.*** Temporary stop-gap fixes to the SGR have had a destabilizing influence on the Medicare program by creating uncertainty for clinicians and beneficiaries, and the short-term overrides of the SGR cause administrative burden for providers and CMS.
- ***Beneficiary access must be preserved.*** Although our review of beneficiary access does not show significant deterioration at the national level, annual crises prompted by pending Medicare payment cuts will only exacerbate any nascent access problems.
- ***The fee schedule for services delivered by physicians and other health professionals must be rebalanced to achieve greater equity of payments between primary care and other specialties.*** The Commission believes that the imbalance in payment between primary care and specialty care must be corrected to ensure adequate beneficiary access to these services and to support the role of primary care in delivery system reform.

The Commission reiterates its 2011 recommendations on moving forward from the sustainable growth rate system

Recommendation 1

The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of [5.9 percent]* for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

Recommendation 2

The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

Recommendation 3

The Congress should direct the Secretary to identify overpriced fee schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in Recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1 percent of fee schedule spending.

Recommendation 4

Under the 10-year update path specified in Recommendation 1, the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee schedule rates. ■

**Note: Based on more recent Congressional Budget Office estimates of repealing the SGR recommendation, in April 2013 the Commission provided an updated estimate of the reduction for services other than primary care of 3 percentage points or less for each of three years. This estimate assumes that primary care fees are held constant throughout the 10-year period and that one-third of the fiscal burden of repeal is borne by physicians and other health professionals paid under the fee schedule.*

- ***Medicare's payment systems must move away from unrestrained FFS and toward new payment models and delivery systems.*** New payment models, such as ACOs and bundled payments, offer an opportunity to correct some of the undesirable incentives to increase volume in FFS and have the potential to reward providers who control costs and improve quality.
- ***Repeal of the SGR should be done in a fiscally responsible way.*** The Commission's recommendations to the Congress are designed to preserve or enhance beneficiary access to quality care while minimizing the financial burden on beneficiaries and taxpayers.

From these principles, the Commission made four distinct recommendations in 2011 and has reiterated these recommendations each year since (see text box).

Repeal the SGR and replace it with a 10-year path of legislated updates, with higher updates for primary care services than for other services Under the Commission's approach, the SGR would be repealed and replaced by a new set of statutory updates over 10 years for services provided by physicians and other health professionals; the update would be different for clinicians who deliver primary care and clinicians who deliver other services. Specifically, fees for non–primary care services would be reduced in each of the first three years, followed by a freeze. Fees for primary care would be frozen for 10 years. Through these reductions and freezes, physicians and

Primary care services and eligible primary care practitioners as defined by the Primary Care Incentive Payment program

Primary care services defined by the Primary Care Incentive Payment program (PCIP) are a subset of evaluation and management services made up primarily of office visits, nursing facility visits, and home visits. Visits to hospital inpatients and emergency department care are not considered PCIP-defined primary care services.

Eligible primary care practitioners include practitioners (1) who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, or physician assistant and (2) for whom PCIP-defined primary care services account for at least 60 percent of allowed charges under the fee schedule (Centers for Medicare & Medicaid Services 2010). ■

other health professionals would shoulder about one-third of the cost of repealing the SGR.

Collect data to improve the relative valuation of services The Secretary lacks current, objective data needed to set the fee schedule's RVUs for practitioner work and practice expenses. The Commission recommended that the Secretary regularly collect data from a cohort of efficient practices to establish more accurate work and practice expense values.

Identify overpriced services and rebalance payments The Commission recommended a change in the process for identifying overpriced services in the fee schedule. The Secretary could use the data collected through the prior recommendation to identify overpriced services and adjust the work and practice expense RVUs for these services.

Encourage ACOs by creating greater opportunities for shared savings The Commission recommended that physicians and health professionals who join or lead two-sided risk ACOs should be afforded a greater opportunity for shared savings compared with those in bonus-only ACOs and those who do not join any ACO.

Per beneficiary payment for primary care

The Commission has been concerned about the current state of support for primary care. Primary care is essential for creating the coordinated health care delivery system of the future, but the Medicare fee schedule undervalues it relative to specialty care. Even though the relative payment for primary care services under the fee schedule has increased over the last decade, compensation for primary care practitioners is still substantially less than that of other specialties (Figure 4-4, p. 100). Disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided. As an indication, the cumulative growth in the volume of E&M services from 2000 to 2013 was less than half the cumulative growth in the volume of imaging, tests, and other procedures (Figure 4-2, p. 93).

In response to its concern, the Commission has made several recommendations over the years to rebalance the fee schedule and bolster support for primary care. The Commission has proposed identifying overpriced services and pricing them appropriately, replacing the SGR with payment updates that are higher for primary care than specialty care, creating a budget-neutral primary care bonus funded from non–primary care services, and establishing a medical home pilot.

PPACA did create a primary care bonus program called the Primary Care Incentive Payment program (PCIP), but it was not budget neutral and thus required additional funding. PCIP provides a 10 percent bonus payment on fee schedule payments for PCIP-defined primary care services provided by eligible primary care practitioners (see text box for definitions). It expires at the end of 2015.

The Commission believes that the additional payments to eligible primary care practitioners should continue. While the amount of the PCIP payment is not large and will probably not drastically change the supply of primary care practitioners, allowing it to expire without a replacement sends a poor signal to primary care practitioners.

New payment for chronic care management services: A comparison with the per beneficiary payment recommendation

Even though fee-for-service (FFS) payment has typically focused on face-to-face activities, CMS has created a new code, which began with the 2015 fee schedule, for non-face-to-face chronic care management (CCM) services (Centers for Medicare & Medicaid Services 2014d). While the Commission supports that effort, the per beneficiary payment model under consideration differs in goals—to replace the expiring primary care bonus payment, to improve support for primary care, and to rebalance the fee schedule—and therefore in design.

Some of the differences are worth emphasizing. First, whereas the CCM code is billable by specialists and primary care practitioners alike, the per beneficiary payment would be paid to eligible primary care practitioners only. Second, beneficiaries are charged cost sharing for the CCM code, but they would not pay cost sharing under the per beneficiary payment design. Finally, CMS is projecting low use of the CCM code, possibly because of the beneficiary criteria, practice requirements, or beneficiary cost sharing. CMS also could be drawing on experience from the recently introduced billing codes for transitional care management, for which use was much lower than expected. However, the CCM code is new, so actual use could turn out to be much different from projections. ■

However, the Commission has also become increasingly concerned that the fee schedule is an ill-suited payment mechanism for primary care. The fee schedule is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward ongoing, non-face-to-face care coordination for a panel of patients. Some patients in the panel will require the coordination of only preventive and maintenance services. Others will have multiple complex chronic conditions and will require extensive care coordination. The fee schedule is not well designed to support these behind-the-scenes activities, and it is precisely these activities that will be crucial in the move to a more coordinated and efficient health care delivery system of the future.

Because of that concern, the Commission recommends continuing the additional payments to primary care practitioners, but in the form of a per beneficiary payment in contrast to the per service payment made under the PCIP. Replacing the PCIP with a per beneficiary payment could be a first step in moving Medicare's payment for primary care from a service-oriented FFS payment approach toward a beneficiary-centered payment approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination.

Although a step in the right direction, the Commission acknowledges that a per beneficiary payment in itself will not guarantee an increase in care coordination activities or even an increase in compensation for eligible primary care practitioners in all instances. The additional funds, like Medicare payments more generally, are paid to practices and other employers of primary care practitioners. These practices could be solo and small practices, large multispecialty practices, or practices owned by hospital systems. These entities may use the additional funds for purposes other than care coordination. Nonetheless, the Commission believes a per beneficiary payment for primary care is needed until new and better payment and delivery system reforms are established.

In developing its approach, the Commission considered several design issues: payment amount, attribution of beneficiaries to practitioners, requirements that practices must meet to receive payment, and the source of funding (Medicare Payment Advisory Commission 2014). The Commission's specific recommendations on these issues are described below.

Finally, CMS established a new payment for chronic care management that began with the 2015 fee schedule. Its structure and purpose differ from the PCIP and from the per beneficiary payment detailed here. However, the Commission is supportive of the new payment for chronic care management and views the two payments as complementary (see text box).

Payment amount

At least as an initial starting point, the Commission supports funding the per beneficiary payment at the same

level as the PCIP. In 2012, bonus payments totaled about 1 percent of fee schedule spending, or $664 million. Payments were made to about 169,000 eligible primary care practitioners (accounting for about 20 percent of practitioners who billed Medicare in that year) for providing PCIP-defined primary care services to about 21 million FFS beneficiaries. On average, practitioners received a bonus payment of about $31 per beneficiary in that year.

At that funding amount, on average, eligible practitioners would receive about $3,900 in additional Medicare revenue per year, and practitioners who provided primary care services to more FFS Medicare beneficiaries than the average practitioner would earn more. For example, consider a primary care practitioner with a panel of 1,400 patients, of whom 280 (20 percent) are FFS Medicare beneficiaries. A $31 per beneficiary payment would provide $8,700 in additional Medicare revenue per year to that practitioner.

That funding amount may not seem like it would provide practitioners with the resources and incentives to undertake significant practice transformation. However, Medicare is not working in isolation. Other payers also are providing per beneficiary payments and other types of support for primary care (Medicare Payment Advisory Commission 2014).

Beneficiary attribution

Unlike the service-based PCIP, a per beneficiary payment necessitates linking a beneficiary to a practitioner to ensure that the right practitioner gets paid and that Medicare does not make duplicate payments to multiple practitioners on behalf of the same beneficiary. The Commission recommends attributing beneficiaries to eligible primary care practitioners prospectively; that is, beneficiaries would be attributed to eligible primary care practitioners at the beginning of the performance year based on the plurality of primary care services provided in the previous year. Eligible primary care practitioners and primary care services are defined as they are in the PCIP (text box, p. 105).

An advantage of this method is the ease with which it could be administered. Like the PCIP, the practitioner would receive payment automatically, without extra paperwork requirements of practitioners or beneficiaries. The practitioner also could be paid throughout the year and thus would be better positioned to make front-end investments in infrastructure and staffing that facilitate care coordination.

One concern regarding prospective attribution is that practitioners could be paid for beneficiaries no longer under their care if beneficiaries switch practitioners from year to year. However, this possibility is not a large concern for two reasons. First, if some beneficiaries switch practitioners from year to year, as long as practitioners care for about the same number of beneficiaries from year to year, per beneficiary payment under prospective attribution would still be similar. Second, even if the number of beneficiaries seen by a practitioner did change markedly from one year to the next, those changes would be reflected in the attribution for the next performance year and per beneficiary payments in the next performance year would move up or down accordingly.

Practice requirements

The Commission recommends having no practice requirements to receive a per beneficiary payment for two reasons. First, a level of funding approximating the PCIP may not be enough for practices to make substantial investments in care coordination activities and technologies that would significantly transform the delivery of care. Second, regardless of the funding level, evidence concerning the effect of practice requirements on improving quality and reducing health care spending has been mixed. However, the issue of practice requirements could be revisited in the future if the per beneficiary payment amount were to increase and if new evidence were to show that certain practice requirements were effective at increasing quality and lowering costs.

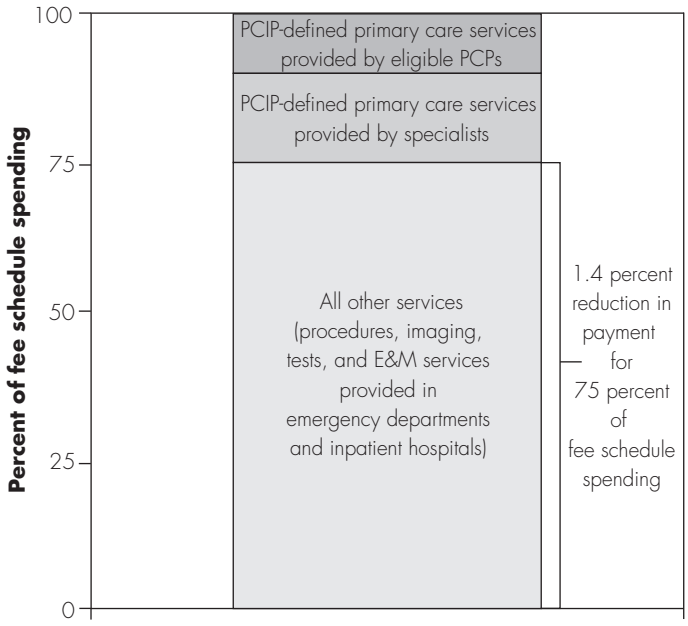
Funding

The Commission recommends funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services provided by any practitioner, regardless of the practitioner's specialty designation or whether PCIP-defined primary care services accounted for at least 60 percent of the practitioner's allowed charges. Beneficiaries would not pay cost sharing, just as beneficiaries do not pay cost sharing to fund the PCIP. This method of funding would be budget neutral and would help rebalance the fee schedule.

All services in the fee schedule other than PCIP-defined primary care services account for about 75 percent of fee schedule spending. Funding a per beneficiary payment at about the same level of funding as the PCIP, or $31 per

FIGURE 4–6

Funding the per beneficiary payment from services other than PCIP-defined primary care services



Note: PCIP (Primary Care Incentive Payment program), PCPs (primary care practitioners), E&M (evaluation and managment). PCIP-defined primary care services are a subset of E&M made up primarily of office visits, nursing facility visits, and home visits. Visits to hospital inpatients and emergency department care are not considered PCIP-defined primary care services. Eligible primary care practitioners include practitioners (1) who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, or physician assistant and (2) for whom PCIP-defined primary care services account for at least 60 percent of allowed charges under the fee schedule (excluding hospital inpatient care and emergency department visits from the calculation).

Source: MedPAC analysis.

beneficiary per year based on 2012, would require a 1.4 percent reduction in payment for all services in the fee schedule other than PCIP-defined primary care services (Figure 4-6).[18]

RECOMMENDATION 4

The Congress should establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. The per beneficiary payment should equal the average per beneficiary payment under the PCIP and should be exempt from beneficiary cost sharing. Funding for the per beneficiary payment should protect PCIP-defined primary care services regardless of the practitioners furnishing the services and should come from reduced fees for all other services in the fee schedule.

RATIONALE 4

Replacing the PCIP after it expires with a per beneficiary payment for primary care would continue the additional support for primary care and so continue to help overcome the undervaluation of primary care services in the fee schedule. Replacing the PCIP with a per beneficiary payment could also be a first step in moving Medicare's payment for primary care from a service-oriented fee-for-service payment approach and toward a beneficiary-centered payment approach. Funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services would be budget neutral and would help rebalance the fee schedule.

IMPLICATIONS 4

Spending

- As a budget-neutral policy, the per beneficiary payment for primary care would not affect federal spending relative to current law.

Beneficiary and provider

- For beneficiaries, the per beneficiary payment could improve care delivery, care coordination, and access to primary care services. Beneficiaries would not pay cost sharing just as they do not pay cost sharing to fund the PCIP; therefore, beneficiaries would not incur additional costs relative to current law.
- For providers, a per beneficiary payment for primary care would continue the additional support for eligible primary care practitioners. (Under current law, the additional support expires at the end of 2015.) A per beneficiary payment for primary care would also redistribute payments from procedurally oriented specialists to eligible primary care practitioners. ■

Endnotes

1 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at http://medpac.gov/documents/payment-basics/physician-and-other-health-professionals-payment-system-14.pdf?sfvrsn=0.

2 The SGR target was set at GDP because Medicare Part B (which pays for physician and other health professional services) is funded in part by general tax revenues, which over the long term have grown with GDP.

3 The survey is conducted through random digit dialing, supplemented with a custom oversample of certain groups of beneficiaries.

4 In 2014, we conducted 18 focus groups in Nashville, TN; Albuquerque, NM; and Harrisburg, PA.

5 Full practice authority occurs when APRNs' ability to diagnose, evaluate, order and interpret tests, manage treatments, and prescribe medication is entirely under the state board of nursing.

6 Providers may be able to charge a retainer for their Medicare beneficiaries and comply with the law as long as the fee is not for Medicare-covered services. The Office of Inspector General has issued guidance about this topic given the trends in retainer-based practices.

7 CMS changed the policy on billing for consultations with the rationale that the relaxation of consultation documentation requirements over time had brought the effort involved in consultations to levels comparable with those of routine E&M visits.

8 When a service is billed as furnished in a facility, Medicare makes a separate facility payment to account for the cost of the service in that setting. Beneficiaries also pay cost sharing on this part of the bill.

9 The sleep study in this example has a billing code of 95811.

10 The effect of the age and gender changes in the overall beneficiary population on spending for physician and other health professional services has generally been small in the recent past, and physician spending is not as variable as total spending by age.

11 Details of the PPA and PPV analyses are presented in online Appendix 3-A to the Commission's June 2014 report, available at http://www.medpac.gov/documents/reports/chapter-3-online-only-appendixes-measuring-quality-of-care-in-medicare-(june-2014-report).pdf?sfvrsn=2.

12 In simple terms, simulated compensation was calculated in two steps. Step 1 was annual total RVUs for the services furnished by a physician multiplied by the Medicare conversion factor. Step 2 was the result of Step 1 multiplied by a ratio that was the physician's actual compensation divided by revenues from the physician's professional services and collections from other sources attributable to the physician, such as laboratory services and injectable drugs. Further details are in the contractor's report.

13 The 15 percent difference between simulated compensation and actual compensation does not mean that Medicare's payments for physician services are 15 percent lower than private payers' payments for those services. The compensation estimates include compensation attributable to physician services and to services other than physician services, such as laboratory services and injectable drugs. In addition, the comparison is simulated Medicare compensation relative to actual compensation that is attributable to private payers' payments but also some Medicare payments.

14 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.

15 The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.

16 To account for differences among specialties in hours worked per week, the contractor's earlier initial analysis for the Commission—with MGMA data for 2007—included comparisons of hourly compensation. The results were similar to those from the analysis of the 2012 data on annual compensation: Hourly compensation for nonsurgical, procedural specialties and radiology was more than double the hourly compensation rate for primary care. Analysis of hourly compensation was not possible with the 2012 data because the newer MGMA survey did not include questions about hours worked.

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

18 These reductions would include reductions in payment for the services other than PCIP-defined primary care services provided by PCPs who otherwise receive the per beneficiary payment.

References

ABIM Foundation. 2014. Specialty society lists of five things physicians and patients should question. http://www.choosingwisely.org/doctor-patient-lists/.

ABIM Foundation. 2012. Choosing wisely. http://choosingwisely.org.

Agency for Healthcare Research and Quality, Department of Health and Human Services. 2014. MEPS web tables. Table 4.1. http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=1&subcomponent=0&year=-1&tableSeries=6&searchText=&searchMethod=1&Action=Search.

American College of Cardiology. 2012. *Findings from the ACC cardiovascular practice consensus.* Washington, DC: ACC. http://www.nccacc.org/news/2012USCVPracticeCensusNorthCarolina.pdf.

American Medical Association. 2013. *2013 national health insurer report card.* Washington, DC: AMA.

Berenson, R., S. Zuckerman, K. Stockley, et al. 2010. *What if all physician services were paid under the Medicare fee schedule: An analysis using Medical Group Management Association data.* A study conducted for the Medicare Payment Advisory Commission by staff from the Urban Institute and the Medical Group Management Association Center for Research. Washington, DC: MedPAC.

Boccuti, C., C. Swoope, A. Damico, et al. 2013. *Medicare patients' access to physicians: A synthesis of the evidence.* Issue brief. Menlo Park, CA: The Kaiser Family Foundation.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014a. The characteristics and perceptions of the Medicare population: Data from the 2012 Medicare Current Beneficiary Survey. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html?DLPage=1&DLSort=0&DLSortDir=descending.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014b. Market basket history and forecasts. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.

Centers for Medicare & Medicaid Services. 2014c. Medicare & Medicaid statistical supplement: 2013 edition. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/index.html.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014d. Medicare program; revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, access to identifiable data for the Center for Medicare and Medicaid Innovation Models & other revisions to Part B for CY 2015. Final rule. *Federal Register* 79, no. 219 (November 13): 67547–68092.

Centers for Medicare & Medicaid Services. 2012a. Medicare & Medicaid statistical supplement: 2012 edition. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2012.html.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012b. *Medicare and Medicaid Research Review. 2012 statistical supplement.* Baltimore, MD: CMS. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2012.html.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Final rule. *Federal Register* 75, no. 228 (November 29): 73169–73860.

Congressional Budget Office. 2014. *Medicare's payments to physicians.* Washington, DC: CBO. http://www.cbo.gov/publication/49770.

Frakt, A. 2014. A shortage of Medicaid doctors? Not if you ask patients. *New York Times*, November 10.

Gunderman, R. 2014. The case for concierge medicine. *The Atlantic*, July 16.

Hoffman, J. R., and R. J. Cooper. 2012. Overdiagnosis of disease: A modern epidemic. *Archives of Internal Medicine* 172, no. 15 (August 13): 1123–1124.

Kenney, G. M., B. Saloner, N. Anderson, et al. 2014. *Access to care for low-income Medicaid and privately insured adults in 2012 in the National Health Interview Survey: A context for findings from a new audit study.* Washington, DC: The Urban Institute. http://www.urban.org/publications/413089.html.

Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14.

Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Redberg, R., M. Katz, and D. Grady. 2011. Diagnostic tests: Another frontier for less is more: Or why talking to your patient is a safe and effective method of reassurance. *Archives of Internal Medicine* 171, no. 7 (April 11): 619.

Shartzer, A., R. Zuckerman, A. McDowell, et al. 2013. *Access to physician services for Medicare beneficiaries*. Issue brief. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Smith, S. K., and M. House. 2006. Snowbirds, sunbirds, and stayers: Seasonal migration of elderly adults in Florida. *Journal of Gerontology: Social Sciences* 61, no. 5 (September): S232–S239.

Welch, H. G., K. J. Hayes, and C. Frost. 2012. Repeat testing among Medicare beneficiaries. *Archives of Internal Medicine* 172, no. 22 (December 10): 1745–1751.

Wieczner, J. 2013. Pros and cons of concierge medicine. *Wall Street Journal*, November 10.

Zismer, D. K., J. Christianson, T. Marr, et al. 2014. *An examination of the professional services productivity for physicians and licensed, advance practice professionals across six specialties in independent and integrated clinical practice*. A study conducted for the Medicare Payment Advisory Commission by the University of Minnesota School of Public Health, Division of Health Policy and Management. Washington, DC: MedPAC.