CHAPTER 4

Physician and other health professional services

RECOMMENDATIONS

4-1 For calendar year 2023, the Congress should update the 2022 Medicare base payment rate for physician and other health professional services by the amount determined under current law.

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

4-2 The Secretary should require that clinicians use a claims modifier to identify audio-only telehealth services.

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

CHAPTER 4

Physician and other health professional services

Chapter summary

Clinicians—including physicians, nurse practitioners, 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. Medicare pays for these services using the physician fee schedule. In 2020, Medicare paid $64.8 billion for clinician services, accounting for just under 17 percent of traditional fee-for-service (FFS) Medicare spending. In the same year, almost 1.3 million clinicians billed the fee schedule, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

In this chapter we recommend a 2023 update to the conversion factor (a fixed dollar amount) used in Medicare's physician fee schedule. Because of standard data lags, the most recent complete data we have for many of our analyses of payment adequacy indicators are from 2020. Where relevant, we have considered the effects of the coronavirus public health emergency (PHE) on our indicators and whether those effects are likely to be temporary or permanent. To the extent that the effects of the PHE are temporary or vary significantly across clinicians, they are best addressed through targeted temporary funding policies rather than a permanent change to all clinicians' payment rates in 2023 and future years. Based on information available at the time of publication, we do not anticipate

In this chapter

- Are Medicare payments adequate in 2022?
- How should Medicare payments change in 2023?
- Adding a claims modifier for audio-only telehealth services
- Appendix: Key findings from the Commission's 2021 access-to-care telephone survey

any long-term effects related to the coronavirus pandemic that would warrant changing the annual update to the physician fee schedule for 2023.

Assessment of payment adequacy

To assess the adequacy of current payment rates for clinician services, we assess beneficiaries' access to care, the quality of their care, and providers' payments and costs.

Beneficiaries' access to care—Overall, beneficiary access to clinician services is comparable to that of privately insured people ages 50 to 64 and comparable to access in prior years, despite the ongoing PHE.

- ***Beneficiaries continue to report relatively good access to care.*** When we surveyed Medicare beneficiaries ages 65 and over in mid-2021, 93 percent were satisfied with the quality of the care they had received in the past year, and, despite the PHE, only 10 percent reported forgoing care that they thought they should have obtained in the past year. Half of beneficiaries reported that during the past year they had accessed clinicians through telehealth, which CMS has temporarily made widely available to allow Medicare beneficiaries to maintain access to care during the PHE. Over 90 percent of beneficiaries in our survey had a primary care provider and had not needed to find a new primary care provider in the past year. However, among those looking for a new clinician, larger shares reported problems finding a new primary care provider than a new specialist—a phenomenon we have observed in our survey for many years, among both Medicare beneficiaries and the privately insured. This difficulty finding a new primary care provider has been one of the core drivers of the Commission's work to improve beneficiary access to primary care services over the last decade.
- ***The supply of clinicians has been growing.*** From 2015 to 2019, the total number of clinicians billing the physician fee schedule grew by about 130,000, and the ratio of clinicians to all Medicare beneficiaries also grew during that period. While the number of clinicians held steady in 2020, the ratio of clinicians to beneficiaries dipped slightly that year because of enrollment growth. Over the 2015 to 2020 period, the mix of clinicians changed: The number of primary care physicians plateaued and then began to shrink, while the number of specialists steadily increased, and the number of advanced practice registered nurses and physician assistants grew rapidly. The share of providers billing Medicare who are enrolled in Medicare's participating provider program—meaning they accept physician fee schedule amounts as payment in full—remains very high, and the share

of beneficiaries who report encountering a clinician who does not accept Medicare is extremely low.

- ***The number of clinician encounters per beneficiary grew before 2020 but declined in 2020.*** From 2015 to 2019, the total number of clinician encounters per beneficiary rose modestly (1.3 percent per year, on average), but in 2020, this number dropped sharply (11.1 percent) due to the effects of the pandemic. Rates of change varied by specialty and type of provider. From 2015 to 2019, before the pandemic, the number of encounters per beneficiary with primary care physicians fell by an average of 2.5 percent per year, while encounters per beneficiary with advanced practice registered nurses and physician assistants rose by an average of 11.2 percent per year.

Quality of care—Quality of care provided by clinicians is difficult to assess in the best of circumstances. In 2020, those difficulties were compounded by the effects of the pandemic on beneficiaries and providers. While we report 2020 results for our quality measures (ambulatory care–sensitive hospitalizations and emergency department visits and patient experience), we have not used those results to inform our conclusions about whether overall quality has improved, worsened, or stayed the same. The 2020 results may reflect temporary changes in the delivery of care and data limitations unique to the PHE rather than trends in the quality of care provided to beneficiaries.

Medicare payments and providers' costs—Although Medicare's total payments for clinician services declined in 2020, overall physician compensation grew slowly.

- ***Medicare payments per beneficiary fell in 2020.*** After growing at an average annual rate of 2 percent from 2015 to 2019, Medicare's allowed charges (i.e., aggregate payments to providers, including beneficiary cost sharing) for clinician services per FFS beneficiary fell in 2020 by 10.6 percent due to care being postponed or forgone during the PHE. Among broad service categories, allowed charges for evaluation and management services fell by 9.4 percent, while imaging services fell by 11.4 percent, major procedures fell by 9.9 percent, other procedures fell by 12.0 percent, tests fell by 14.1 percent, and anesthesia fell by 14.1 percent.
- ***Clinicians' lost revenue during the first year of the pandemic was at least partially offset by federal relief funds.*** Medicare spending on clinician services in 2020 was $8.7 billion lower than it was in 2019; it is too soon to tell whether clinicians experienced revenue declines in 2021. The Congress

has provided clinicians with tens of billions of dollars to offset their pandemic-related revenue losses. This support accelerated the growth of national spending on clinician services, with spending on these services (by all sources, not just Medicare) growing by 5.4 percent in 2020 (up from 4.2 percent growth in 2019). We estimate that, in 2020 and 2021, clinicians received at least $17 billion through the Provider Relief Fund and up to $18 billion in forgiven loans through the Paycheck Protection Program.

- ***Private insurance payment rates continue to be higher than Medicare payment rates.*** In 2020, private insurance payment rates for clinician services were 138 percent of Medicare FFS rates, up from 136 percent in 2019. The growth of private insurance prices could be a result of greater consolidation of physician practices and the acquisition of practices by hospitals, which gives providers more leverage to negotiate higher prices for clinician services with private plans.
- ***Physician compensation continues to rise.*** Despite reduced Medicare spending on clinician services due to the pandemic, median physician compensation from all payers across all specialties continued to grow in 2020, rising 1.0 percent. During the prepandemic period (2016 to 2019), compensation grew at an average annual rate of 2.5 percent. Median compensation in 2020 remained much lower for primary care physicians than for many specialists—underscoring concerns about the mispricing of physician fee schedule services and its impact on the number of physicians who choose to practice primary care. Although CMS recently raised payment rates for evaluation and management office/outpatient visits (commonly furnished by primary care clinicians), more should be done to improve the accuracy of the fee schedule and increase payments for primary care services. The Commission has made several recommendations and discussed other policies to accomplish these goals over the last decade.
- ***Clinicians' input costs are growing.*** In 2020, the Medicare Economic Index—which measures the annual change in input prices and is adjusted for economy-wide productivity—grew by 1.9 percent, and CMS currently projects that it increased in 2021 by 2.2 percent and will increase in 2022 and 2023 by 2.3 percent and 1.8 percent, respectively.

How should Medicare payment rates change in 2023?

The Medicare Access and CHIP Reauthorization Act of 2015 mandates no update for clinicians for 2023 (however, clinicians are eligible for annual performance-based payment adjustments through Medicare's Merit-based Incentive Payment System, or they can receive an annual bonus worth 5

percent of their Medicare professional services payments if they participate in advanced alternative payment models). The Commission's analyses suggest that, in aggregate, Medicare's payments for clinician services are adequate. Although clinicians have experienced declines in their Medicare service volume and revenue due to the pandemic, the Congress has provided tens of billions of dollars in relief funds to clinicians during the PHE, and we expect volume and revenue to rebound to prepandemic levels (or higher) by 2023. Therefore, the Commission's recommendation is that, for calendar year 2023, the Congress should update the 2022 Medicare base payment rate for physician and other health professional services by the amount determined under current law. Consistent with the Commission's process for developing a payment update recommendation for 2023, we will continue to monitor our indicators of payment adequacy each year using the most current available data and will make recommendations accordingly in future years.

Adding a claims modifier for audio-only telehealth services

Before the coronavirus public health emergency (PHE), CMS paid for telehealth services under the physician fee schedule only if the services were provided using an interactive telecommunications system that included two-way audio and video communication technology. During the PHE, however, CMS waived this requirement for certain services because not all beneficiaries have the capability to engage in a video telehealth visit from their home. In our March 2021 report to the Congress, the Commission presented a policy option whereby CMS would continue to temporarily cover some telehealth services (including those delivered through an audio-only interaction) after the PHE when the agency determines there is potential for clinical benefit. During this limited period (e.g., one to two years after the expiration of the PHE), policymakers would gather more evidence about the impact of telehealth services (including audio-only services) on access, quality, and cost, and they should use this evidence to decide whether to pay for certain telehealth services (including audio-only interactions) permanently.

However, apart from telehealth services for mental health and substance use disorders and certain evaluation and management services, there is no information on Medicare claims that indicates whether a telehealth service was delivered by an audio-only interaction or an audio-video interaction. Consequently, CMS and others are unable to use claims data to assess the impact of many audio-only telehealth services on access, quality, and cost.

Therefore, the Commission recommends that CMS require clinicians to use a claims modifier to identify all audio-only telehealth services, as the agency has done for audio-only telehealth services for mental health conditions and substance use disorders. This recommendation applies whether Medicare is covering these services temporarily (as during the current PHE) or permanently. ■

The Commission's prior work to improve the accuracy of physician fee schedule payments and increase payments for primary care

High-quality primary care is essential for creating a coordinated health care delivery system. The Commission has a long-standing interest in ensuring that Medicare payments for primary care services—such as ambulatory evaluation and management (E&M) visits—are accurate.[1] Ambulatory E&M visits make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, rheumatology, and neurology). These services have historically been underpriced in the physician fee schedule relative to other services, and the nature of fee-for-service payment allows certain specialties to increase the volume of services they provide—and the payments they receive—more easily than primary care clinicians. These issues have contributed to substantial compensation disparities between primary care physicians and certain other specialties (see pp. 147–148). In response to these concerns, the Commission has made several recommendations over the years to improve the accuracy of payments for fee schedule services and increase payments for primary care services.

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

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Background

Clinicians—including physicians, nurse practitioners, and other health professionals—who bill under Medicare's physician fee schedule deliver a wide range of services, including office visits, surgical procedures, and diagnostic and therapeutic services, in a variety of settings. In 2020, the Medicare program paid $64.8 billion for clinician services, which is $8.7 billion less than in 2019 and equivalent to just under 17 percent of spending in traditional fee-for-service (FFS) Medicare (Boards of Trustees 2021).[2] In 2020, almost 1.3 million clinicians, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners, billed Medicare for at least one beneficiary.

To determine Medicare payment rates for clinician services, CMS uses a fee schedule, known as the physician fee schedule, that consists of relative values for about 8,000 services. The relative values are based on the amount of clinician work required to provide each service, along with estimates of expenses related to maintaining a practice and professional liability insurance costs. These three factors are adjusted for variation in the input prices in different markets, and the sum of these factors is multiplied by the physician fee schedule's conversion factor (a fixed dollar amount equal to $34.61 in 2022) to produce a total payment amount.[3] When clinician services are provided in certain facilities, such as hospitals or skilled nursing facilities, CMS also makes payments to the facilities through other Medicare payment systems, which are discussed in separate chapters in this report.

For many years, the Commission has expressed concern about the accuracy of the physician fee schedule, the underpricing of primary care services relative to other services, and the impact of these problems on the pipeline of future primary care physicians. The underpricing of primary care services likely contributes to compensation disparities among specialties and may be a substantial factor in the decline of primary care physicians that we have observed since 2015. We have made several recommendations to improve the accuracy of the fee schedule and increase payments for primary care services (see text box).

The Commission's prior work to improve the accuracy of physician fee schedule payments and increase payments for primary care (cont.)

services require relative to one another. Some types of services—such as procedures, imaging, and tests—experience efficiency gains over time, as advances in technology, technique, and clinical practice enable clinicians to deliver them faster. However, ambulatory E&M visits do not lend themselves to such efficiency gains because they consist largely of activities that require the clinician's time. When efficiency gains reduce the amount of work needed for a service but the work RVUs for the affected service are not decreased, the service becomes overvalued. Because budget-neutrality rules apply to changes in RVUs, a reduction in the payment rates of these overvalued services would raise the payment rates for all other services, such as ambulatory E&M visits. But this two-step sequence tends not to occur (Medicare Payment Advisory Commission 2018a). As a result, ambulatory E&M visits have become passively devalued over time.

To establish more accurate prices for clinician services, the Commission recommended in 2011 that the Congress direct the Secretary to regularly collect data—including service volume and work time—from a cohort of efficient practices (Medicare Payment Advisory Commission 2011a, Medicare Payment Advisory Commission 2011b). These data should be used to calculate the amount of time that a clinician worked over the course of a week or month and compare it with the time estimates in the physician fee schedule for all of the services that the clinician billed for over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates—and, hence, the RVUs—are too high. This recommendation has not been adopted by the Congress.

In 2015, the Commission recommended that the Congress establish a per beneficiary payment for primary care clinicians to replace the expired Primary Care Incentive Payment (PCIP) program, which provided a 10 percent bonus payment on physician fee schedule payments for certain E&M visits provided by primary care clinicians (Medicare Payment Advisory Commission 2015). These additional payments to primary care clinicians should be in the form of a per beneficiary payment to move away from the approach of paying separately for each discrete service. The payment would provide funds to support the investment in infrastructure and staff that facilitate care coordination. Primary care clinicians who receive the per beneficiary payment would continue to receive fee schedule payments for each service they provide to beneficiaries; the per beneficiary payment would supplement their existing fee schedule payments. Funding for the per beneficiary payment would come from reducing payment rates for all services in the fee schedule other than ambulatory E&M visits provided by any clinician. This method of funding would be budget neutral and would help rebalance the fee schedule toward primary care clinicians. This recommendation has not been adopted by the Congress.

In our June 2018 report to the Congress, the Commission described a budget-neutral approach to rebalance the physician fee schedule that would increase payment rates for ambulatory E&M services while reducing payment rates for other services (e.g., procedures, imaging, and tests) (Medicare Payment Advisory Commission 2018a). Under this approach, the higher payment rates would apply to ambulatory E&M services provided by all clinicians, regardless of specialty. In the report, we estimated that a 10 percent increase would raise annual spending for ambulatory E&M services by $2.4 billion. To maintain budget neutrality, payment rates for all other fee schedule services would be reduced by 3.8 percent. Primary care specialties would receive a substantial increase in their total fee schedule payments (on net) as a result of this change. For example, family practice physicians would receive a 4.9 percent net increase in fee schedule payments, on average.

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The Commission's prior work to improve the accuracy of physician fee schedule payments and increase payments for primary care (cont.)

In 2019, the American Medical Association/Specialty Society Relative Value Scale Update Committee recommended that CMS substantially increase the work RVUs for E&M office/outpatient visits—the most common type of ambulatory E&M visit (Centers for Medicare & Medicaid Services 2020c). In response, CMS increased the RVUs for E&M office/outpatient visits in 2021, thus raising payment rates for these services (Centers for Medicare & Medicaid Services 2020c). For example, CMS increased the total RVUs for a Level 3 E&M visit for an established patient in a freestanding office (Healthcare Common Procedure Coding System code 99213) by 27 percent between 2020 and 2021. Owing to budget-neutrality requirements, CMS offset the increase to rates for E&M office/outpatient visits in 2021 by reducing rates for all physician fee schedule services. The Congress subsequently scaled back this across-the-board reduction by raising 2021 payment rates for all fee schedule services by 3.75 percent and delaying by three years the implementation of a new add-on code for E&M office/outpatient visits.[4] Recently, the Congress increased 2022 payment rates by 3.0 percent. In 2023, these two temporary payment increases will expire and the full rebalancing of the fee schedule will take effect.

The Commission strongly supported raising the RVUs for E&M office/outpatient visits because this action is an important first step in addressing the long-term devaluation of these services (Medicare Payment Advisory Commission 2020). We also supported CMS's decision to implement this change in a budget-neutral manner because doing so will help to rebalance the fee schedule from services that have become overvalued (e.g., procedures, imaging, and tests) to services that have become undervalued—thus improving payment accuracy (Centers for Medicare & Medicaid Services 2020c). Maintaining budget neutrality could also help to reduce the large gap in compensation between primary care physicians and certain specialists.

The Commission has also explored ideas to increase the share of physicians choosing to practice primary care. In our June 2019 report to the Congress, we described a potential scholarship or loan repayment program for physicians who provide primary care to Medicare beneficiaries (Medicare Payment Advisory Commission 2019b). By reducing or eliminating educational debt, a scholarship or loan repayment program could provide medical students and residents with a financial incentive to choose a primary care specialty, such as geriatrics. At our November 2019 meeting, we presented ideas for raising payments to primary care physicians that came from our interviews with two dozen primary care experts, ideas such as testing alternative payment models that support primary care on a national basis instead of only in certain regions and creating new billing codes for comprehensive geriatric assessments and fall risk assessments (Medicare Payment Advisory Commission 2019a). Interviewees also suggested ways to increase residents' exposure to high-functioning, community-based primary care practices, such as requiring residency programs that receive Medicare graduate medical education funding to have geriatric rotations. ■

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a schedule of annual updates to the physician fee schedule's conversion factor. At the same time, MACRA also established: (1) bonuses for clinicians who participate in advanced alternative payment models (A–APMs), such as accountable care organization models that require providers to take on financial risk, and (2) payment adjustments for clinicians who participate in the Merit-based Incentive Payment System (MIPS) (Table 4-1, p. 122). A-APM

TABLE 4–1

Clinicians are eligible for MIPS performance-based payment adjustments or A–APM bonuses but no updates to their base payment rates in 2023

	2021	2022	2023	2024	2025	2026 and later
A–APM clinicians						
Update	0%	0%	0%	0%	0%	0.75%
A–APM bonus*	5%	5%	5%	5%	N/A	N/A
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
MIPS adjustments*	(–7% to +7%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)
Additional MIPS adjustments for "exceptional" performance*	$500 million	$500 million	$500 million	$500 million	N/A	N/A
All clinicians						
Payment increase*	3.75%	3.0%	N/A	N/A	N/A	N/A
Sequestration*	0%	0% (3 months), –1% (3 months), –2% (6 months)	–2%	–2%	–2%	–2%

Note: MIPS (Merit-based Incentive Payment System), A–APM (advanced alternative payment model), N/A (not applicable). A-APM bonuses and MIPS adjustments are based on clinicians' A–APM participation decisions and quality measure performance from two years prior. The annual change to the conversion factor (a fixed dollar amount) for Medicare's physician fee schedule is based on the statutory payment updates listed above and an adjustment to ensure that changes to the fee schedule's work relative value units are budget neutral (not shown). Subsequent to the Medicare Access and CHIP Reauthorization Act of 2015 , the Congress increased 2021 fee schedule payments by 3.75 percent and increased 2022 payments by 3.0 percent relative to 2020 payment rates. The Congress also suspended the 2 percent sequester, which normally reduces Medicare payments, from May 2020 through March 2022 and changed the size of the sequester to 1 percent from April through June of 2022; absent additional congressional intervention, the 2 percent sequestration will resume in July 2022.
*Applies in the given year only and is not included in subsequent years' payment rates.

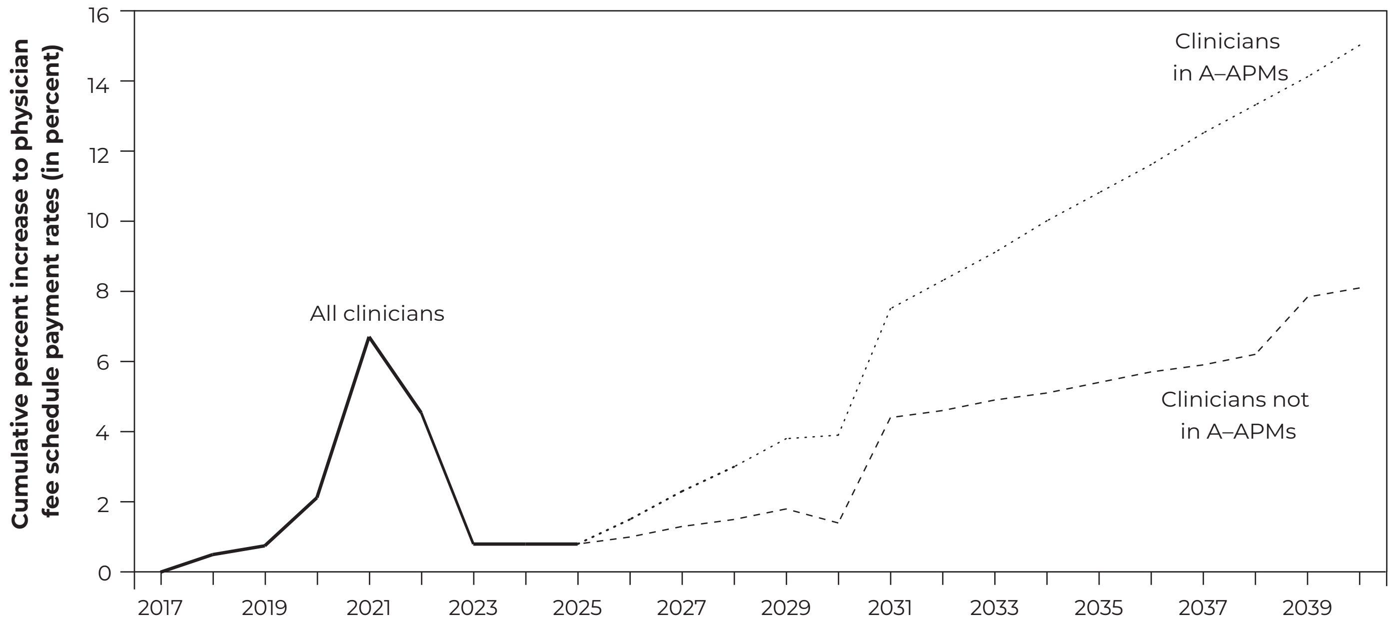
Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015; the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, 2021; and the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021.

bonuses and MIPS adjustments are based on clinicians' A-APM participation and quality measure performance from two years prior.

Under MACRA, there is no statutory update to the fee schedule's conversion factor in 2023. Instead, clinicians qualifying for the A–APM incentive payment will receive a lump-sum payment worth 5 percent of their annual Medicare professional services payments. MACRA allows CMS to give the clinicians in MIPS payment adjustments between −9 percent and +9 percent (or higher) in 2023 based on their performance, but historically CMS has given much smaller adjustments of less than +2 percent. For example, in 2021, top performance on MIPS measures yielded a +1.79 percent MIPS adjustment, which is comparable to prior years' top MIPS adjustments. In 2021, about 1 million clinicians received additional payments beyond their base Medicare payment rates: About 800,000 received a

FIGURE 4–1

Cumulative effect of statutory updates to Medicare physician fee schedule base payment rates under current law, relative to 2017 payment rates



Note: A–APM (advanced alternative payment model). Figure shows increases to payment rates in nominal terms. Figure does not show annual Merit-based Incentive Payment System (MIPS) adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or annual 5 percent A–APM bonuses available from 2019 to 2024 because these annual adjustments are not built into subsequent years' payment rates. Figure also does not show CMS adjustments to ensure that changes to the fee schedule's work relative value units are budget neutral.

Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015; the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, 2021; and the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021.

positive MIPS adjustment, and about 200,000 received the 5 percent A–APM bonus. Hundreds of thousands of clinicians received no payment adjustment because they are exempt from MIPS (e.g., due to a low volume of Medicare patients). About 3,000 clinicians received negative MIPS adjustments of up to –7 percent, primarily because they failed to report MIPS measure data (Centers for Medicare & Medicaid Services 2020d, Centers for Medicare & Medicaid Services 2018).

As currently implemented, MACRA creates incentives for clinicians to participate in A–APMs, first through bonuses that have historically been larger than MIPS adjustments and then through differential payment updates: Starting in 2026, Medicare payment rates for clinicians in A–APMs will increase by 0.75 percent per year, while rates for MIPS clinicians will increase by only 0.25 percent per year (Figure 4-1). Over time, the difference between payment rates for clinicians in A–APMs and MIPS will grow, making nonparticipation in A–APMs increasingly unattractive financially. Since clinicians who practice in a wide variety of clinical settings are paid under the physician fee schedule, using the fee schedule to incentivize participation in A–APMs has the potential to encourage a variety of provider types to participate in A–APMs.

Figure 4-1 also captures temporary increases to clinicians' payment rates in 2020, 2021, and 2022:

- In response to the coronavirus pandemic, the Congress suspended the 2 percent sequester that normally applies to Medicare payments for part of

2020, all of 2021, and part of 2022. (In 2030, the size of the sequester will increase, and in 2031 it will expire—raising payment rates from then on.[5])

- Unrelated to the pandemic, the Congress enacted onetime increases to the physician fee schedule conversion factor of 3.75 percent in 2021 and 3.0 percent in 2022 to partially offset a reduction to the conversion factor. The conversion factor was reduced in 2021 to accommodate an increase to the work relative value units (RVUs) of evaluation and management office/outpatient visits because aggregate changes to the work RVUs of fee schedule services must be budget neutral under current law. (These onetime payment increases in 2021 and 2022 are not included in subsequent years' payment rates.)

Together, these payment increases boosted clinicians' payments per service in 2021 by nearly 6 percent compared with 2019 and by nearly 4 percent in 2022 compared with 2019. In 2023, as these temporary payment policies expire, clinicians' payment rates will return to prepandemic levels (Figure 4-1, p. 123).

Are Medicare payments adequate in 2022?

To assess whether FFS Medicare payments for clinician services are adequate, we examine indicators in three categories:

- ***Beneficiaries' access to care***—including beneficiaries' reports of their experience accessing care, growth in the supply of clinicians, and growth in the number of clinician encounters per beneficiary;
- ***The quality of beneficiaries' care***—including rates of ambulatory care–sensitive hospitalizations and emergency department visits and patient experience; and
- ***Medicare payments and providers' costs***—including growth in Medicare payments per beneficiary, the ratio of commercial payment rates to Medicare's rates for clinician services, growth in physician compensation from all payers, and the change in input costs for clinician services.

Several payment adequacy indicators show significant change from prior years due to the PHE (e.g., reductions in service volume and allowed charges). However, we contend that the changes are largely temporary and are not an indication that payment rates are inadequate (see text box on implications of the pandemic).

Beneficiaries' access to care

According to the Commission's annual survey, Medicare beneficiaries' access to clinician services is largely comparable to that of privately insured individuals. Despite the PHE, most beneficiaries reported no difficulty obtaining the care they needed over the past year. Recent analysis of Medical Expenditure Panel Survey data has also found that around age 65, when most people gain eligibility for Medicare, there is a reduction in reports of being unable to get necessary care and being unable to get needed care because of the cost (Jacobs 2021). In addition, the number of clinicians billing the physician fee schedule grew faster than beneficiary enrollment in Medicare before the pandemic, and the number of clinician encounters per beneficiary was growing steadily before the pandemic.

Beneficiaries continue to report relatively good access to care

Overall, findings from the surveys and focus groups we use to assess Medicare beneficiaries' access to care (see text box, p. 126) are consistent with one another and similar to prior years. The vast majority of beneficiaries report being satisfied with their care and not experiencing trouble accessing care. Yet a few subgroups of Medicare beneficiaries—non-elderly beneficiaries, beneficiaries in certain racial and ethnic groups, and lower-income beneficiaries—report more difficulties accessing care than others.

Continued high satisfaction with health care quality

Medicare beneficiaries remain highly satisfied with their care. Our mid-2021 survey found that among the 94 percent of beneficiaries who received health care in the past year, 93 percent were satisfied with the overall quality of their care. This satisfaction rate is not significantly different statistically from the satisfaction rate for privately insured people ages 50 to 64.[6] We also heard during our focus groups that most beneficiaries were satisfied with their insurance coverage.

The coronavirus public health emergency and the Commission's payment adequacy assessment for physician and other health professional services

The coronavirus pandemic has had tragic effects on beneficiaries and material effects on providers' patient volume, costs, and overall profitability. It has also had a damaging impact on the nation's health care workforce, with frontline health care workers facing burnout and risks to their health and safety treating COVID-19 cases. The effects of the pandemic have varied considerably over time, and it is not clear when they will end.

From the perspective of assessing the adequacy of Medicare payments, the public health emergency (PHE) has also affected the Commission's payment adequacy indicators. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2020. Although it is important to analyze 2020 data to understand what happened to beneficiaries' access to care, quality of care, and Medicare's payments and providers' costs, it will be more difficult to interpret these indicators than is typically the case.

As the Commission stated last year, to the extent that the effects of the coronavirus PHE are temporary—even if over multiple years—or vary significantly across individual clinicians, they are best addressed through targeted temporary funding policies rather than a permanent change to all clinicians' payment rates in 2023 and future years. Only permanent effects of the pandemic will be factored into the Commission's recommended changes in Medicare base payment rates. ■

Most beneficiaries did not forgo care during the pandemic According to a special supplement to CMS's Medicare Current Beneficiary Survey, fielded by phone several times during the PHE, the first few months of the pandemic saw reduced access to care (with 21 percent of beneficiaries reporting forgoing care during these early months) (Centers for Medicare & Medicaid Services 2020a). Fortunately, access was largely restored by summer 2020: When surveyed in fall 2020 and spring 2021, only 7 percent to 8 percent of beneficiaries reported forgoing some care in the prior few months (Centers for Medicare & Medicaid Services 2021a, Centers for Medicare & Medicaid Services 2021b). This finding is consistent with what we heard from clinicians and beneficiaries during our focus groups, with care mainly being delayed during the early months of the pandemic. The most common types of care that Medicare beneficiaries have forgone have been dental care, regular check-ups, treatment for an ongoing condition, and diagnostic or medical screening tests (Centers for Medicare & Medicaid Services 2021b, Centers for Medicare & Medicaid Services 2021a, Centers for Medicare & Medicaid Services 2020a).

The Commission's annual telephone survey assesses Medicare beneficiaries' access to care over a longer, one-year period. When we surveyed people in mid-2021, 10 percent of Medicare beneficiaries reported forgoing care over the past year—which is not a statistically significant difference from prior years or from privately insured survey respondents ages 50 to 64. Notably, every year our survey consistently finds that a small subset of respondents forgo care—usually because they did not think a problem was serious enough to warrant medical attention or because they just put it off. In our 2020 and 2021 surveys, respondents' reasons for forgoing care shifted—with more respondents pointing to the pandemic as their reason for forgoing care—but the overall share of respondents forgoing care was consistent with prepandemic years.

We use beneficiary surveys and focus groups to assess access to care

We use three data sources to assess beneficiaries' access to clinician services:

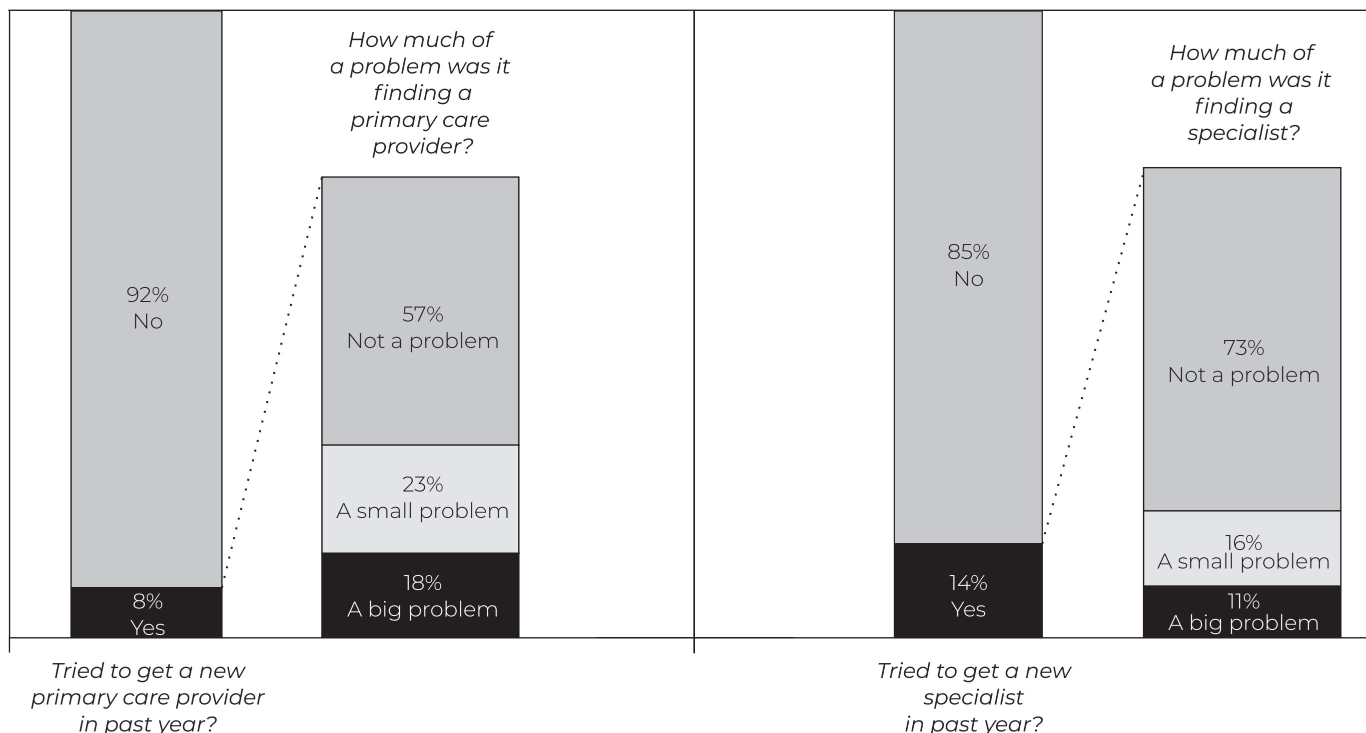
- ***The Commission's annual telephone survey of 4,000 Medicare beneficiaries ages 65 and over and 4,000 privately insured individuals ages 50 to 64.*** The goal in surveying these two populations is to assess whether any access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year's survey was fielded from April through September of 2021. Our survey includes beneficiaries in fee-for-service (FFS) Medicare and Medicare Advantage (MA), since it is difficult to differentiate between these two types of coverage in a brief survey. MA plans also often pay providers rates that are comparable to those of FFS Medicare, and our analyses of CMS's beneficiary survey find no substantial differences in these two types of beneficiaries' care experiences (Trish et al. 2017). Key findings from the Commission's survey can be found in the appendix to this chapter.
- ***CMS's 2019 Medicare Current Beneficiary Survey, a nationally representative in-person survey fielded among 14,000 community-dwelling Medicare beneficiaries.*** CMS's beneficiary survey is not as timely as the Commission's survey, but it includes more questions and is fielded among a larger sample of beneficiaries (including non-elderly beneficiaries). We use CMS's beneficiary survey to confirm and supplement the trends we observe in the Commission's 2021 phone survey. Like the Commission's survey, CMS's survey is fielded among beneficiaries in FFS Medicare and MA.
- ***Focus groups conducted annually by the Commission to obtain an in-depth description of beneficiary and provider experiences with the Medicare program.*** In the summer of 2021, we conducted three virtual focus groups with Medicare beneficiaries (in both FFS Medicare and MA) in each of three different urban markets. One of the groups in each market was composed of beneficiaries dually eligible for Medicare and Medicaid. We also conducted three focus groups with beneficiaries residing in rural areas of Midwestern plains and mountain states. In addition, we conducted three virtual focus groups with clinicians in each of the three urban markets: primary care physicians, specialist physicians, and primary care nurse practitioners and physician assistants. ■

During the PHE, the Congress and CMS have temporarily expanded coverage of telehealth services to ensure that beneficiaries continue to have access to care and to reduce the risk of exposure to COVID-19 (see text box on the use of telehealth during the PHE, p. 128).

More problems finding new primary care physicians than specialists Consistent with prior years, higher shares of Medicare beneficiaries reported having a primary care provider (93 percent) compared with privately insured people ages 50 to 64 (87 percent) in the Commission's 2021 survey. However, among the 8 percent of Medicare beneficiaries looking for a new primary care provider, 41 percent reported a problem finding a new one (equivalent to 3 percent of all beneficiaries) (Figure 4-2). Beneficiaries have an easier time finding a new specialist: Among the 14 percent of beneficiaries looking for a new specialist, only 27 percent reported a problem finding a new one (equivalent to 4 percent of all beneficiaries). We have observed this finding in our annual beneficiary survey

FIGURE 4–2

Medicare beneficiaries had more problems finding a new primary care provider than a new specialist, 2021



Note: Numbers may not sum to 100 percent because the figure does not show the share of respondents who said they didn't know or refused to answer the question.

Source: MedPAC's annual access-to-care telephone survey, 2021.

for many years, among both Medicare beneficiaries and the privately insured. To shore up the declining supply of primary care physicians in the United States, the Commission has made several recommendations over the last decade to increase Medicare payments for primary care services (see text box, pp. 119–121).

Across our focus groups, most primary care and specialty clinicians were accepting new Medicare patients. Beneficiaries' access to specialty care varied, with wait times to see a new specialist ranging from a few days to months. A few beneficiaries reported that wait times had been exacerbated by the pandemic. Clinicians described particular specialties—especially psychiatry—as having access challenges for Medicare beneficiaries.

Fewer delays in getting appointments for illnesses or injuries than for routine care As we have observed for many years, beneficiaries responding to our survey continue to experience fewer delays in getting appointments for illnesses or injuries than for routine care (Table 4A-1, p. 152). In 2021, among beneficiaries who needed appointments, 31 percent reported waiting longer than they wanted for an appointment for routine care, while 20 percent waited longer than they wanted for an appointment for an illness or injury. In our focus groups, most beneficiaries described having timely access to primary care, especially when

Expansion of telehealth during the public health emergency

During the coronavirus public health emergency (PHE), the Congress and CMS temporarily expanded coverage of telehealth services, giving providers broad flexibility to furnish such services to ensure that beneficiaries continued to have access to care while reducing the risk of exposure to COVID-19. For example, clinicians can bill for telehealth services provided to beneficiaries in their homes in both urban and rural areas; before the PHE, Medicare paid for telehealth services only if they were provided to beneficiaries in a clinician's office or facility in a rural area. (For more information on the telehealth expansions, see the Commission's March 2021 report, Chapter 14 (Medicare Payment Advisory Commission 2021).) Clinicians responded to these changes by rapidly adopting telehealth services. The following is an update on the use of telehealth services in Medicare and clinicians' and beneficiaries' experiences with telehealth during the PHE.

Use of telehealth services in Medicare in 2020

As providers and beneficiaries shifted from in-person to telehealth services during the PHE, traditional fee-for-service (FFS) Medicare spending for telehealth services grew dramatically. In 2020, allowed charges for telehealth services paid under the physician fee schedule (PFS) totaled $4.2 billion (about 5 percent of PFS spending), compared with $59 million in 2019 (less than 1 percent of PFS spending). Evaluation and management services accounted for almost all (98 percent) of the allowed charges for telehealth.

In 2020, 14.3 million FFS Medicare beneficiaries received at least 1 telehealth service (40 percent of FFS beneficiaries with Part B). The monthly number of beneficiaries who received telehealth services peaked at 5.7 million in April, then declined to 2.6 million by October as in-person visits began to rebound, and then rose again to 3.3 million in December. The increase at the end of the year likely reflected the growth of new COVID-19 cases during the pandemic's third wave in winter 2020.

We also examined changes in the share of primary care services in 2020 that were delivered to FFS Medicare beneficiaries through telehealth. The growth in telehealth primary care services partially offset the steep drop in the use of in-person primary care services in March and April (Figure 4-3). In April, telehealth accounted for 6.9 million primary care services, or 47 percent of the total. As in-person services began growing after April, telehealth's share of primary care visits declined, making up 19 percent of primary care visits by June. Telehealth's share of primary care services continued to fall before rising again in November and December, climbing to 17 percent of primary care visits in December. More recent data (not shown) indicate that telehealth accounted for about 10 percent of primary care visits in September 2021, which suggests that telehealth continues to have an important role in the delivery of primary care during the PHE.

We also examined the use of telehealth services in FFS Medicare in 2020 by disease category.[7] Mental, behavioral, and neurodevelopmental disorders accounted for the highest share of allowed charges for telehealth (25 percent), which indicates that telehealth services have played an important role in treating mental and behavioral health conditions during the PHE.[8] Diseases of the circulatory system (e.g., hypertension and heart disease) also represented a substantial share of allowed charges for telehealth services (14 percent).

Beneficiaries' experiences with telehealth

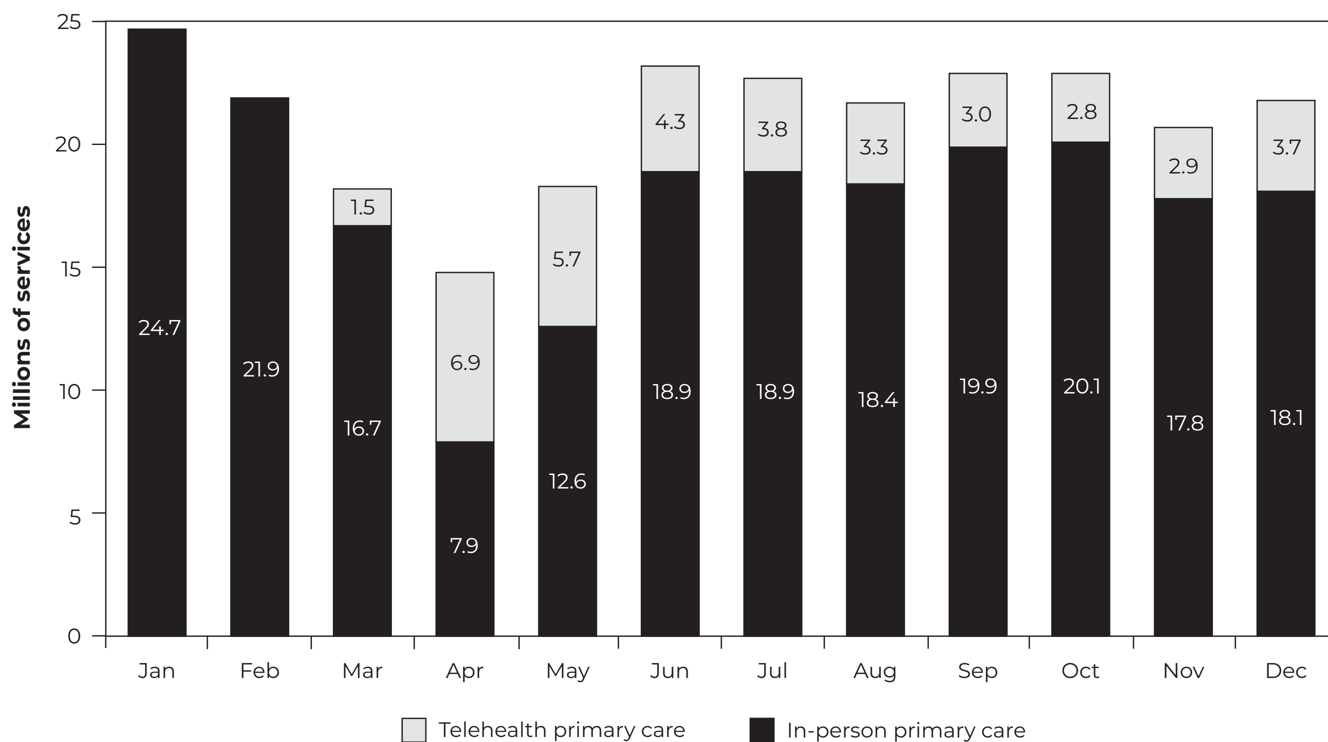
Large shares of Medicare beneficiaries in the Commission's 2021 survey and focus groups (see text box, p. 126) reported using telehealth at some point in the past year. About half of Medicare respondents to our survey (47 percent) had one or more telehealth appointments over the past year, with more than a third (37 percent) having an audio-only telephone visit and a quarter (23 percent) having a video visit. In our focus groups, most beneficiaries said that they had received a telehealth visit in 2021—usually to see clinicians with whom they had

(continued next page)

Expansion of telehealth during the public health emergency (cont.)

FIGURE 4–3

Telehealth accounted for almost half of all primary care services in April 2020, then declined to 19 percent in June



Note: Primary care services include the following physician fee schedule services: office/outpatient evaluation and management (E&M) visits, home E&M visits, E&M visits to patients in certain non-inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care), audio-only E&M visits, chronic care management, transitional care management, Welcome to Medicare visits, annual wellness visits, e-visits, and advance care planning services.

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

an existing relationship, although a few beneficiaries used telehealth to see new clinicians for the first time.

Beneficiaries' views about telehealth were mixed. Among respondents to our survey who had received a telehealth visit, 89 percent were very or somewhat satisfied with their visits. However, only about half of the respondents who had received a telehealth visit reported that they would be interested in continuing to use telehealth after the PHE. Similarly, in our focus groups, beneficiaries appreciated having the option of telehealth visits, especially during the height of the PHE, but there was a common perception that telehealth visits are not as thorough and are not appropriate for all health issues.

(continued next page)

Expansion of telehealth during the public health emergency (cont.)

Clinicians' experiences with telehealth

Clinicians in our focus groups reported that the volume of telehealth visits varied considerably by specialty, but most of them offered a mix of telehealth and in-person visits. Some clinicians appreciated the convenience and flexibility of telehealth in terms of the visit length or location (working from home or the office), while others preferred in-person visits due to perceived better quality of care or because procedures and tests require in-person care. Clinicians agreed that certain conditions or services were better suited to in-person visits than telehealth. Examples included services that involve a physical examination (e.g., checking a patient's blood pressure, listening to a patient's heart, or assessing a patient's pulmonary function) and services that require lab tests. Clinicians also described situations in which telehealth is suitable, such as for patients with stable medical conditions; medication refills; chronic disease management; remote monitoring, such as continuous glucose monitoring for patients with diabetes; and psychiatry visits.

Clinicians in our focus groups believed that telehealth will remain a permanent part of the health care landscape, and most of them planned to continue offering audio and video telehealth visits after the PHE. Clinicians thought a combination of in-person and telehealth care would be ideal in the future. ■

they had an acute care issue. Beneficiaries said that for acute issues, they could usually be seen quickly—sometimes the same day, and usually within a few days. In a departure from previous years, in our 2021 survey, higher shares of Medicare beneficiaries ages 65 and up reported waiting longer than they wanted for appointments for both routine care and for illnesses or injuries than did privately insured people ages 50 to 64. Among beneficiaries who had to wait longer than they wanted for an appointment, most took the appointment date offered to them.[9]

The Commission's 2021 survey also found that, compared with prepandemic years, more Medicare beneficiaries (21 percent) and privately insured people (17 percent) reported seeing a nurse practitioner (NP) or physician assistant (PA) for most or all of their primary care. Beneficiaries' reported access to specialists appears to have been unaffected by the pandemic: Compared with 2019, there was no statistically significant change in 2020 or 2021 in the number of specialists that Medicare beneficiaries reported having seen in the past year. That said, analysis of claims data suggests that the *number* of visits beneficiaries had with specialists likely declined during the early months of the pandemic.

In our focus groups, nearly all beneficiaries reported having a usual source of primary care. Most beneficiaries—including beneficiaries in rural areas—had a physician as their designated primary care provider, but a few had an NP or PA as their primary care provider.

Beneficiaries report good access to care in CMS's 2019 beneficiary survey As with the Commission's survey, CMS's 2019 Medicare Current Beneficiary Survey (the most recent year available) found that beneficiaries generally had good access to care. In 2019, CMS's survey found that:

- 91 percent of beneficiaries had a usual source of care that was not a hospital emergency department or an urgent care center;
- 95 percent of those who received health care in the past year were satisfied with their care;

- 95 percent of those who received care were satisfied with the ease with which they could get to the doctor from where they live;
- 91 percent of those who received care were satisfied with the availability of care during nights and weekends;
- 94 percent of those who received care from their usual care provider in the past year said their provider usually or always spent enough time with them;
- 83 percent of those who received care were satisfied with their out-of-pocket costs;
- 10 percent of Medicare beneficiaries had a problem paying a medical bill;
- the average wait for beneficiaries' last appointment with a specialist was 20 days (when scheduled by the beneficiary, as opposed to the practice); and
- 7 percent of beneficiaries had a health problem that they thought they should see a doctor for in the past year but did not.

Results from CMS's survey and the Commission's survey are not expected to match perfectly because the two surveys are fielded among different types of Medicare beneficiaries in different years and, in some cases, ask about slightly different concepts. The Commission's survey reflects the experiences of beneficiaries ages 65 and over in 2021, whereas CMS's survey reflects the experiences of beneficiaries of all ages (including beneficiaries under age 65) in 2019.

Care experiences of subpopulations of Medicare beneficiaries The Commission's survey and CMS's survey allow us to identify disparities in the care experiences of different subgroups of Medicare beneficiaries. Specifically, we find that non-elderly beneficiaries (most of whom are disabled), beneficiaries of certain races and ethnicities, and beneficiaries with lower incomes have worse care experiences than other beneficiaries. We find little to no difference in the care experiences of rural and urban beneficiaries or of elderly beneficiaries of different ages.

Non-elderly (mostly disabled) beneficiaries reported worse access to care than elderly beneficiaries. CMS's 2019 survey found that non-elderly beneficiaries (the vast majority of whom are disabled) consistently had worse care experiences than elderly beneficiaries ages 65 and over. (We rely entirely on CMS's survey for this particular analysis, since the Commission's survey does not include beneficiaries under age 65.)

According to CMS's survey, a much higher share of non-elderly beneficiaries said that they had a problem paying a medical bill compared with elderly beneficiaries (29 percent vs. 7 percent). And lower shares of non-elderly beneficiaries were satisfied with their out-of-pocket costs compared with elderly beneficiaries (73 percent vs. 85 percent). Non-elderly beneficiaries were more likely to report forgoing care in the past year than were elderly beneficiaries (15 percent vs. 6 percent).

A lower share of non-elderly beneficiaries was satisfied with the availability of care on nights and weekends compared with elderly beneficiaries (85 percent vs. 92 percent). And a lower share reported having a usual source of care that was not a hospital emergency department or an urgent care center (86 percent vs. 92 percent). Lower shares of non-elderly beneficiaries were satisfied with the ease with which they could get to the doctor from where they live compared with elderly beneficiaries (89 percent vs. 96 percent). And a slightly lower share of non-elderly beneficiaries said their usual care provider usually or always spent enough time with them compared with elderly beneficiaries (92 percent vs. 95 percent).

Some of the difficulties reported by non-elderly Medicare beneficiaries could stem from the fact that they have lower incomes, on average, than elderly beneficiaries (Jacobson et al. 2017).

Given these findings, it is perhaps not surprising that lower shares of non-elderly beneficiaries reported being satisfied with the overall quality of the care they had received in the past year compared with elderly beneficiaries (90 percent vs. 96 percent).

Some disparities exist in care experiences by race and ethnicity. Our survey found a number of differences in the care experiences of Black, Hispanic, and White beneficiaries (Table 4A-2, p. 153).[10] In many cases, the difference between one racial or ethnic group and White beneficiaries' experience is statistically significant, but the difference between another racial

or ethnic group and White beneficiaries' experience is not; in the passage that follows, we identify only those differences that are statistically significant.

Our 2021 survey found that lower shares of Hispanic beneficiaries reported having a primary care provider (90 percent) compared with White beneficiaries (94 percent). Meanwhile, a different pattern was observed among the privately insured, with lower shares of Hispanic individuals (86 percent) and White individuals (87 percent) having a primary care provider compared with Black individuals (91 percent).

Higher shares of Hispanic Medicare beneficiaries reported seeing no specialists in the past year (40 percent) compared with White beneficiaries (31 percent). A similar disparity was observed among the privately insured.

Lower shares of Hispanic beneficiaries reported being satisfied with the quality of their care (88 percent) compared with White beneficiaries (95 percent). Meanwhile, among the privately insured, there was no statistically significant difference by race on this metric.

Higher shares of Black Medicare beneficiaries reported forgoing care that they thought they should have obtained in the past year (13 percent) compared with White beneficiaries (9 percent). Among beneficiaries who needed appointments for an illness or injury, a higher share of Black beneficiaries reported having to wait longer than they wanted for these appointments (30 percent) compared with Hispanic (20 percent) and White beneficiaries (19 percent). And among beneficiaries who needed an appointment for routine care in the past year, higher shares of Black beneficiaries reported waiting longer than wanted for such appointments (40 percent) compared with White beneficiaries (29 percent). Similar disparities were observed among the privately insured.

A lower share of Hispanic beneficiaries reported getting most or all of their care from an NP or PA (16 percent) compared with White beneficiaries (22 percent) and Black beneficiaries (24 percent)—which may reflect the low share of Hispanic beneficiaries who live in rural areas (5 percent), where NPs and PAs are more prevalent. Differences among the privately insured were smaller and not statistically significant.

CMS's 2019 Medicare beneficiary survey includes a larger number of beneficiaries, thus allowing us to examine experiences of other racial groups, in addition to Black, Hispanic, and White beneficiaries. Like the Commission's survey, CMS's survey found some differences by race and ethnicity. The largest differences were in the share of beneficiaries who had a problem paying a medical bill. A higher share of Black (20 percent), Multiracial (19 percent), and Hispanic (13 percent) beneficiaries had a problem compared with White (9 percent) and Asian (5 percent) beneficiaries. Similarly, the share who were satisfied with their out-of-pocket costs was lower among Black (77 percent) and Multiracial (77 percent) beneficiaries than White beneficiaries (84 percent).

The share of beneficiaries who reported forgoing care that they thought they should have obtained was higher among Multiracial (14 percent) and Hispanic (9 percent) beneficiaries compared with White (7 percent) beneficiaries. (Only 8 percent of Black beneficiaries reported forgoing care, which was not statistically significantly different from White beneficiaries.)

The share of beneficiaries with a usual source of care that was not a hospital emergency department or an urgent care center was somewhat lower among Black (87 percent), Multiracial (88 percent), and Hispanic (90 percent) beneficiaries compared with White (92 percent) beneficiaries.

A number of factors may be driving differences in care experiences for Black, Hispanic, and White beneficiaries. One factor may be income, since income influences a person's ability to afford health care: Our 2021 survey found that notably higher shares of Hispanic and Black beneficiaries had household incomes of $50,000 or less compared with White beneficiaries, and that beneficiaries in lower-income households had slightly worse experiences accessing care. Health status is another factor that could be influencing disparities in care experiences: A prior analysis found that higher shares of Black and Hispanic Medicare beneficiaries report being in "fair" or "poor" health compared with White beneficiaries (Kaiser Family Foundation 2016), and our own analysis of CMS's 2019 survey finds that beneficiaries who report "fair" or "poor" health status tend to report worse care experiences. Black and Hispanic beneficiaries may also obtain care from lower-quality providers, which could

in turn influence their care experiences: A recent study found that Black and Hispanic beneficiaries are more likely to be hospitalized at one-star hospitals than at five-star hospitals (Ochieng et al. 2021). Another study found that among Medicare beneficiaries experiencing heart attacks, Black patients were more likely to be taken to lower-performing hospitals than White patients, even when these patients all lived in the same ZIP code (Chandra et al. 2020).

Although Asian beneficiaries' care experiences tended to be similar to, or better than, those of White beneficiaries, Asian beneficiaries were the least likely to feel that their usual care provider spent enough time with them (88 percent) compared with Black (90 percent), Hispanic (92 percent), and White (95 percent) beneficiaries. Prior studies have hypothesized that this may be due to cultural differences; for example, when an Asian patient smiles and nods at a doctor, they may be intending to show respect for a doctor, yet the doctor may mistake this body language for agreement with a treatment plan and end an appointment before a patient is ready to do so (Ngo-Metzger et al. 2004).

On a more positive note, there were little or no differences by race or ethnicity in the share of beneficiaries who were satisfied with the quality of the care they received in the past year, were satisfied with the ease with which they could get to a doctor's office from where they live, and were satisfied with the availability of care on nights and weekends.

Individuals with lower incomes have slightly worse care experiences. This year, we examined differences in care experiences by income, comparing Medicare beneficiaries with household incomes of less than $50,000 (our lower-income group), $50,000 to $100,000 (our middle-income group), and more than $100,000 (our higher-income group). We found that, on most indicators, individuals with less income had slightly worse experiences accessing care.

In CMS's 2019 survey, fewer lower-income beneficiaries reported having a usual source of care that was not an emergency department or an urgent care center (89 percent) compared with middle-income and higher-income beneficiaries (93 percent and 94 percent). The Commission's 2021 survey found a similar disparity, with a lower share of lower-income beneficiaries reporting having a primary care provider (92 percent) compared with higher-income beneficiaries (96 percent). The Commission's 2021 survey also found that lower-income beneficiaries were more likely to report getting most or all of their primary care from an NP or PA compared with middle-income and higher-income beneficiaries (24 percent vs. 18 percent vs. 16 percent).

The Commission's 2021 survey found that lower-income and middle-income beneficiaries were more likely to report waiting longer than they wanted for appointments for routine care (32 percent and 31 percent) compared with higher-income beneficiaries (24 percent). Similarly, a higher share of lower-income beneficiaries reported unwanted delays in getting appointments for illnesses or injuries than did higher-income beneficiaries (22 percent vs. 15 percent). CMS's 2019 survey found that lower-income beneficiaries were slightly less likely to report that their usual care provider usually or always spent enough time with them compared with middle-income and higher-income beneficiaries (93 percent vs. 95 percent vs. 96 percent).

CMS's 2019 survey found that lower-income beneficiaries were more likely to report forgoing care that they thought they should have obtained compared with middle-income and higher-income beneficiaries (9 percent vs. 6 percent vs. 3 percent). Similarly, the Commission's 2021 survey found that lower-income beneficiaries were slightly more likely to report forgoing care compared with higher-income beneficiaries (11 percent vs. 8 percent).

The Commission's survey also found that lower-income beneficiaries were more likely to have seen no specialists in the past year compared with middle-income and higher-income beneficiaries (36 percent vs. 29 percent vs. 26 percent). CMS's 2019 survey found that lower-income beneficiaries were less likely to report being satisfied with their out-of-pocket costs than middle-income and higher-income beneficiaries (81 percent vs. 87 percent vs. 90 percent) and were more likely to report problems paying a medical bill (15 percent vs. 4 percent vs. 2 percent).

On a more positive note, the Commission's 2021 survey found no statistically significant difference in the shares of beneficiaries of different incomes who reported problems finding a new primary care provider or a new specialist. And the surveys found only slight

differences in the share of beneficiaries of different incomes who were satisfied with the quality of their care, satisfied with how easy it was to get to a doctor from where they live, and satisfied with the availability of care on nights and weekends.

Very few differences exist in the care experiences of rural and urban beneficiaries. We find only a few statistically significant differences in the care experiences of urban and rural Medicare beneficiaries.[11] The biggest difference between rural and urban beneficiaries in our 2021 survey was the share who reported receiving most or all of their primary care from an NP or PA, as 30 percent of rural beneficiaries reported, compared with 19 percent of urban beneficiaries. This discrepancy was also observed among the privately insured and is a trend we have observed for a number of years. The other difference seen this year was a small decline in the share of rural beneficiaries who were satisfied with the quality of their care; this resulted in a lower share of rural beneficiaries being satisfied with the quality of their care compared with urban beneficiaries (90 percent vs. 94 percent). Satisfaction rates fluctuate from year to year in our survey: In some years, there is no statistically significant difference between urban and rural beneficiaries, while in other years (including this year), urban beneficiaries are somewhat more satisfied.

In our 2021 survey, no statistically significant differences were seen in the shares of rural and urban beneficiaries who reported having a primary care provider, who looked for a new primary care provider or a new specialist in the past year, who had problems finding a new primary care provider or a new specialist, who had to wait longer than they wanted for an appointment for routine care or for an appointment for an illness or injury, or who reported forgoing care that they thought they should have obtained (Table 4A-3, p. 154). There was also no statistically significant difference in the number of specialists that rural and urban beneficiaries saw.

Consistent with these findings, CMS's 2019 survey found little to no difference in urban and rural beneficiaries' experiences accessing care. The few differences that were statistically significant were small. Among those who received health care in the previous year, slightly lower shares of rural beneficiaries were satisfied with their out-of-pocket costs compared with urban beneficiaries (81 percent vs. 83 percent), with the availability of care on nights and weekends (89 percent vs. 91 percent), and with the ease with which they could get to the doctor from where they live (93 percent vs. 96 percent).

There were no statistically significant differences in CMS's 2019 survey in the shares of rural and urban beneficiaries who were satisfied with the overall quality of their care, who said their usual care provider usually or always spent enough time with them, who reported forgoing care in the past year, and who had a problem paying a medical bill.

Most beneficiaries in our rural focus groups indicated that they could access primary care as soon as they needed it. Many of them said they could get in to see someone on the same day or within a few days. Some beneficiaries in rural areas had an urgent care clinic in their town or within 20 miles that they could access if they could not get in to see their doctor. Other beneficiaries would have to drive a substantial distance—for one beneficiary, about 75 miles—to go to an urgent care clinic. In general, beneficiaries in our focus groups from rural areas did not think the distance to travel for care was a problem and had not delayed care due to the travel distance.

Elderly beneficiaries of different ages have comparable care experiences. When we compare the experiences of beneficiaries ages 65 to 74, 75 to 84, and 85 and up, we find very few substantive differences in their care experiences, both in the Commission's 2021 survey and in CMS's 2019 survey. Our 2021 survey found no statistically significant differences in the shares of beneficiaries who reported being satisfied with the overall quality of their care, the shares who reported problems finding a new primary care provider or a new specialist, the shares who waited longer than they wanted for appointments, or the shares who reported forgoing care that they thought they should have obtained in the past year.

In a departure from prior years, our 2021 phone survey found that a lower share of beneficiaries ages 85 and up reported having a primary care provider (89 percent) compared with beneficiaries ages 75 to 84 (94 percent) and 65 to 74 (93 percent). We also found that a higher share of beneficiaries ages 85 and up reported getting most or all of their care from an NP or PA (27 percent), compared with beneficiaries ages 65 to 74 (20 percent) and 75 to 84 (22 percent).

TABLE 4–2

The number of clinicians billing Medicare's physician fee schedule increased and the mix of clinicians changed, 2015–2020

	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
Year	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total
2015	141	439	178	161	919	2.8	8.7	3.5	3.2	18.1
2016	141	447	198	166	952	2.7	8.6	3.8	3.2	18.3
2017	140	455	218	172	985	2.6	8.5	4.1	3.2	18.4
2018	139	462	237	178	1,015	2.5	8.4	4.3	3.2	18.6
2019	139	468	258	184	1,048	2.5	8.4	4.6	3.3	18.7
2020	135	468	268	175	1,047	2.4	8.2	4.7	3.1	18.3

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialties" includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." "Other practitioners" includes clinicians such as physical therapists, psychologists, social workers, and podiatrists. The number of clinicians shown in this table includes only those with a caseload of more than 15 beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in Medicare Part B, whether in fee-for-service or in Medicare Advantage, based on the assumption that clinicians generally furnish services to beneficiaries in both programs. Numbers exclude nonperson providers, such as clinical laboratories and independent diagnostic testing facilities.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2021 annual report of the Boards of Trustees of the Medicare trust funds.

CMS's 2019 survey yielded only a few substantive differences in the care experiences of community-dwelling (noninstitutionalized) elderly beneficiaries of different ages. The two older groups of beneficiaries were less likely to report problems paying their medical bills compared with beneficiaries ages 65 to 74 (5 percent vs. 6 percent vs. 9 percent). And the oldest beneficiaries reported much shorter waits for their last appointment with a specialist (14 days) compared with the two younger groups of elderly beneficiaries (21 days and 20 days).

In 2020, growth in the number of clinicians billing Medicare plateaued and the mix of clinicians continued to change

From 2015 to 2019, the number of clinicians billing the fee schedule grew relative to the size of the overall Medicare population, which suggests that clinicians had sufficient incentive to serve Medicare beneficiaries. However, in 2020, the ratio of clinicians to the number of Medicare beneficiaries shrank slightly (likely due to the PHE), and the mix of clinicians has changed over time.

We limited this part of our analysis of clinicians to those who billed for more than 15 Medicare beneficiaries in a given year. This minimum threshold helps us (1) better measure clinicians who substantially participate in Medicare and are therefore likely critical to ensuring beneficiary access to care and (2) avoid year-to-year variability in clinician counts (i.e., because we exclude clinicians who billed for one or two beneficiaries in one year but may not have billed for any beneficiaries the following year).[12]

Using the 15-beneficiary threshold, we found that the number of clinicians billing the fee schedule between 2015 and 2020 grew from about 919,000 to 1,047,000 (Table 4-2). Over the 2015 to 2019 period, the total number of clinicians per 1,000 beneficiaries increased from 18.1 to 18.7 before falling to 18.3 in 2020.[13] Although the ratio of clinicians to Medicare beneficiaries

decreased in 2020, probably due to the PHE, the effect on the overall supply of clinicians was relatively small and may be temporary. One study that compared billing patterns in 2020 with 2019 found a substantial increase in physicians who had no Medicare claims during March, April, and May 2020, but almost all of those physicians had resumed billing by June; physicians who did not return were predominantly older and closer to retirement (Neprash and Chernew 2021). Meanwhile, according to the Bureau of Labor Statistics, the number of workers (clinicians and nonclinicians) employed by physician offices declined by a few hundred thousand in 2020 but has since returned to prepandemic levels (Wager et al. 2021). The 2020 decline in the number of physician office employees suggests that physician practices were able to reduce costs in response to the pandemic.

While the total number of clinicians billing the fee schedule rose between 2015 and 2020, trends varied by type and specialty of clinicians. Since 2015, the number of primary care physicians billing the fee schedule has slowly declined—yielding a net loss of about 6,000 primary care physicians by 2020. Over the same five-year period, the number of advanced practice registered nurses (APRNs) and PAs billing the fee schedule grew rapidly from about 178,000 to 268,000.[14] Meanwhile, the number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased at a steady pace.

Medicare beneficiaries rarely encounter a clinician who does not accept Medicare According to a federal survey, 85 percent of office-based physicians in the U.S. treated Medicare patients in 2019. Among physicians taking new patients, 80 percent accepted new Medicare patients, 90 percent accepted new commercially insured patients, and 66 percent accepted new Medicaid patients (National Center for Health Statistics 2021).[15] This degree of acceptance of Medicare appears to be sufficient to meet the vast majority of beneficiaries' needs: According to the Commission's 2021 telephone survey, only 1 percent of Medicare beneficiaries encountered a primary care provider or a specialist who did not accept Medicare. Specifically, among the small subset of Medicare beneficiaries who looked for a new primary care provider and had a problem finding one, only 17 percent encountered a primary care provider who did not accept Medicare (equivalent to 1 percent of Medicare beneficiaries overall). Similarly, among the small subset of beneficiaries who looked for a new specialist and had a problem finding one, only 19 percent of this subset encountered a specialist who did not accept Medicare (equivalent to 1 percent of Medicare beneficiaries).

There are a variety of ways clinicians can participate in the Medicare program, which yield different payment rates for their services. In 2020, 98 percent of clinicians billing the physician fee schedule were "participating" providers. Participating providers agree to take assignment for all claims, which means that they accept the fee schedule amount (which includes Medicare's payment plus beneficiary cost sharing) as payment in full.

"Nonparticipating" providers can choose whether to take assignment for their claims on a claim-by-claim basis. Nonparticipating providers who take assignment on a claim receive 95 percent of the physician fee schedule amount for participating providers, with Medicare paying 80 percent of the reduced amount and beneficiaries paying 20 percent of that amount in cost sharing. Nonparticipating providers who do not take assignment on a claim may "balance bill" beneficiaries up to 109.25 percent of the physician fee schedule amount for participating providers. Medicare then repays beneficiaries a portion of the amount that was balance billed.[16] While balance billing is allowed, clinicians rarely balance bill beneficiaries for physician fee schedule services; in 2020, 99.7 percent of fee schedule claims were paid on assignment.

Clinicians can also sign up as "opt-out" providers if they wish to bill beneficiaries for services directly, outside of the Medicare benefit. The 27,000 clinicians who chose to opt out of Medicare as of October 2021 were concentrated in the specialties of behavioral health (42 percent), oral health (29 percent), and primary care (13 percent) (Centers for Medicare & Medicaid Services 2021d).[17,18,19] The number of clinicians who opted out in 2021 was comparable to the number in 2020.

Total number of clinician encounters per beneficiary grew from 2015 to 2019 before declining in 2020

We use the quantity of encounters between beneficiaries and clinicians as another measure of

TABLE 4–3

In 2020, total encounters per FFS beneficiary fell and the mix of clinicians furnishing them changed

Specialty category	Encounters per FFS beneficiary 2015	2019	2020	Percent change Average annual (2015–2019)	2019–2020
Total (all clinicians)	21.1	22.3	19.8	1.3%	–11.1%
Primary care physicians	3.8	3.5	3.1	–2.5	–10.9
Specialists	12.7	12.9	11.4	0.4	–11.7
APRNs/PAs	1.6	2.5	2.4	11.2	–2.7
Other practitioners	3.0	3.4	2.9	3.3	–15.1

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service. Numbers do not account for "incident to" billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare's "incident to" rules are included in the physician totals. We use the number of fee-for-service Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Components may not sum to totals due to rounding, and percent change columns were calculated on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries and 2021 annual report of the Boards of Trustees of the Medicare trust funds.

access to care. Encounters are a measure of entry into the health care system. Entry can be a first step toward timely use of services (Office of Disease Prevention and Health Promotion 2019).

We use a claims-based definition of encounters.[20] Clinicians submit a claim when they furnish one or more services to a beneficiary in FFS Medicare. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would count that as one encounter. About 97 percent of beneficiaries enrolled in FFS Medicare had at least one encounter in 2020.[21]

We found that the number of encounters per FFS Medicare beneficiary grew modestly from 2015 to 2019 before dropping somewhat in 2020. Specifically, from 2015 to 2019, the number of total encounters per beneficiary per year rose from 21.1 to 22.3—an average annual increase of 1.3 percent (Table 4-3). From 2019 to 2020, the number of encounters per beneficiary fell from 22.3 to 19.8—a decrease of 11.1 percent. The change in the number of encounters was not uniform throughout the year: Encounters declined sharply in spring 2020 in response to the coronavirus pandemic but largely recovered by June and remained close to 2019 levels through the remainder of the year.

Change in the number of encounters per beneficiary varied by specialty and type of provider From 2019 to 2020, the number of encounters per beneficiary with primary care physicians declined by about 10.9 percent (Table 4-3). Over the same period, the number of encounters per beneficiary with APRNs or PAs declined by only 2.7 percent, the number of encounters with specialist physicians (who account for a majority of all encounters) fell by 11.7 percent, and encounters with other practitioners (e.g., physical therapists) dropped by 15.1 percent. We are likely undercounting the number of encounters by APRNs and PAs because services performed by APRNs and PAs that are billed "incident to" a physician's service appear as a physician's service in claims data.[22] The size of the 2020 decline in encounters is likely related to the pandemic

and therefore likely to be temporary, but it does reflect longer-term changes (from 2015 to 2019) in the mix of specialties providing services to Medicare beneficiaries. Over time, the share of encounters furnished by primary care physicians has been declining and the share of encounters provided by the other types of clinicians has been increasing (encounters with APRNs and PAs are growing the fastest).

The decline in beneficiary encounters with primary care physicians has occurred across a broad range of services. Even before the pandemic started, from 2015 to 2019, the average annual change in the number of encounters per beneficiary with primary care physicians for E&M services, other procedures, imaging services, and tests was −2.5 percent, −3 percent, −5 percent, and −5 percent, respectively (data not shown).[23]

Recent research has documented that similar drops in encounters with primary care physicians also have occurred among the privately insured population (Ganguli et al. 2019). This trend suggests that primary care physicians are not filling their patient panels with privately insured patients in lieu of Medicare beneficiaries. Rather, the consistent declines across patient populations suggest that the overall supply of primary care physicians is shrinking.

The rapid growth in encounters with APRNs and PAs raises questions about whether these encounters are replacing services that were once provided by primary care physicians. Using claims data, we are unable to determine whether APRNs and PAs work in primary care practices or specialist practices. Therefore, the Commission has recommended that the Secretary collect more detailed information on the specialties in which APRNs and PAs practice (Medicare Payment Advisory Commission 2019b). Studies published between 2011 and 2019 estimate that about half of nurse practitioners (the largest subgroup of APRNs) and one-quarter of PAs work in primary care, although these practice patterns might have changed since then (Agency for Healthcare Research and Quality 2011, Health Resources & Services Administration 2014, National Commission on Certification of Physician Assistants 2019). While these studies suggest that only a portion of APRNs and PAs work in primary care, our analysis found that the decline in beneficiary encounters with primary care physicians coincided with a dramatic rise in encounters with APRNs or PAs, suggesting that these clinicians furnish at least some services once performed by primary care physicians. These findings could also help to explain why the Commission's annual telephone survey has not found a substantial decline in the share of beneficiaries with a primary care provider in recent years (93 percent in 2021), even though our claims analysis finds that encounters with primary care physicians have declined substantially; beneficiaries are still able to access primary care, but different clinicians may be furnishing it.

Before the pandemic, encounters per beneficiary had been growing across service types Examining beneficiary encounters by service type, we found that over the 2015 to 2019 period, the number of E&M encounters per beneficiary provided by all clinicians rose by an annual average of 0.9 percent, from 12.6 to 13.1, before declining to 11.9 (a decrease of 9 percent) in 2020 (Table 4-4). From 2015 to 2019, major procedure encounters grew by an average of 1.2 percent per year before declining by 11.1 percent in 2020, and encounters involving a procedure other than a major procedure (i.e., "other" procedures) grew by 2.8 percent per year before declining by 14.7 percent in 2020. "Other procedures" include skin procedures and various forms of outpatient therapy (physical therapy, occupational therapy, and speech–language pathology).

Quality of care is difficult to assess

Quality of care provided by clinicians is difficult to assess even in the best of circumstances. In 2020, these difficulties were compounded due to the effects of the PHE on beneficiaries and providers. In previous years, we tracked changes in quality measures and determined whether they had improved, worsened, or stayed the same. While we report 2020 results for our quality measures, we have not used those results to inform our conclusions about trends in the quality of care provided to Medicare beneficiaries. The 2020 results may reflect temporary changes in the delivery of care and data limitations unique to the PHE rather than trends in quality of care.

We report on the quality of the ambulatory care environment for Medicare beneficiaries using outcome measures assessing ambulatory care–sensitive (ACS) hospitalizations and emergency department visits as

TABLE 4–4

Encounters per FFS beneficiary, by service type, 2015–2020

	Encounters per FFS beneficiary			Percent change	
Type of service	**2015**	**2019**	**2020**	**Average annual (2015–2019)**	**2019–2020**
Total (all services)	21.1	22.3	19.8	1.3%	–11.1%
Evaluation and management	12.6	13.1	11.9	0.9	–9.0
Major procedures	0.2	0.2	0.2	1.2	–11.1
Other procedures	4.3	4.8	4.1	2.8	–14.7
Imaging	4.0	4.1	3.6	1.0	–14.2
Tests	2.1	2.2	1.8	1.1	–15.4
Anesthesia	0.5	0.6	0.5	3.9	–15.2

Note: FFS (fee-for-service). We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service. We use the number of fee-for-service Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Values by type of service do not sum to the total because encounters with multiple service types are counted separately for each type of service but counted only once for the total. For example, if an imaging service and a test were billed in the same encounter, we count that as one encounter for imaging and one for tests (for a total of two encounters), but we count the services as one encounter for the total row. All numbers in the table are rounded, but unrounded data are used for calculations.

Source: MedPAC analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries and 2021 annual report of the Boards of Trustees of the Medicare trust funds.

well as patient experience measures (measured using the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®)).[24] This approach is consistent with the Commission's principle that Medicare's quality incentive programs should use a small set of population-based outcome, patient experience, and value measures to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, FFS Medicare, and accountable care organizations (ACOs) in defined market areas as well as those cared for by particular hospitals, groups of clinicians, and other providers (Medicare Payment Advisory Commission 2018a). Also, we are limited in our ability to assess the quality of clinicians' care because Medicare does not collect FFS beneficiary–level clinical information (e.g., blood pressure, lab results) or patient-reported outcomes (e.g., improving or maintaining physical and mental health).

CMS measures the performance of clinicians using the Merit-based Incentive Payment System (MIPS). The basic design principle of MIPS is that clinician quality of care and payment adjustments for quality can and should be determined primarily at the individual clinician level, based on measures that clinicians themselves choose to report. But a system built on this design is inequitable because clinicians are evaluated and compared on dissimilar measures. The majority of the measures focus on processes of care as opposed to patient outcomes, and many have compressed performance (i.e., "topped out," which means that all clinicians are performing well on the measure). In addition, many clinicians are not evaluated at all because, as individuals, they do not have a sufficient number of cases for statistically reliable scores. Further, the design is at odds with the fact that quality outcomes for patients—the principal objective of any value improvement program—are determined primarily through the combined efforts of many providers rather than by the actions of any one clinician.

For these reasons, we concluded previously that despite the laudable goal of measuring the quality

TABLE 4–5

Distribution of risk-standardized rates of ambulatory care–sensitive hospitalizations and emergency department visits across hospital service areas, 2020

	Risk-standardized rate per 1,000 FFS beneficiaries			
	10th percentile (high performing)	**50th percentile**	**90th percentile (low performing)**	**Ratio of 90th to 10th percentile**
Ambulatory care–sensitive hospitalizations	24.2	34.4	46.6	**1.9**
Ambulatory care–sensitive ED visits	43.7	72.7	112.5	**2.6**

Note: FFS (fee-for-service), ED (emergency department). Lower rates are better. To measure population-based outcomes for FFS Medicare beneficiaries, we calculated the risk-standardized rates of admissions and ED visits tied to a set of acute and chronic conditions per 1,000 FFS Medicare beneficiaries in hospital service areas (HSAs). There are about 3,400 Dartmouth-defined HSAs. The average population of FFS Medicare beneficiaries in each HSA is about 10,000 beneficiaries. We excluded any hospital service area with fewer than 1,000 FFS Medicare beneficiaries.

Source: MedPAC analysis of 2020 fee-for-service Medicare claims data.

of clinician care and adjusting payments on the basis of measured quality, at its core, MIPS was too fundamentally flawed. As a result, in March 2018, the Commission recommended eliminating MIPS. In MIPS's place, we recommended a voluntary value program, through which groups of clinicians would receive increases or decreases to their payment rates based on their performance on a uniform set of measures assessing outcomes, patient experience, and value (Medicare Payment Advisory Commission 2018b).

Effectiveness and timeliness of care outside the hospital: Ambulatory care–sensitive hospitalizations and emergency department visits

Many factors related to the PHE affected rates of hospitalizations, including both higher demand for beds because of patients suffering from COVID-19, which strained hospital capacity, and lower demand for beds by other patients as nonemergency surgeries were canceled or delayed and patients avoided visiting emergency departments due to fears of infection. Further, the Commission's quality metrics rely on risk-adjustment models that use performance from previous years to predict beneficiary risk. COVID-19 is a new diagnosis and is not included in the current risk-adjustment models, though many associated conditions are. As a result, our models may not adequately represent the acuity and mix of patients receiving care in 2020. Therefore, we report 2020 quality measure results but do not draw conclusions about whether overall quality has improved, worsened, or stayed the same.

The Commission developed two claims-based outcome measures—ACS hospitalizations and emergency department (ED) visits—to compare quality of care within and across different populations (i.e., FFS Medicare beneficiaries in different local market areas), given the adverse impact on beneficiaries and high cost of these events. Two categories of ACS conditions are included in the measures: chronic (e.g., diabetes, asthma, hypertension) and acute (e.g., bacterial pneumonia, cellulitis). Conceptually, an ACS hospitalization or ED visit refers to hospital use that could have been prevented with timely, appropriate, high-quality care. For example, if a diabetic patient's primary care physician and specialists effectively control the condition and they have a system to allow urgent visits, then the patient may be able to avoid a visit to the ED for a diabetic crisis.

In 2020, the distribution of risk-standardized rates of avoidable hospitalizations and ED visits per 1,000 FFS beneficiaries varied widely across Dartmouth-defined hospital service areas (HSAs) (Table 4-5). This variation signals opportunities to improve the quality of ambulatory care, even with the measurement issues related to the PHE.[25] The HSA at the 90th percentile of ACS hospitalizations had a rate that was 1.9 times the HSA at the 10th percentile. The HSA at the 90th percentile of ACS ED visits had a rate that was 2.6 times the HSA in the 10th percentile.[26] Relatively poor performance on a local market's ACS hospitalization and ED visit measures can identify opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can identify best practices for ambulatory care systems.

Patient experience scores

The Agency for Healthcare Research and Quality's CAHPS surveys initiative develops a variety of standardized patient surveys that ask well-tested questions using a consistent methodology across a large sample of respondents. CAHPS surveys generate standardized and validated measures of patient experience that enable health care providers, purchasers, and policymakers to track, compare, and improve patients' experiences in different health care settings. CAHPS surveys measure a key component of quality of care because they assess whether something that should happen in a health care setting (such as clear communication with a provider) actually happened or how often it happened. When patients have a better experience, they are more likely to adhere to treatments, return for follow-up appointments, and engage with the health care system by seeking appropriate care.

CMS annually fields a CAHPS survey among a subset of FFS beneficiaries. The survey questions relate to the beneficiary's experience of care with Medicare and their FFS providers. CMS halted collection of the 2019 experience survey because it was being fielded during the early months of the pandemic (i.e., March through May 2020). Because of the missing data and the effects of the pandemic on how beneficiaries experienced care, we do not interpret trends in beneficiary experience over time.

The *getting needed care and seeing specialists* measure score based on 2020 FFS CAHPS survey responses was 83 (score on a scale of 0 to 100) and the score for *getting appointments and care quickly* was 78 (Table 4-6, p. 142). The *rating of health plan (FFS Medicare)* measure score was 84, and *rating of health care quality* score was 86. These scores have been stable since 2016. Seventy-seven percent of beneficiaries reported receiving an annual flu vaccine, which is an increase from 72 percent in 2016 (Table 4-6).

Medicare payments and providers' costs

To assess Medicare payments, we examine growth in Medicare's allowed charges (i.e., payments to providers, including beneficiary cost sharing) for physician fee schedule services. We also consider how private insurance rates paid by preferred provider organizations (PPOs) for clinician services compare with Medicare's FFS rates. In addition, we examine growth in all-payer physician compensation and compare compensation across specialties. Because clinicians do not report their costs to CMS, we assess annual changes in input prices for clinician services (adjusted for economy-wide productivity) using the Medicare Economic Index (MEI).

Although Medicare's total allowed charges for clinician services declined in 2020, overall physician compensation continued to slowly increase. We found that between 2019 and 2020, Medicare-allowed charges per FFS beneficiary for clinician services fell 10.6 percent, likely due to the reduced volume of services furnished during the PHE. In 2020, commercial payment rates for PPOs were 138 percent of Medicare FFS rates for clinician services, compared with 136 percent in 2019. From 2016 to 2019, median physician compensation across all specialties grew at an average annual rate of 2.5 percent, then grew by 1.0 percent between 2019 and 2020, despite the pandemic. Median compensation in 2020 remained much lower for primary care physicians than for physicians in many other specialties. Meanwhile, the MEI increased by 1.9 percent in 2020, and CMS projects that it will increase by 1.8 percent in 2023.

After growing from 2015 to 2019, allowed charges fell in 2020

Allowed charges are the total payments a clinician receives (including beneficiary cost sharing) from providing physician fee schedule services to FFS beneficiaries. Allowed charges are a function of the

TABLE 4–6

Medicare FFS CAHPS performance scores, 2016–2020

CAHPS composite measure	2016	2017	2018	2019	2020
Getting needed care and seeing specialists	84%	84%	83%	N/A	83%
Getting appointments and care quickly	77	77	77	N/A	78
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	86	86	85	N/A	85
Rating of health plan (FFS Medicare)	84	83	83	N/A	84
Rating of health care quality	85	85	85	N/A	86
Annual flu vaccine	72	74	74	N/A	77

Note: FFS (fee-for-service), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), N/A (not applicable). CMS halted collection of the 2019 beneficiary experience survey at the start of the pandemic. Response options for questions in rows 1 to 3 are "Never," "Sometimes," "Usually," and "Always." CMS converts these to a linear mean score on a 0 to 100 scale. Questions in rows 4 and 5 have responses of 1 to 10, which CMS converts to a linear mean score on a 0 to 100 scale. The question in row 6 is a yes/no response. "Plan" in row 4 refers to the Medicare FFS program.

Source: FFS CAHPS mean scores provided by CMS.

physician fee schedule's relative value units (RVUs), the fee schedule's conversion factor, and other payment adjustments, such as those determined by geographic practice cost indexes.

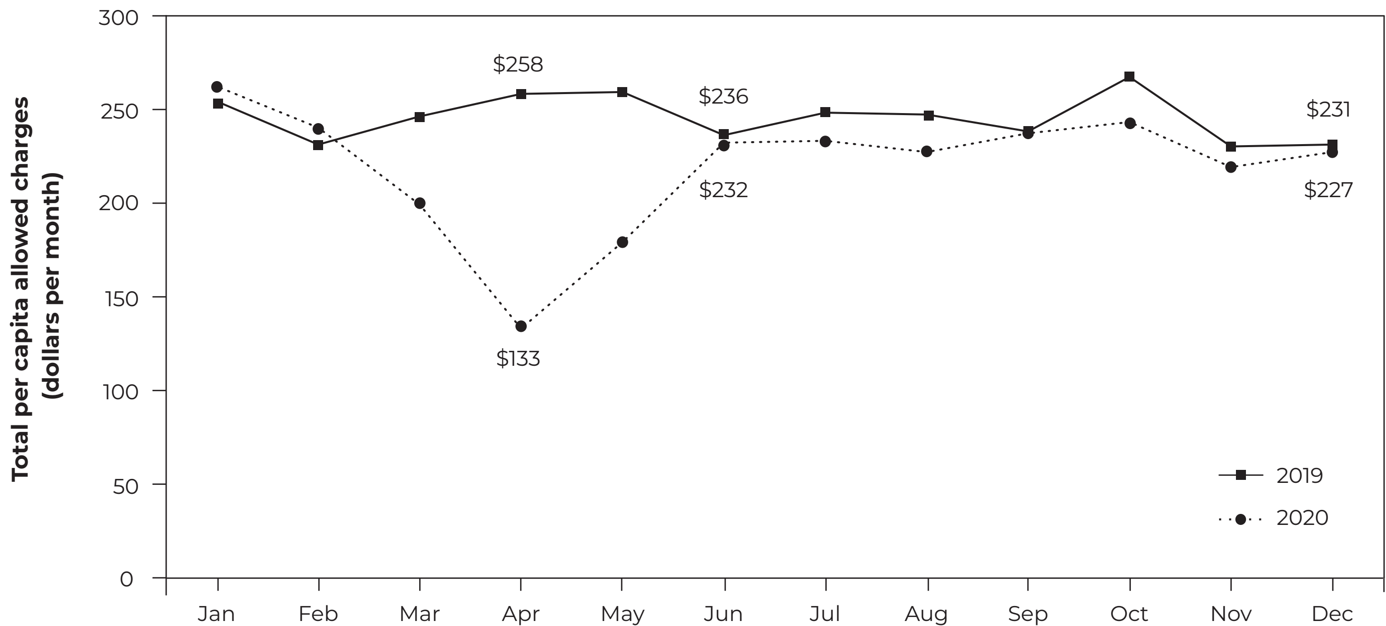
We used claims data from 2015, 2019, and 2020 to analyze changes in allowed charges for the services furnished by clinicians billing under the physician fee schedule. We grouped individual service codes into broad service categories that are clinically meaningful (e.g., E&M, major procedures). Each broad service category contains multiple subcategories of similar services (e.g., E&M includes office/outpatient services, hospital inpatient services, and other subcategories).

We also present changes in units of service per beneficiary. A difference between a change in allowed charges and a change in units of service means that a factor other than volume is affecting the amount of allowed charges. For example, if providers substitute higher-RVU computed tomography (CT) scans for lower-RVU X-rays, the allowed charges for imaging services would increase at a higher rate than would units of service for imaging. However, physician fee schedule–allowed charges are also affected by shifts in the site of service: Decreases in allowed charges could be related to the movement of services from freestanding offices to hospitals, in addition to changes in the volume or intensity of services provided (see text box on shifts in billing, pp. 146–147).

From 2015 to 2019, the average annual growth in allowed charges per beneficiary was 2.0 percent. But between 2019 and 2020, allowed charges per FFS beneficiary fell by 10.6 percent, as beneficiaries put off care in the early months of the pandemic (Table 4-7, p. 144). As shown in Figure 4-4, allowed charges per beneficiary for all physician fee schedule services were about 3 percent higher in January and February 2020 compared with allowed charges during those two months in 2019. Starting in March, however, allowed charges began to fall sharply, and by April these charges were $125 less per beneficiary than during the same month in 2019—almost a 50 percent drop. By

FIGURE 4–4

Monthly physician fee schedule allowed charges per fee-for-service beneficiary, 2019 and 2020



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

June, allowed charges had largely rebounded and were only $4 per beneficiary less than in June 2019. For the rest of 2020, monthly physician fee schedule–allowed charges per beneficiary were between 1 percent and 9 percent less than during equivalent months in 2019. Spending trends for the privately insured in 2020 followed a similar pattern (FAIR Health 2021).

The Congress has provided tens of billions of dollars in relief funds to clinicians to offset their pandemic-related revenue losses from Medicare and other payers. This support accelerated the growth of national spending on clinician services, with spending on these services (by all sources, not just Medicare) growing by 5.4 percent in 2020 (up from 4.2 percent in 2019) (Hartman et al. 2022). We estimate that in 2020 and 2021, clinicians received at least $17 billion through the Provider Relief Fund and up to $18 billion in forgiven loans through the Paycheck Protection Program.

Among broad service categories, the changes in allowed charges per beneficiary between 2019 and 2020 were −9.4 percent for E&M services, −11.4 percent for imaging services, −9.9 percent for major procedures, −12.0 percent for other procedures, −14.1 percent for tests, and −14.1 percent for anesthesia services (Table 4-7, p. 144).

Monthly changes within these service categories largely reflect the overall pattern seen for all services, but the size of the changes varied among categories. For instance, allowed charges per beneficiary for tests and anesthesia in April 2020 were more than 60 percent lower than for the same month in 2019, allowed charges for major procedures and other procedures declined by roughly 55 percent, and charges for E&M services declined by around 40 percent (data not shown). This variation likely reflects differences in whether a service was considered elective and the

TABLE 4–7

Allowed charges per FFS beneficiary for physician fee schedule services, 2015–2020

	Change in units of service per beneficiary		Change in allowed charges per beneficiary		
Type of service	**Average annual 2015–2019**	**2019–2020**	**Average annual 2015–2019**	**2019–2020**	**Share of 2020 allowed charges**
All services	**1.6%**	**–11.7%**	**2.0%**	**–10.6%**	**100.0%**
Evaluation and management	**0.6**	**–8.7**	**1.7**	**–9.4**	**50.7**
Office/outpatient services	0.9	–9.4	1.9	–11.1	25.5
Hospital inpatient services	– 1.1	–6.8	–0.3	–6.3	11.0
Nursing facility services	1.9	–3.3	2.8	–4.0	3.2
Emergency department services	– 1.1	–20.1	–0.5	–18.3	2.6
Ophthalmological services	0.7	–23.4	2.0	–20.1	2.5
Behavioral health services	3.4	–4.9	4.3	–1.3	2.1
Critical care services	2.9	9.2	2.7	9.5	1.8
Care management/coordination	–1.1	15.7	24.8	6.0	1.1
Observation care services	4.1	–20.0	4.3	–19.9	0.6
Home services	0.0	–0.1	0.4	–1.5	0.4
Imaging	**0.4**	**–13.3**	**2.1**	**–11.4**	**10.9**
Standard X-ray	–1.3	–14.4	0.3	–13.2	3.0
Ultrasound	1.1	–14.0	1.7	–13.0	2.8
CT	4.3	–9.3	5.6	–8.2	2.1
Nuclear	–1.1	–15.0	2.0	–6.8	1.3
MR	2.4	–13.4	2.3	–13.5	1.2
Major procedures	**1.0**	**–10.0**	**2.7**	**–9.9**	**7.7**
Musculoskeletal	1.3	–9.2	2.4	–10.3	2.8
Vascular	0.8	–7.9	8.2	–5.0	1.6
Cardiovascular	2.2	–12.1	1.9	–13.8	0.9
Other organ systems	0.9	–11.3	0.8	–10.9	0.9
Digestive/gastrointestinal	–0.6	–11.2	–0.7	–12.0	0.7
Skin	0.9	–7.6	1.1	–8.9	0.5
Eye	0.3	–13.3	–1.0	–13.1	0.2
Other procedures	**3.8**	**–13.9**	**2.6**	**–12.0**	**22.6**
Skin	1.8	–14.3	3.4	–9.8	4.6
Physical, occupational, and speech therapy	8.2	–15.5	9.2	–15.1	4.1
Musculoskeletal	1.4	–14.7	2.9	–12.2	2.4
Radiation oncology	1.5	–6.0	0.1	–3.8	2.1
Eye	3.0	–12.2	1.6	–22.9	2.0
Other organ systems	2.4	–13.8	2.5	–11.1	1.7
Dialysis	–1.2	–4.0	0.6	0.0	1.2
Digestive/gastrointestinal	0.7	–17.7	–1.8	–18.7	1.1
Vascular	–5.4	–6.3	–3.3	–11.7	1.0
Chiropractic	–0.6	–14.4	0.4	–14.1	0.8
Chemotherapy administration	–1.5	–1.4	–0.3	–1.1	0.5
Injections and infusions: non-oncologic	–0.2	–12.3	–5.6	–15.9	0.3
Tests	**1.6**	**–15.3**	**2.2**	**–14.1**	**4.9**
Anatomic pathology	1.7	–11.4	1.5	–10.7	2.1
Cardiography	1.7	–12.9	5.8	–3.7	1.4
Neurologic	1.1	–20.1	1.3	–30.3	0.6
Pulmonary function	–0.2	–32.0	–0.6	–33.1	0.2
Anesthesia	**1.9**	**–12.7**	**1.3**	**–14.1**	**2.8**

Note: FFS (fee for service), CT (computed tomography), MR (magnetic resonance). Some low-spending categories are not shown but are included in the calculations. Allowed charges per beneficiary are calculated for FFS beneficiaries enrolled in Part B. Components may not sum to totals due to rounding.

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

willingness of Medicare beneficiaries to be treated in person during the initial months of the pandemic. The impact of the pandemic on E&M services probably would have been larger if not for the significant increase in 2020 in E&M telehealth visits (see text box on telehealth, pp. 128–130).

Within broad service categories, services for some subcategories experienced significant variation in allowed charges per beneficiary. Table 4-7 shows that from 2019 to 2020, within the E&M category, ophthalmological services fell by 20.1 percent while critical care services grew by 9.5 percent.

Services that had experienced high growth in allowed charges in previous years—specifically 2015 to 2019—were not immune to declines in 2020. Major vascular procedures, which had grown in previous years by an average of 8.2 percent per beneficiary per year, fell by 5.0 percent in 2020. Similarly, in previous years, physical, occupational, and speech therapy had experienced annual growth of 9.2 percent but fell by 15.1 percent in 2020 (Table 4-7).

A small number of service categories experienced notably small declines in allowed charges or even increased in 2020 compared with 2019. For example, spending per beneficiary on dialysis services did not change in 2020, and chemotherapy administration fell by just 1.1 percent. Only two categories experienced increases in per beneficiary spending: Critical care services rose by 9.5 percent and care management and coordination services increased by 6.0 percent. The increase in care management was likely attributable to the growth of relatively new codes for chronic care management services, and presumably much of the growth in critical care services was associated with care furnished to beneficiaries with COVID-19.[27]

Private PPO payment rates remain higher than Medicare payment rates for clinician services

We compare rates paid by private insurance plans with Medicare rates for clinician services because extreme disparities in payment rates might create an incentive for clinicians to focus primarily on patients with private insurance. In 2020, payment rates paid by private PPO health plans for clinician services were 138 percent of Medicare's FFS payment rates, up from 136 percent in 2019.[28] The ratio in 2020 varied by type of service. For example, private insurance rates were 130 percent of Medicare rates for E&M office visits for established patients but 172 percent of Medicare rates for coronary artery bypass graft surgery.

The gap between private insurance rates and Medicare rates has grown in recent years as private insurance rates have risen while Medicare rates have remained relatively stable. In 2011, private insurance rates were 122 percent of Medicare rates. Notwithstanding the growth in the ratio of private insurance rates to Medicare rates, the vast majority of clinicians continue to participate in the Medicare program. The number of clinicians who have opted out of Medicare as of October 2021 (27,000) is substantially outweighed by the number who continue to bill the physician fee schedule (almost 1.3 million in 2020).

The growth in private insurance prices is probably a result of greater consolidation of physician practices and hospitals' acquisition of physician practices, which give providers greater leverage to negotiate higher prices for clinician services with private plans. In recent years, the number of physicians joining larger groups, hospitals, and health systems has risen sharply. For example, between 2016 and 2018, the share of all physicians who were vertically affiliated with health systems climbed from 40 percent to 51 percent (Furukawa et al. 2020).[29]

Studies show that private insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation (Baker et al. 2014, Capps et al. 2018, Clemens and Gottlieb 2017, Neprash et al. 2015). Our own research found that independent practices with larger market shares and hospital-owned practices received higher private insurance prices for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). For example, independent practices with a large market share of E&M visits received an average private insurance price for an E&M visit that was 141 percent of the FFS Medicare rate. By contrast, the average private insurance price received by the smallest independent practices for an E&M visit was about equal to Medicare's rate.

Evidence also suggests that private insurance prices for physician services vary widely across markets. A study by the Congressional Budget Office (CBO)

Shifts in billing from freestanding offices to hospitals reduce physician fee schedule payments but raise overall Medicare spending

Medicare spending is sensitive to shifts in the site of care. Medicare makes both a physician fee schedule payment and a facility payment under the outpatient prospective payment system (OPPS) when a service is provided in a hospital outpatient department (HOPD) (the facility payment accounts for the cost of the service in an HOPD). However, the program makes only a fee schedule payment when a service is furnished in a freestanding office. In 2022, for example, a level 3 evaluation and management (E&M) office/outpatient visit for an established patient (Healthcare Common Procedure Coding System code 99213) has an average nonfacility (freestanding office) fee schedule payment rate of $92. By contrast, the average fee schedule payment rate for the visit when provided in an HOPD is $67, and the facility payment to the HOPD is $121 (for a combined payment of $189).[30] Thus, the shift of level 3 E&M office/outpatient visits from freestanding offices to HOPDs reduces the fee schedule payment (from $92 to $67) but raises the total Medicare payment amount (from $92 to $189).

In recent years, the number of services billed in HOPDs has been increasing, while the number of services provided in freestanding offices has been declining. From 2013 to 2019, for example, the number of E&M office/outpatient visits performed in HOPDs grew by 25 percent, compared with a 5 percent decline in freestanding offices. Similarly, the number of chemotherapy administration services delivered in HOPDs rose by 45 percent, while the number provided in freestanding offices fell by 12 percent. This change in the billed setting increases overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in HOPDs than in freestanding offices (Medicare Payment Advisory

(continued next page)

using data from 2014 found that the average ratio of private insurance prices to Medicare FFS prices for 20 common physician services was at least 70 percent higher in the most costly market than in the least costly market (Congressional Budget Office 2018). CBO found much less variation in the average ratio of Medicare Advantage (MA) prices to Medicare FFS prices across and within markets. MA plans paid much lower prices than private insurance plans for the 20 services examined in the study, and the median MA prices for these services were almost the same as the median Medicare FFS prices. Similarly, a study by Trish and colleagues found that, from 2007 through 2012, MA payment rates for physician services were similar to Medicare FFS rates, whereas commercial prices were higher than Medicare FFS prices (Trish et al. 2017).

Considering our other payment adequacy indicators, we do not believe that beneficiaries' access to clinician services is at risk in the near term. However, in the long run, if private payers do not restrain the growth in clinicians' payment rates, eventually the difference between private insurance rates and Medicare rates could grow so large that some clinicians might choose to focus primarily on patients with private insurance instead of Medicare patients.

Median physician compensation grew more slowly in 2020 than between 2016 and 2019

To examine compensation clinicians received from all payers, we analyzed data from SullivanCotter's Physician Compensation and Productivity Survey; most of the clinician practices in this survey are affiliated with a large hospital or health system. From 2016 to 2019, median compensation across all physician specialties grew at an average annual rate of 2.5 percent, then grew by 1.0 percent during 2020, despite the pandemic. From 2019 to 2020, median

Shifts in billing from freestanding offices to hospitals reduce physician fee schedule payments but raise overall Medicare spending (cont.)

Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012). For example, we estimate that in 2019, the Medicare program spent $1.4 billion more than it would have if payment rates for E&M office/outpatient visits in HOPDs were the same as freestanding office rates. In the same year, beneficiaries' cost sharing was $360 million more than it would have been had payment rates been the same in both settings.

To address the increased spending that results when services shift from freestanding offices to HOPDs, the Commission has recommended adjusting payment rates in the OPPS so that Medicare pays the same amount for E&M office/outpatient visits in freestanding offices and HOPDs (Medicare Payment Advisory Commission 2012). Medicare currently pays a comparable amount for E&M office/outpatient visits in freestanding offices and off-campus HOPDs; however, Medicare continues to pay a higher amount for these visits when provided in on-campus HOPDs.[31] The Commission also has recommended adjusting OPPS rates for services in ambulatory payment classification (APC) groups that meet certain criteria so that payment rates are equal or more closely aligned between HOPDs and freestanding offices (Medicare Payment Advisory Commission 2014).[32] APCs that meet these criteria are those that are unlikely to have costs associated with operating an emergency department, do not have extra costs associated with higher patient complexity in HOPDs, and include services that are frequently performed in freestanding offices (which indicates that these services are likely safe and appropriate to provide in a freestanding office). ■

compensation for primary care physicians increased by 0.8 percent, faster than surgical specialties (–0.2 percent), radiology (0.0 percent), and nonsurgical, procedural specialties (0.6 percent) but slower than nonsurgical, nonprocedural specialties (1.1 percent).[33]

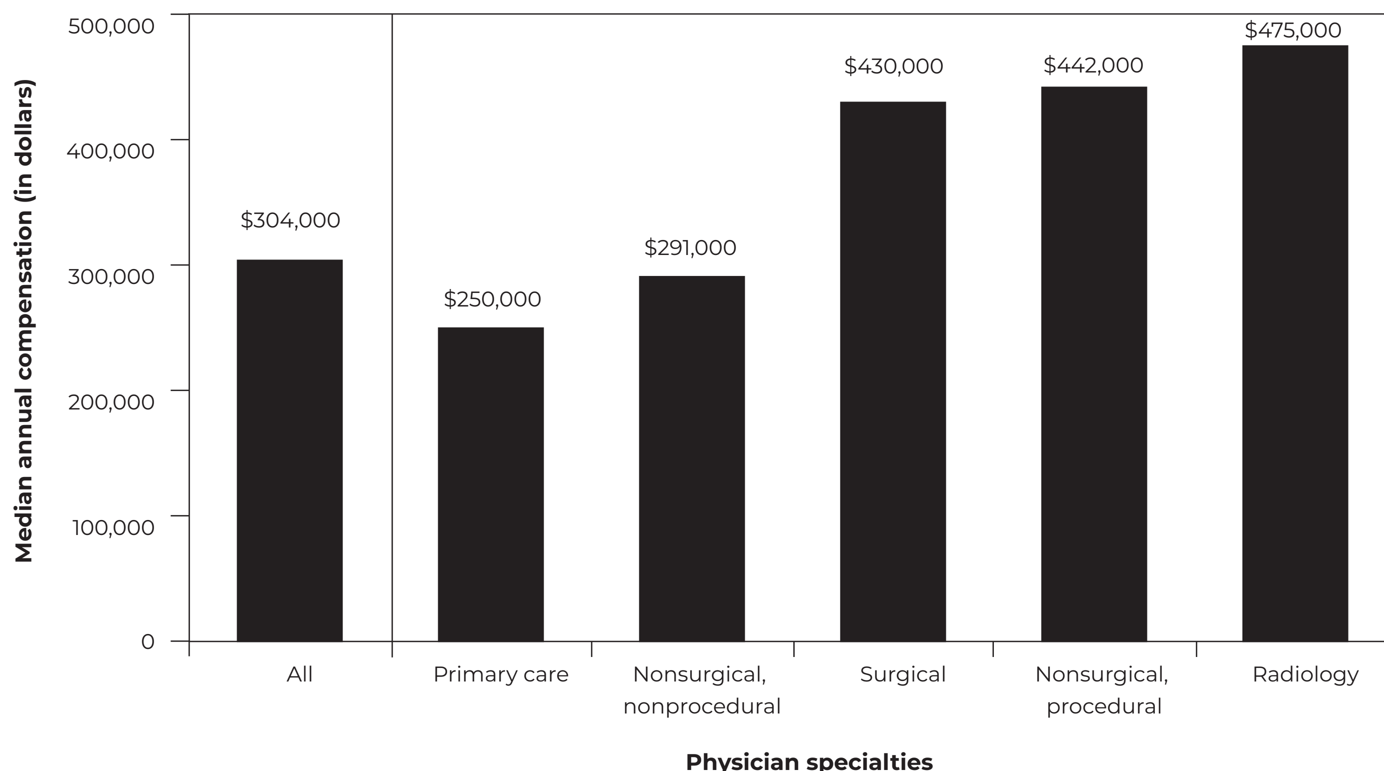
Compensation is much higher for certain specialties than for primary care

In 2020, median compensation across all physician specialties was $304,000, but compensation was much higher for many specialists than for primary care physicians. Specialties with the highest median compensation were radiology ($475,000); nonsurgical, procedural specialties ($442,000); and surgical specialties ($430,000) (Figure 4-5, p. 148).[34] Median compensation for radiology was 90 percent higher than median compensation for primary care ($250,000), and median compensation for nonsurgical, procedural specialties was 77 percent higher than that of primary care. Psychiatry—which is in the nonsurgical, nonprocedural group—had median compensation of $259,000.[35] By comparison, nurse practitioners had median compensation of $118,000 and physician assistants had median compensation of $121,000.

Physician compensation from all payers reflects the structure of Medicare's physician fee schedule because many private insurers base their payment rates on the fee schedule's relative prices (Clemens and Gottlieb 2017, Congressional Budget Office 2018). Therefore, physician compensation from all payers likely reflects the fee schedule's historical underpricing of ambulatory E&M visits relative to other services, such as procedures (Medicare Payment Advisory Commission 2018a).[36] Ambulatory E&M visits make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology). The fee schedule's underpricing of these services has contributed to an

FIGURE 4–5

Compensation for primary care physicians was much lower than for most specialists, 2020



Note: Figure includes all physicians who reported their annual compensation in the survey (*n* = 96,434). The primary care group includes family medicine, internal medicine, and general pediatrics. The nonsurgical, nonprocedural group includes psychiatry, emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The nonsurgical, procedural group includes cardiology, dermatology, gastroenterology, pulmonology, and hematology/oncology.

Source: SullivanCotter's Physician Compensation and Productivity Survey, 2021.

income disparity between primary care physicians and certain specialists, which in turn has contributed to the decline in the number of primary care physicians in recent years.

In 2021, CMS substantially increased the RVUs for E&M office/outpatient visits—the most common type of ambulatory E&M visit (see text box on primary care, pp. 119–121). The Commission supported this action because it is an important first step in addressing the long-term devaluation of these services. Increasing the RVUs for E&M office/outpatient visits could also help to reduce the large gap in compensation between primary care physicians and certain specialists, which could increase the supply of primary care physicians.

Input costs for clinicians are projected to increase from 2022 to 2023

In 2020, the Medicare Economic Index (MEI), which measures the average annual price change in the market basket of inputs used by clinicians to furnish services and is adjusted for economy-wide productivity, increased by 1.9 percent. CMS's forecasted growth for the MEI (as of the third quarter of 2021) in 2021, 2022, and 2023 is 2.2 percent, 2.3 percent, and 1.8 percent, respectively (projections are subject to change).

The MEI consists of two main categories: (1) physicians' compensation and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, rent, equipment, and professional liability insurance). The

index's cost categories (e.g., physician compensation, medical equipment) and cost weights (each category's share of total costs) are based on data on physicians' expenses from 2006, which raises questions about the continued accuracy of the MEI.[37] CMS lacks a reliable, ongoing source of data to update the MEI's cost categories and cost weights. In 2011, the Commission recommended that CMS regularly collect data from a cohort of efficient practices to establish more accurate work and practice expense RVUs. As part of this data collection, CMS could gather data on physicians' practice costs and use that information to update the MEI.

How should Medicare payments change in 2023?

The Commission's deliberations on payment adequacy for clinicians are informed by data assessing beneficiaries' access to clinicians' services, the quality of beneficiaries' care, and Medicare payments and providers' costs. We find that, on the basis of these indicators, aggregate payments appear adequate. Under current law, there will be no update to payment rates in 2023. Although clinicians experienced declines in their Medicare service volume and revenue in the early months of the pandemic, we expect service volume and revenue to return to prepandemic levels (or higher) by 2023. In addition, the Congress provided tens of billions of dollars in relief funds to clinicians in 2020 and 2021 to offset losses in revenue from Medicare and non-Medicare patients, leading to an acceleration in national spending on clinician services in 2020 compared to 2019 (Hartman et al. 2022).

RECOMMENDATION 4-1

For calendar year 2023, the Congress should update the 2022 Medicare base payment rate for physician and other health professional services by the amount determined under current law.

RATIONALE 4-1

Overall, access to clinician services for Medicare beneficiaries appears stable and comparable to that for privately insured individuals. Quality of care is difficult to assess due to the effects of the coronavirus pandemic on beneficiaries and providers. We expect volume and revenue to return to prepandemic levels (or higher) by 2023. Therefore, the Commission does not see a reason to diverge from the current-law policy of no update for 2023. The payment update applies to all clinician services. If there are concerns about payment adequacy for primary care services, they should be addressed through a targeted approach instead of the payment update mechanism (see the text box on primary care, pp. 119–121). Consistent with the Commission's process for developing a payment update recommendation for 2023, we will continue to monitor our indicators of payment adequacy each year using the most current available data and will make recommendations accordingly in future years.

IMPLICATIONS 4-1

Spending

- No change relative to current law.

Beneficiary and provider

- The Commission's recommendation of the current-law update should not affect beneficiaries' access to care or providers' willingness and ability to furnish care.

Adding a claims modifier for audio-only telehealth services

Before the PHE, CMS paid for telehealth services under the physician fee schedule only if they were provided using an interactive telecommunications system that included two-way audio and video communication technology. During the PHE, however, CMS has waived this requirement for some services because not all beneficiaries have the capability to engage in a video telehealth visit from their home (Medicare Payment Advisory Commission 2021). During the PHE, CMS allows audio-only interactions to meet the telehealth requirements for 86 Healthcare Common Procedure Coding System (HCPCS) codes (Centers for Medicare & Medicaid Services 2020b, Centers for Medicare & Medicaid Services 2020c). For example, CMS pays for some E&M services and most behavioral health services that are provided through an audio-only interaction but does not pay for audio-only physical therapy or eye exams. Only 3 of the 86 HCPCS codes that CMS covers during the PHE if they were provided through an audio-only interaction indicate whether the service

was delivered by telephone in the code's description: 99441–99443 (telephone E&M service by a physician or other qualified health professional). The descriptions of the other 83 codes are the same whether the service was provided in person, through an audio-video interaction, or through an audio-only interaction.[38]

In our March 2021 report, the Commission presented a policy option in which CMS would continue to cover some telehealth services (including audio-only services) temporarily after the PHE when the agency determines there is potential for clinical benefit (Medicare Payment Advisory Commission 2021). During this limited period (e.g., one to two years after the expiration of the PHE), policymakers would gather more evidence about the impact of telehealth services (including audio-only services) on access, quality, and cost and use this evidence to decide whether to pay for certain telehealth services permanently.

The Consolidated Appropriations Act, 2021, permanently covered telehealth services that are used to diagnose, evaluate, or treat a mental health disorder when they are provided to a beneficiary at home, whether the beneficiary lives in a rural or urban area; this provision takes effect after the PHE ends. When CMS implemented this provision, the agency also decided to permanently cover audio-only telehealth services used to diagnose, evaluate, or treat a mental health disorder or substance use disorder (SUD) when they are furnished to a beneficiary at home, as long as the clinician is capable of using an audio and video communications system but the patient is not capable of using, or does not consent to the use of, video technology (Centers for Medicare & Medicaid Services 2021c).[39] CMS also required clinicians who provide audio-only telehealth services for mental health disorders or SUDs to include a service-level claims modifier when they bill Medicare for these services.[40] The purpose of this modifier is to allow CMS to monitor use of these audio-only services and ensure compliance with the requirement that clinicians who provide audio-only services have audio and video technology capability but use audio-only technology due to beneficiary choice or limitations. This modifier is required for audio-only services for mental health disorders or SUDs but not for other audio-only services.

However, apart from telehealth services for mental health disorders and SUDs and telephone E&M services, there is no information on Medicare claims that indicates whether the telehealth service was delivered by an audio-only interaction or an audio-video interaction. Consequently, CMS and others are unable to use claims data to assess the impact of many audio-only telehealth services on access, quality, and cost or to evaluate whether audio-only and audio-video interactions have similar effects on quality and cost. Without this evidence, it might be difficult for policymakers to decide whether to pay permanently for additional audio-only telehealth services. Therefore, CMS should require clinicians to use a claims modifier to identify all audio-only telehealth services, as the agency has done for audio-only telehealth services for mental health conditions and SUDs. This recommendation applies whether Medicare is covering these services temporarily (as during the current PHE) or permanently.

RECOMMENDATION 4-2

The Secretary should require that clinicians use a claims modifier to identify audio-only telehealth services.

RATIONALE 4-2

Requiring clinicians to use a claims modifier for all audio-only telehealth services would enable CMS, the Commission, and researchers to assess the impact of such services on access, quality, and cost; to evaluate whether audio-only and audio-video interactions have similar effects on quality and cost; and to examine the characteristics of beneficiaries who use audio-only services. In addition, a claims modifier would allow CMS to monitor the use of these services and help protect Medicare and beneficiaries from unnecessary spending and potential fraud.

IMPLICATIONS 4-2

Spending

- No change relative to current law.

Beneficiary and provider

- This recommendation should not affect beneficiaries' access to care or providers' willingness and ability to furnish care. ■

APPENDIX

4-A

Key findings from the Commission's 2021 access-to-care telephone survey

TABLE 4A–1

Medicare beneficiaries and the privately insured generally had comparable access to care, but slightly more Medicare beneficiaries experienced delays getting appointments during the pandemic, 2021

	Medicare beneficiaries (ages 65 and older)					Privately insured (ages 50–64)				
Survey question	**2017**	**2018**	**2019**	**2020**	**2021**	**2017**	**2018**	**2019**	**2020**	**2021**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"										
For routine care										
Never	73%[ab]	70%[a]	72%[b]	69%[a]	67%[a]	69%[ab]	64%[ab]	74%[b]	73%[ab]	78%[a]
Sometimes	20[ab]	20[ab]	20[b]	22[a]	23[a]	22[ab]	26[ab]	19	20[ab]	17[a]
Usually	3[b]	5	3[b]	3[b]	5[a]	4[b]	5[b]	4[b]	4[b]	3[a]
Always	3	3[a]	3	3	3[a]	3[b]	4[ab]	3[b]	3[b]	2[a]
For illness or injury										
Never	80[a]	79[a]	80	79	78[a]	76[ab]	74[ab]	81	80[b]	83[a]
Sometimes	15[a]	15[a]	14	15	16[a]	18[ab]	19[ab]	15	15	13[a]
Usually	2	2	2	2	2	2	3[b]	2	3	2
Always	1[a]	2	2	2	2	2[ab]	2	1	2	1
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"										
Share answering "Yes"	11	11[a]	9	10	10	12[b]	14[ab]	10	11[b]	9
Looking for a new provider: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")										
Primary care provider	9[a]	10[b]	8	8	8	11[ab]	10[b]	9[b]	7	6
Specialist	17[ab]	19[ab]	17[b]	15	14[a]	20[ab]	21[ab]	15[b]	13[b]	11[a]
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it..."										
Primary care provider										
No problem	69[ab]	71[b]	72[ab]	60	57	59[a]	67	62[a]	57	59
Share of total insurance group	*6[b]*	*7[b]*	*5*	*5*	*4*	*6[b]*	*7[b]*	*5[b]*	*4*	*4*
Small problem	13[b]	13[b]	13[ab]	16[a]	23	18	16[b]	20[a]	24[a]	25
Share of total insurance group	*1[ab]*	*1*	*1[ab]*	*1*	*2*	*2[a]*	*2*	*2[a]*	*2*	*2*
Big problem	14	14	14	22	18	22[a]	16	17	18	15
Share of total insurance group	*1[a]*	*1*	*1*	*2*	*1*	*2[ab]*	*2[b]*	*2*	*1*	*1*
Specialist										
No problem	83[b]	84[b]	85[ab]	79[b]	73	81	80	79[a]	77	76
Share of total insurance group	*14[b]*	*16[b]*	*14[ab]*	*12*	*10[a]*	*16[b]*	*17[b]*	*12[ab]*	*10[b]*	*8[a]*
Small problem	11[b]	7[b]	6[ab]	9[b]	16	11[b]	9[b]	11[ab]	11[b]	17
Share of total insurance group	*2*	*1[b]*	*1[b]*	*1[b]*	*2*	*2*	*2*	*2*	*1*	*2*
Big problem	5[ab]	8	8	11	11	8[a]	10	9	11	8
Share of total insurance group	*1[ab]*	*1*	*1*	*2*	*2[a]*	*2[ab]*	*2[b]*	*1[b]*	*2[b]*	*1[a]*

Note: Totals may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample sizes for each group (Medicare and private insurance) are approximately 4,000 each year. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.

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

[b] Statistically significant difference from 2021 within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted from 2017 to 2021.

TABLE 4A–2

More Black beneficiaries waited longer than they wanted for appointments and reported forgoing care compared with White beneficiaries, 2021

Survey question	Medicare beneficiaries (ages 65 and older)			Privately insured (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
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	69%[ab]	57%[b]	60%[ab]	82%[ab]	66%[b]	72%[ab]
Sometimes	23[a]	27	24	14[ab]	27[b]	22[b]
Usually	4[a]	6	5	2[a]	3	4
Always	2[b]	6[ab]	7[ab]	1	2[a]	1[a]
For illness or injury						
Never	80[ab]	68[ab]	77	85[ab]	78[ab]	80
Sometimes	16[ab]	23[b]	16	12[ab]	18[b]	14
Usually	2	3[b]	0[ab]	1[b]	3	3[ab]
Always	2[b]	4[ab]	4[b]	1	1[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?"						
Share answering "Yes"	9[b]	13[b]	12	8	10	9
Looking for a new provider: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care provider	7	9	11	6	6	6
Specialist	14[a]	12	16	10[a]	9	11
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it..."						
Primary care provider						
No problem	56	71	56	58	73[b]	37[b]
Share of total insurance group, by race	*4*	*6*	*6*[a]	*4*	*4*	*2*[a]
Small problem	25	12	24	26	22	32
Share of total insurance group, by race	*2*	*1*	*2*	*2*	*1*	*2*
Big problem	17	17	20	16	5	30
Share of total insurance group, by race	*1*	*2*	*2*	*1*	*0*	*2*
Specialist						
No problem	73	70	79	74	87	76
Share of total insurance group, by race	*10*[a]	*9*	*13*	*8*[a]	*8*	*8*
Small problem	15	4	18	17	7	20
Share of total insurance group, by race	*2*	*0*[b]	*3*[b]	*2*	*1*	*2*
Big problem	11[b]	26[ab]	3[b]	9	6[a]	4
Share of total insurance group, by race	*1*[b]	*3*[ab]	*0*[b]	*1*	*1*[a]	*0*

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "Don't know" and "Refused." "White" refers to non-Hispanic White respondents. "Black" refers to non-Hispanic Black respondents. "Hispanic" refers to Hispanic respondents of any race. The small size of our survey prevents us from breaking out results for other races. Sample sizes for each insurance group (Medicare beneficiaries and the privately insured) were approximately 4,000 in 2021. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.
[a] Statistically significant difference between the Medicare and private insurance groups 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 survey conducted in 2021.

TABLE 4A–3

Beneficiaries in urban and rural areas had comparable access to care, 2021

Survey question	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
	Urban	**Rural**	**Urban**	**Rural**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"				
For routine care				
Never	67%[a]	67%[a]	77%[a]	81%[a]
Sometimes	23[a]	25[a]	17[a]	17[a]
Usually	5[a]	4[a]	3[a]	1[a]
Always	3[a]	2	2[a]	0
For illness or injury				
Never	78[a]	79	83[a]	84
Sometimes	17[a]	17	13[a]	12
Usually	2	1	2	1
Always	2	1	2	1
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"				
Share answering "Yes"	10	10	9	10
Looking for a new provider: "In the past 12 months, have you tried to get a new…?" (Share answering "Yes")				
Primary care provider	8	7	7	7
Specialist	14[a]	13	11[a]	10
Problems getting a new provider: Among those who tried to get an appointment with a new primary care provider or specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it…"				
Primary care provider				
No problem	57	55	60	45
Share of total insurance group, by area	*4*	*4*	*4*	*3*
Small problem	25	20	25	29
Share of total insurance group, by area	*2*	*1*	*2*	*2*
Big problem	16	21	15	26
Share of total insurance group, by area	*1*	*1*	*1*	*2*
Specialist				
No problem	73	69	76	84
Share of total insurance group, by area	*10*[a]	*9*	*8*[a]	*9*
Small problem	16	17	16	9
Share of total insurance group, by area	*2*	*2*	*2*	*1*
Big problem	11	12	8	7
Share of total insurance group, by area	*2*[a]	*2*	*1*[a]	*1*

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample sizes for each insurance group (Medicare beneficiaries and the privately insured) were approximately 4,000 in 2021. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65. "Urban" respondents reside in an urban or suburban part of a metropolitan statistical area (MSA); the Census Bureau defines MSAs as having at least one urbanized area with a population of 50,000 or more and including adjacent territory that has a high degree of social and economic integration as measured by commuting ties. "Rural" respondents reside outside of an MSA.
[a] Statistically significant difference between Medicare beneficiaries and the privately insured in the given year (at a 95 percent confidence level).
[b] Statistically significant difference by area type within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2021.

Endnotes

1 Ambulatory E&M services include office visits, hospital outpatient department visits, nursing facility visits, and home visits.

2 Although most clinician services are paid under the physician fee schedule, some are paid under the payment systems for federally qualified health centers and rural health clinics.

3 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/document-type/payment-basic/.

4 The new add-on code is G2211 (visit complexity inherent to evaluation and management). The 3.75 percent increase to payment rates expired at the end of 2021.

5 Sequestration applies only to Medicare program payments and does not reduce the size of payments clinicians collect through beneficiaries' cost sharing.

6 In this chapter, when referring to the share of individuals who are satisfied with some aspect of their care, we now use a narrower denominator than in prior years. Previously, our denominators included all individuals asked a survey question about their satisfaction (including individuals who received no care in the past year and thus were not given the opportunity to rate their satisfaction). This year, our denominators are restricted to individuals who actually received care in the past year and were thus given the opportunity to rate their satisfaction with that care.

7 We used the Clinical Classifications Software Refined from the Agency for Healthcare Research and Quality, which aggregates diagnosis codes from claims into 21 body systems. The diagnosis codes are based on the International Classification of Diseases, Tenth Revision, Clinical Modification, which consists of more than 70,000 diagnosis codes.

8 The Consolidated Appropriations Act, 2021 (CAA), removed Medicare's geographic restrictions and added the patient's home as an originating site for telehealth services that are used to diagnose, evaluate, or treat a mental health disorder. The CAA requires that a non-telehealth service (i.e., an in-person visit) be provided by the clinician furnishing mental telehealth services within six months before the initial telehealth service. In the PFS final rule for 2022, CMS also required that the clinician provide a non-telehealth service at least once every 12 months while the beneficiary is receiving mental telehealth services, with limited exceptions (Centers for Medicare & Medicaid Services 2021c).

9 Among beneficiaries who had to wait longer than they wanted for an appointment for routine care, 69 percent took the appointment date offered to them, 12 percent went to a walk-in clinic instead, 7 percent went to a hospital emergency department (ED), and 5 percent opted not to schedule the appointment. When faced with long waits for appointments for an illness or injury, 59 percent took the appointment date offered, 17 percent went to a walk-in clinic, 14 percent went to a hospital ED, and 3 percent opted not to schedule the appointment.

10 This year, we begin breaking out results for specific racial and ethnic categories instead of grouping them together as "non-White" individuals since racial and ethnic groups sometimes have quite different care experiences.

11 "Urban" respondents reside in an urban or suburban part of a metropolitan statistical area (MSA); the Census Bureau defines MSAs as having at least one urbanized area with a population of 50,000 or more and including adjacent territory that has a high degree of social and economic integration as measured by commuting ties. "Rural" respondents reside outside an MSA.

12 A substantial number of clinicians billed for 15 or fewer beneficiaries in a given year, but they accounted for a small share of services and allowed charges. For example, in 2019, about 17 percent of clinicians who billed the fee schedule billed for 15 or fewer beneficiaries, but these clinicians billed for less than 1 percent of total allowed charges.

13 For this analysis, we used the total number of Part B beneficiaries, including those in FFS Medicare and Medicare Advantage, to calculate the ratio of physicians and other health professionals per 1,000 beneficiaries because we assume that clinicians generally furnish services to beneficiaries covered under both programs.

14 APRNs include clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.

15 This survey excluded anesthesiologists, radiologists, and pathologists.

16 In such scenarios, the beneficiary pays the provider the total amount billed by the provider (which is limited to 109.25 percent of the fee schedule amount for participating

providers), but Medicare will reimburse the beneficiary for 80 percent of 95 percent of the fee schedule amount for participating providers.

17 The behavioral health clinicians referenced here are psychiatrists, clinical psychologists, and clinical social workers.

18 The oral health professionals referenced here are dentists, oral surgeons, and maxillofacial surgeons.

19 The primary care specialties referenced here are family medicine, internal medicine, and pediatric medicine.

20 Specifically, we define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers (NPIs) of the clinicians who billed for the service.

21 This number is based on our count of beneficiaries who had at least one encounter recorded in claims data and the total number of FFS Medicare beneficiaries enrolled in Part B from the 2021 Medicare Trustees report.

22 Under "incident to" billing, Medicare allows APRNs and PAs to bill under the NPI of a supervising physician if certain conditions are met. The Commission recommended in 2019 that the Congress require APRNs and PAs to bill Medicare directly, eliminating "incident to" billing for services they provide (Medicare Payment Advisory Commission 2019b).

23 Primary care physicians billed for very few services classified as "major procedures" or "anesthesia," so these categories of services were excluded from this analysis.

24 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

25 The roughly 3,400 Dartmouth-defined HSAs are a collection of ZIP codes whose residents receive most of their hospitalizations from that area's hospitals.

26 Although the 2020 ratios of HSAs at the 90th to 10th percentiles are about the same as in 2019, the risk-standardized rates per 1,000 FFS beneficiaries dropped substantially in 2020 because of the pandemic's effects.

27 Starting in 2015, Medicare began making a separate monthly payment under the physician fee schedule for chronic care management services furnished to beneficiaries with multiple chronic conditions.

28 This analysis used data on paid claims for PPO enrollees of a large national insurer that covers a wide geographic area across the United States. The payments reflect the insurer's allowed amount (including allowed cost sharing). The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments. Only services paid under Medicare's physician fee schedule were included, and anesthesia services were excluded.

29 In this study, health systems are organizations with at least one acute care hospital and one physician group providing comprehensive care that were connected through common ownership or joint management (Furukawa et al. 2020).

30 When this type of visit is provided in an HOPD, it is billed as Healthcare Common Procedure Coding System code G0463 under the OPPS. The fee schedule rate is lower when the visit is provided in an HOPD because the HOPD's equipment, supplies, staff, and overhead costs are paid for under the OPPS. The component payments do not sum to the total Medicare payment amount due to rounding.

31 Section 603 of the Bipartisan Budget Act of 2015 prohibits HOPDs that began billing under the OPPS on or after November 2, 2015, and are located off a hospital campus from billing under the OPPS after January 1, 2017. In 2022, the payment rate for services provided at these off-campus HOPDs is equal to 40 percent of the rate under the OPPS. On-campus HOPDs, off-campus HOPDs that began billing before November 2, 2015, and dedicated emergency departments are permitted to continue billing under the OPPS. However, as of 2022, Medicare pays all off-campus HOPDs (regardless of when they began billing under the OPPS) an amount equal to 40 percent of the OPPS rate for office/outpatient E&M visits.

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

33 To control for annual changes in survey respondents, we based the percentage change on a cohort analysis in which the sample was restricted to physicians who were present in the data in 2016, 2019, and 2020.

34 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, pulmonology, and hematology/oncology.

35 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.

36 Ambulatory E&M services include office visits, hospital outpatient department visits, visits to patients in certain other settings such as nursing facilities, and home visits.

37 CMS uses price proxies (such as the consumer price index and employment cost index) to calculate annual changes in the MEI.

38 CMS created a claims modifier to indicate whether a service was provided by telehealth, but this modifier is the same whether the service was delivered using audio-video technology or audio-only technology.

39 Medicare began covering telehealth services to treat SUDs for beneficiaries in urban and rural areas and in patients' homes on July 1, 2019.

40 CMS also covers the use of audio-only technology by opioid treatment programs (OTPs) when they deliver certain counseling and therapy services to beneficiaries (Centers for Medicare & Medicaid Services 2021c). OTPs must use a service-level claims modifier when they bill for a counseling and therapy add-on code if that service is provided using an audio-only interaction.

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