SECTION

7

Ambulatory care

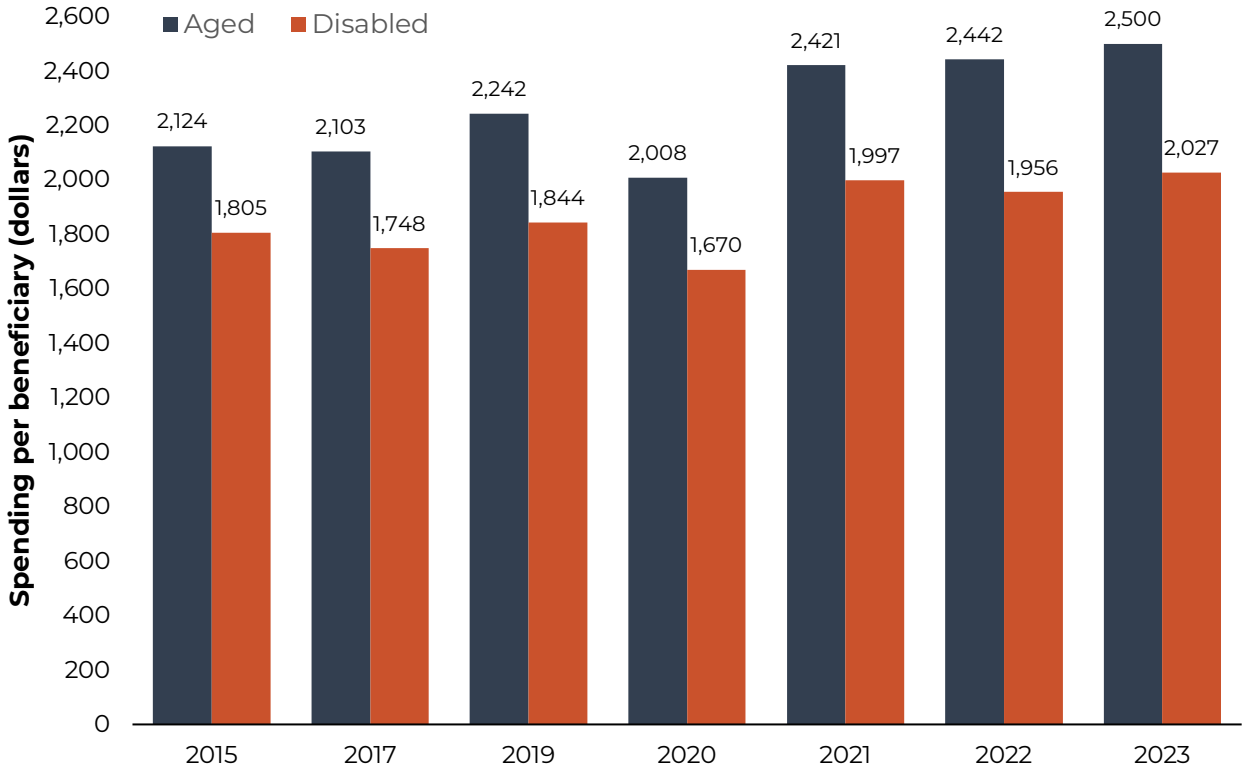
Physicians and other health professionals

Hospital outpatient services

Ambulatory surgical centers

Results of MedPAC's access-to-care survey

Chart 7-1 Medicare spending per FFS beneficiary on services in the physician fee schedule, 2015–2023



Note: FFS (fee-for-service). Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The "disabled" category excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the "aged" category. Dollar amounts are nominal figures, not adjusted for inflation.

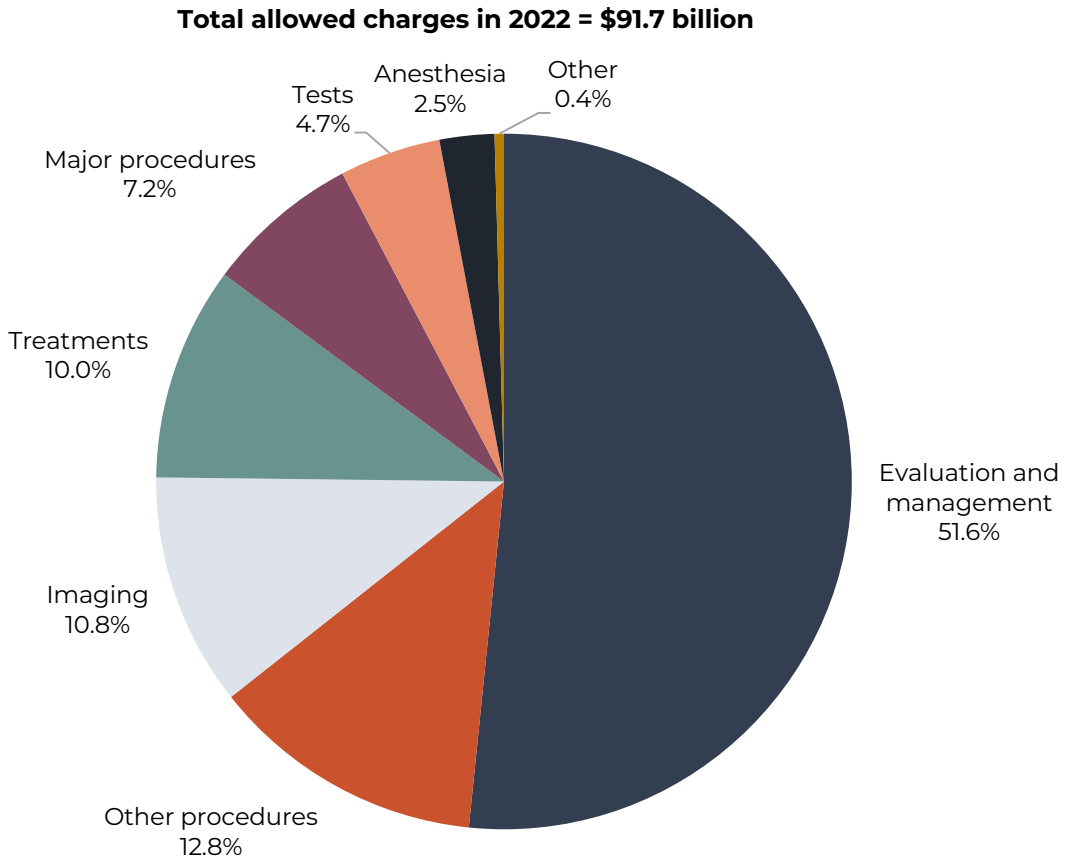
Source: The annual report of the Boards of Trustees of the Medicare trust funds, 2024.

> The physician fee schedule includes a broad range of services, such as office visits, surgical procedures, and diagnostic and therapeutic services. Total fee schedule spending (excluding beneficiary cost sharing) was $70.9 billion in 2023 (data not shown).

> Spending per FFS beneficiary for fee schedule services remained largely stable between 2015 and 2017, then increased in 2019 (on a nominal basis). Spending per FFS beneficiary declined in 2020 due to the effects of the coronavirus pandemic, but spending rebounded in 2021. From 2021 to 2023, spending per beneficiary has continued to grow among aged beneficiaries and has been flat for those with disabilities.

> Per capita spending for beneficiaries with disabilities (under age 65) is lower than per capita spending for aged beneficiaries (ages 65 and over). In 2023, for example, per capita spending for beneficiaries with disabilities was $2,027 compared with $2,500 for aged beneficiaries. Over the 2015 to 2023 period, spending per capita for aged beneficiaries grew at a faster rate (1.7 percent per year) than it did among beneficiaries with disabilities (1.2 percent per year).

Chart 7-2 Physician fee schedule–allowed charges by type of service, 2022



Note: This chart shows "other procedures" and "treatments" as separate categories; versions of this chart that were published before 2023 had combined them.

Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries.

> In 2022, allowed charges for physician fee schedule services totaled $91.7 billion. "Allowed charges" includes both program spending and beneficiary cost sharing. Allowed charges declined by 1.2 percent from 2021 (data not shown). That decline is attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare as enrollment in Medicare Advantage continues to grow.

> In 2022, more than half of all allowed charges were for evaluation and management (E&M) services.

> Within the E&M category, about half of allowed charges were for office/outpatient visits (data not shown). The remaining allowed charges within the E&M category were for various types of services provided across a broad range of settings, including hospital inpatient departments, emergency departments, and nursing facilities (data not shown).

> The treatments category includes physical therapy, cancer treatments, and dialysis. The two procedure categories (major and other) include various eye, cardiovascular, skin, and vascular procedures. The distinction between major procedures and other procedures is determined by the size of the payment rate for each procedure and whether it is typically furnished in an inpatient setting.

Chart 7-3 Total number of encounters per FFS beneficiary was higher in 2022 compared with 2017, and the mix of clinicians furnishing them changed

Specialty category	Encounters per beneficiary 2017	2021	2022	Percent change in encounters per beneficiary: Average annual 2017–2021	2021–2022
Total (all clinicians)	21.5	21.6	22.3	0.1%	3.1%
Primary care physicians	3.7	3.1	3.1	–3.7	–0.3
Specialists	12.7	12.3	12.4	–0.8	1.3
APRNs/PAs	2.0	2.7	3.0	8.0	10.4
Other practitioners	3.2	3.5	3.7	2.3	6.7

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 the national provider identifiers of the clinicians who billed for the service. Figures 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 FFS beneficiaries enrolled in Part B to define encounters per beneficiary. Components may not sum to totals due to rounding.

Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> An "encounter" is a measure of beneficiary interaction with clinicians. For example, if a physician billed for an office visit and an X-ray on the same claim, we count that as one encounter.

> The overall number of encounters per beneficiary grew by just 0.1 percent over the 2017 to 2021 period. The low growth rate was due to the effects of the coronavirus pandemic, which sharply reduced encounters in 2020, but also a partial rebound that occurred in 2021 and 2022.

> Encounters with specialist physicians accounted for the majority of all encounters. These encounters fell by an average of 0.8 percent per year between 2017 and 2021 but grew by 1.3 percent from 2021 to 2022.

> Encounters with APRNs and PAs grew rapidly from 2017 to 2022 (50 percent in total), and encounters with primary care physicians declined substantially (–16 percent). These changes continue a longer-term trend of declines in services billed by primary care physicians and rapid increases in the number of services billed by APRNs and PAs.

> The decline in encounters with primary care physicians occurred across a broad range of services, including evaluation and management services, tests, procedures, and imaging services (data not shown).

Chart 7-4 The number of clinicians billing Medicare's physician fee schedule increased, and the mix of clinicians changed, 2017–2022

	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
2017	140	455	218	168	981	2.6	8.5	4.1	3.1	18.4
2018	139	462	237	174	1,012	2.5	8.4	4.3	3.2	18.5
2019	138	468	258	180	1,045	2.5	8.4	4.6	3.2	18.7
2020	135	468	268	172	1,044	2.4	8.2	4.7	3.0	18.2
2021	134	473	286	180	1,073	2.3	8.1	4.9	3.1	18.4
2022	133	477	308	185	1,103	2.2	8.0	5.2	3.1	18.5

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 beneficiaries enrolled in traditional Medicare Part B and those 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. Components may not sum to totals due to rounding.

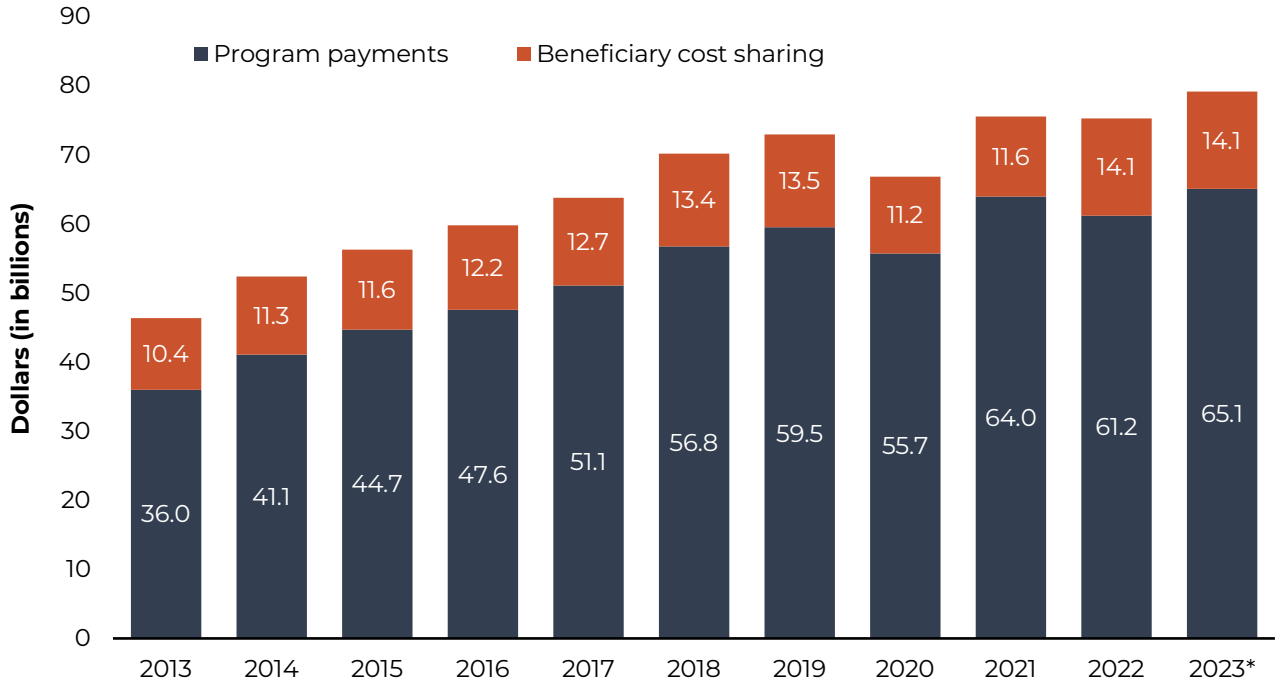
Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> From 2017 to 2019, the total number of clinicians billing the fee schedule grew in absolute terms and relative to the size of the overall Medicare population. In 2020, the overall number of clinicians shrank slightly, likely due to the effects of the coronavirus pandemic, but rebounded in 2021.

> The total number of clinicians per 1,000 beneficiaries increased from 18.4 to 18.7 over the 2017 to 2019 period before falling to 18.2 in 2020. Although the ratio of clinicians to Medicare beneficiaries decreased in 2020 (probably due to the pandemic), the effect on the overall supply of clinicians was relatively small. The fact that the ratio grew to 18.5 in 2022 suggests that the reduction in 2020 was temporary.

> Over the 2017 to 2022 period, the number of primary care physicians billing the fee schedule slowly declined—yielding a net loss of about 7,000 primary care physicians by 2022. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 218,000 to 308,000. The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased at a steady pace.

Chart 7-5 Spending on hospital outpatient services covered under the outpatient PPS increased, 2013–2023



Note: PPS (prospective payment system). Spending amounts are for services covered by the Medicare outpatient PPS. They do not include services paid on separate fee schedules (such as ambulance services and durable medical equipment) or those paid on a cost basis (such as corneal tissue acquisition and flu vaccines) or payments for clinical laboratory services, except those packaged into payment bundles. Dollar amounts are nominal figures, not adjusted for inflation.
*Figures in 2023 are estimated.

Source: CMS, Office of the Actuary.

> The Office of the Actuary estimates that spending under the outpatient PPS was $79.2 billion in 2023 ($65.1 billion in program spending, $14.1 billion in beneficiary cost sharing). We estimate that the outpatient PPS accounted for about 6.5 percent of total Medicare program spending in 2023 (data not shown).

> From calendar year 2013 to 2023, overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS increased by 71 percent, an average of 5.5 percent per year on a nominal basis. The Office of the Actuary projects continued growth in total spending, averaging 5.3 percent per year from 2023 to 2025 (data not shown).

> Beneficiary cost sharing under the outpatient PPS includes the Part B deductible and coinsurance for each service. Under the outpatient PPS, beneficiary cost sharing was about 18 percent in 2023.

Chart 7-6 Most hospitals provide outpatient services

Year	Acute care hospitals	Share offering:		
		Outpatient services	Outpatient surgery	Emergency services
2010	3,518	95%	90%	N/A
2012	3,483	95	91	93%
2014	3,429	96	92	93
2016	3,370	96	93	93
2018	3,301	96	93	90
2020	3,194	96	93	91
2021	3,189	96	93	91
2023	3,158	96	93	91

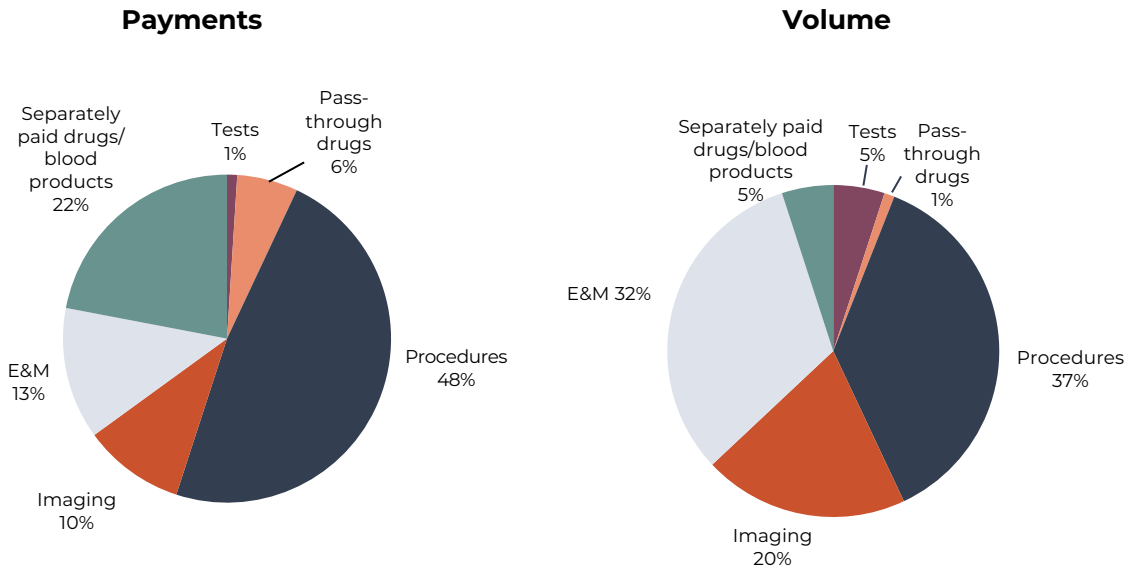
Note: N/A (not applicable). We list emergency services for 2010 as "N/A" because the data source we used for this chart changed the variable for identifying hospitals' provision of emergency services. This change in variable definition would make it appear that the share of hospitals providing emergency services increased sharply from 2010 to 2012, but we question whether such a large increase occurred. This chart includes services provided or arranged by acute care short-term hospitals and excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

> The number of acute care hospitals declined slowly from 3,518 in 2010 to 3,158 in 2023. In 2023, most of these hospitals (3,144) furnished services under Medicare's outpatient prospective payment system.

> The share of hospitals providing outpatient services remained stable, and the share offering outpatient surgery steadily increased from 2010 through 2016 and has remained stable since then. The share offering emergency services declined slightly from 2016 to 2018.

Chart 7-7 Procedures were the type of service with the highest payments and volume under the Medicare hospital outpatient PPS, 2022



Note: PPS (prospective payment system), E&M (evaluation and management). "Payments" includes both program spending and beneficiary cost sharing. We grouped services into the following categories, according to the Berenson-Eggers Type of Service codes developed by CMS: evaluation and management, procedures, imaging, and tests. "Pass-through drugs" and "separately paid drugs/blood products" are classified by their payment status indicator in the outpatient prospective payment system.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2022.

> Hospitals provide many types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.

> The payments for services are distributed differently from volume. For example, in 2022, procedures accounted for 48 percent of payments but only 37 percent of volume.

> Procedures (such as endoscopies, surgeries, skin and musculoskeletal procedures) accounted for the greatest share of payments for services (48 percent) in 2022, followed by separately paid drugs and blood products (22 percent), E&M services (13 percent), and imaging services (10 percent).

Chart 7-8 Hospital outpatient services with the highest Medicare expenditures, 2022

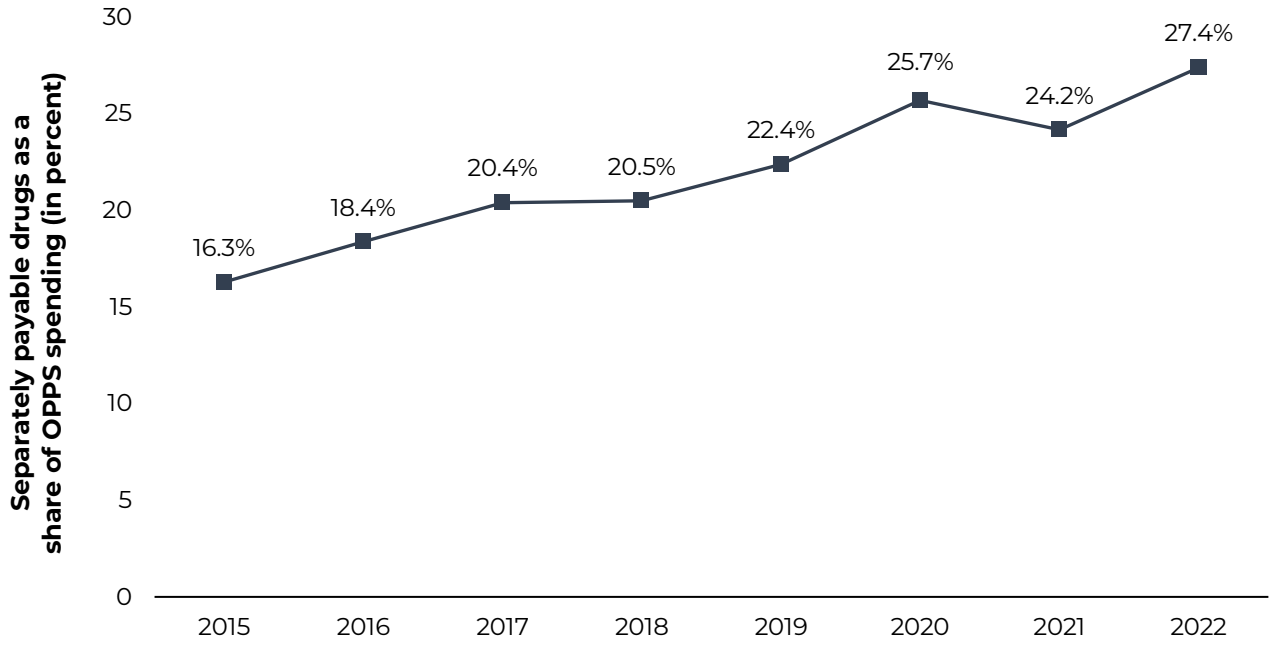
APC title	Share of Medicare expenditures	Volume (thousands)	Payment rate
Level 5 musculoskeletal procedures	8%	429	$12,593
All emergency visits	5	9,655	364
Clinic visits	4	27,392	121
Comprehensive observation services	3	925	2,332
Level 3 electrophysiologic procedures	3	89	21,916
Level 3 endovascular procedures	2	115	10,258
Level 4 musculoskeletal procedures	2	186	6,397
Level 3 drug administration	2	5,437	209
Level 3 radiation therapy	1	1,830	554
Level 2 ICD and similar procedures	1	31	33,547
Level 1 laparoscopy and related procedures	1	172	5,168
Level 4 imaging without contrast	1	1,742	493
Level 1 endovascular procedures	1	286	2,962
Level 2 imaging with contrast	1	2,238	376
Level 2 imaging without contrast	1	7,511	111
Level 2 lower GI procedures	1	878	1,059
Level 3 nuclear medicine and related services	1	585	1,335
Level 3 pacemaker and similar procedures	1	71	10,619
Level 4 drug administration	1	2,33	326
Level 2 laparoscopy and related services	1	80	19,096
Level 4 endovascular procedures	1	45	16,402
Level 3 imaging without contrast	1	3,007	235
Level 1 intraocular procedures	1	329	2,121
Level 5 urology and related services	1	152	4,506
Level 4 nuclear medicine and related services	1	448	1,512
Level 5 neurostimulator and related procedures	1	21	30,063
Level 3 vascular procedures	1	198	2,924
Level 1 imaging without contrast	1	6,949	83
Total	49		
Average for all APCs		620	$444

Note: APC (ambulatory payment classification), ICD (implantable cardioverter-defibrillator), GI (gastrointestinal). The payment rate for "all emergency visits" is a weighted average of payment rates for 10 emergency-visit APCs (not listed on this chart). The average APC figures in the last line represent averages for all APCs.

Source: MedPAC analysis of 100 percent analytic files of outpatient claims for calendar year 2022.

> Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a few categories that have high volume, high payment rates, or both.

Chart 7-9 Separately payable drugs have increased as a share of total spending in the outpatient prospective payment system, 2015–2022



Note: OPPS (outpatient prospective payment system). "Separately payable drugs" includes those that are new to the market and those that are established in the drug market but are deemed by CMS to qualify for separate payments because they are relatively expensive.

Source: MedPAC analysis of hospital outpatient standard analytic claims files from 2015 through 2022.

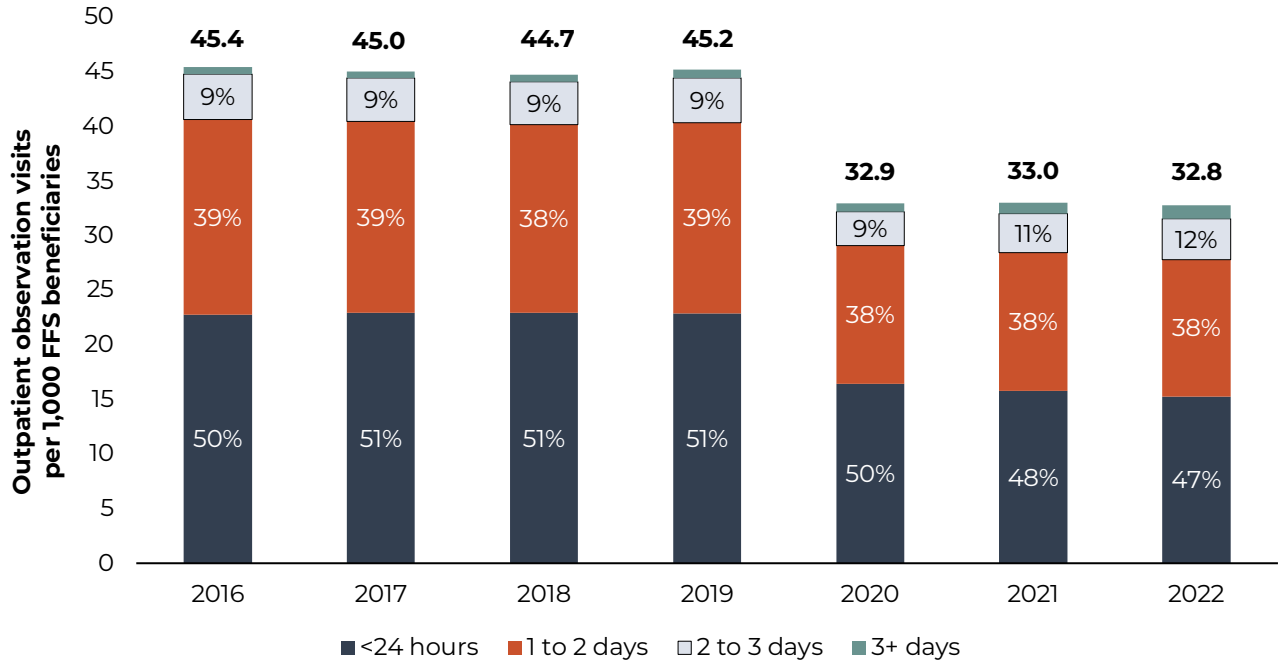
> Under the OPPS, most drugs are packaged, meaning their cost is reflected in the payment for the related services. However, drugs that are new to the market and established drugs that are relatively expensive are paid separately.

> Separately payable drugs have become an increasingly large share of OPPS spending, growing from 16.3 percent in 2015 to 27.4 percent in 2022.

> Except for 2021, the share of OPPS spending attributable to separately payable drugs increased each year from 2015 to 2022, though the increase was relatively small from 2017 to 2018. The small increase during that period was the result of a policy implemented by CMS that substantially decreased the payment rates for relatively expensive established drugs that hospitals obtained through the 340B Drug Pricing Program. Without that policy, we estimate that separately payable drugs would have been 22.7 percent of OPPS spending in 2018 and 24.8 percent in 2019.

> On September 28, 2022, the U.S. Supreme Court ruled that CMS's policy of paying reduced payment rates for the established drugs that are relatively expensive and are obtained through the 340B program was unlawful because the Secretary of Health and Human Services did not first conduct a survey of hospitals' acquisition costs. Consequently, for the remainder of 2022, CMS set the OPPS payment rates for these drugs at the standard OPPS payment rates and reprocessed the OPPS claims for 340B-acquired drugs from January 1, 2022, through September 27, 2022. This reprocessing of claims provided 340B hospitals with an additional $1.5 billion in OPPS payments for drugs in 2022, substantially increasing the share of total OPPS spending that was attributable to separately payable drugs that year.

Chart 7-10 Number of Medicare FFS outpatient observation visits per capita remained at a relatively low level in 2022



Note: FFS (fee-for-service). Observation visits are separately payable visits with a length of stay of at least eight hours. Data for outpatient observation visits include short-term acute care hospitals in the U.S. (exclusive of territories) paid under the inpatient prospective payment system or under the Maryland state waiver. "Outpatient observation visits per 1,000 FFS beneficiaries" refers to observation visits that did not result in an inpatient admission per Medicare FFS Part B beneficiary. Years are calendar years. Components do not sum to 100 percent due to rounding and component values that are not shown.

Source: MedPAC analysis of hospital outpatient standard analytic claims files from 2016 through 2022.

> Hospitals sometimes use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.

> The number of Medicare FFS outpatient observation visits per capita remained relatively steady from 2016 to 2019, at about 45 visits per 1,000 beneficiaries. The distribution of observation visits by length of stay also remained steady, with about half longer than 24 hours, including 10 percent that spanned more than 2 days.

> In 2020, with the onset of the coronavirus pandemic, the number of Medicare FFS outpatient observation visits per capita declined 30 percent to about 33 visits per 1,000 beneficiaries, though the distribution by length of stay remained similar to prior years. The number of emergency room visits also declined (data not shown). In 2021 and 2022, the number of outpatient observation visits per capita was relatively unchanged from 2020.

Chart 7-11 Number of Medicare-certified ASCs increased by 12 percent, 2016–2022

	2016	2017	2018	2019	2020	2021	2022
Medicare payments (billions of dollars)	$4.3	$4.6	$4.9	$5.2	$4.9	$5.7	$6.1
Percent growth in payments	4.9%	7.4%	6.4%	7.3%	–6.4%	17.6%	5.8%
New centers (during year)	172	217	237	246	186	265	220
Closed or merged centers (during year)	121	128	146	131	86	108	92
Net total number of centers (end of year)	5,473	5,562	5,653	5,768	5,868	6,025	6,153
Net percent growth in number of centers	0.9%	1.6%	1.6%	2.0%	1.7%	2.7%	2.1%
Volume per 1,000 FFS Part B beneficiaries	190	193	197	202	174	205	210
Share of all centers that are:							
Urban	93	93	93	93	94	94	94
Rural	7	7	7	7	6	6	6

Note: ASC (ambulatory surgical center), FFS (fee-for-service). "Medicare payments" includes program spending and beneficiary cost sharing for ASC facility services. Some figures differ from Chart 7-15 in our 2023 data book because CMS updated the Provider of Services file. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of Provider of Services file from CMS, 2023. Payment data are from MedPAC analysis of carrier standard analytic claims files.

> ASCs are distinct entities that furnish ambulatory surgical services that do not require an overnight stay in a hospital. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.

> Total Medicare payments per FFS Medicare beneficiary for ASC services increased by approximately 8 percent per year, on average, from 2016 through 2022 on a nominal basis (data not shown). From 2021 to 2022, total payments per FFS beneficiary rose 10 percent as the average complexity of services provided to FFS beneficiaries in ASCs increased (data not shown).

> The number of Medicare-certified ASCs grew at an average annual rate of 2.0 percent from 2016 through 2022. In this same period, an annual average of 220 new facilities entered the market, while an average of 116 closed or merged with other facilities.

Chart 7-12 Between 34 and 71 low-value services were provided per 100 FFS beneficiaries in 2022; Medicare spent between $1.9 billion and $5.8 billion on these services

	Broader version of measure			Narrower version of measure		
Measure	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)
Imaging for nonspecific low back pain	13.1	9.5%	$260	3.7	3.3%	$73
PSA screening at age > 75 years	10.3	7.0	93	6.0	4.9	54
Spinal injection for low back pain	6.7	3.7	1,311	2.6	1.6	502
PTH testing in early CKD	6.2	3.7	118	5.2	3.2	99
Colon cancer screening for older adults	6.0	5.7	413	0.2	0.2	2
T3 level testing for patients with hypothyroidism	5.5	3.3	34	5.5	3.3	34
Carotid artery disease screening in asymptomatic adults	4.0	3.7	217	3.3	3.1	180
Preoperative chest radiography	3.4	3.1	51	0.8	0.7	11
Head imaging for uncomplicated headache	3.2	2.9	220	2.0	1.9	136
Stress testing for stable coronary disease	2.8	2.6	799	0.3	0.3	83
Cervical cancer screening at age > 65 years	1.5	1.5	31	1.3	1.3	28
Homocysteine testing in cardiovascular disease	1.1	0.8	9	0.2	0.1	1
Head imaging for syncope	1.0	1.0	70	0.6	0.6	40
Preoperative echocardiography	1.0	0.9	79	0.3	0.3	24
BMD testing at frequent intervals	0.6	0.6	13	0.4	0.4	8
Preoperative stress testing	0.6	0.6	169	0.2	0.2	50
CT for uncomplicated rhinosinusitis	0.6	0.5	41	0.2	0.2	18
Vitamin D testing in absence of hypercalcemia or decreased kidney function	0.5	0.5	9	0.5	0.5	9
Imaging for plantar fasciitis	0.5	0.4	10	0.2	0.2	4
Screening for carotid artery disease for syncope	0.4	0.4	24	0.3	0.3	15
PCI/stenting for stable coronary disease	0.3	0.3	1,155	0.04	0.04	173
Cancer screening for patients with CKD on dialysis	0.3	0.2	8	0.1	0.05	1
Hypercoagulability testing after DVT	0.2	0.1	6	0.1	0.1	2
Vertebroplasty/kyphoplasty for osteoporotic vertebral fractures	0.2	0.1	312	0.2	0.1	306
Arthroscopic surgery for knee osteoarthritis	0.2	0.2	135	0.03	0.03	22
Preoperative PFT	0.2	0.1	2	0.1	0.1	0.8
IVC filter to prevent pulmonary embolism	0.1	0.1	16	0.1	0.1	16
Renal artery angioplasty/stenting	0.1	0.1	138	0.01	0.01	32
EEG for headache	0.04	0.04	2	0.02	0.02	1
Carotid endarterectomy for asymptomatic patients	0.03	0.03	83	0.01	0.01	34
Pulmonary artery catheterization in ICU	0.01	0.01	0.2	0.004	0.004	0.2
Total	70.5	36.1	5,827	34.3	22..4	1,921

(Chart continued next page)

Chart 7-12 Between 34 and 71 low-value services were provided per 100 FFS beneficiaries in 2022; Medicare spent between $1.9 billion and $5.8 billion on these services (continued)

Note: FFS (fee-for-service), PSA (prostate-specific antigen), PTH (parathyroid hormone), CKD (chronic kidney disease), CT (computed tomography), BMD (bone mineral density), PFT (pulmonary function test), PCI (percutaneous coronary intervention), DVT (deep vein thrombosis), IVC (inferior vena cava), EEG (electroencephalography), ICU (intensive care unit). "Count" refers to the number of unique services. Some totals do not equal the sum of their components due to rounding. The total for "share of beneficiaries affected" does not equal the column sum because some beneficiaries received services covered by multiple measures. "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2022. This method was developed by Schwartz et al. (2014). The broad and narrow versions of the measures for T3 level testing for patients with hypothyroidism and IVC filter to prevent pulmonary embolism are the same.

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

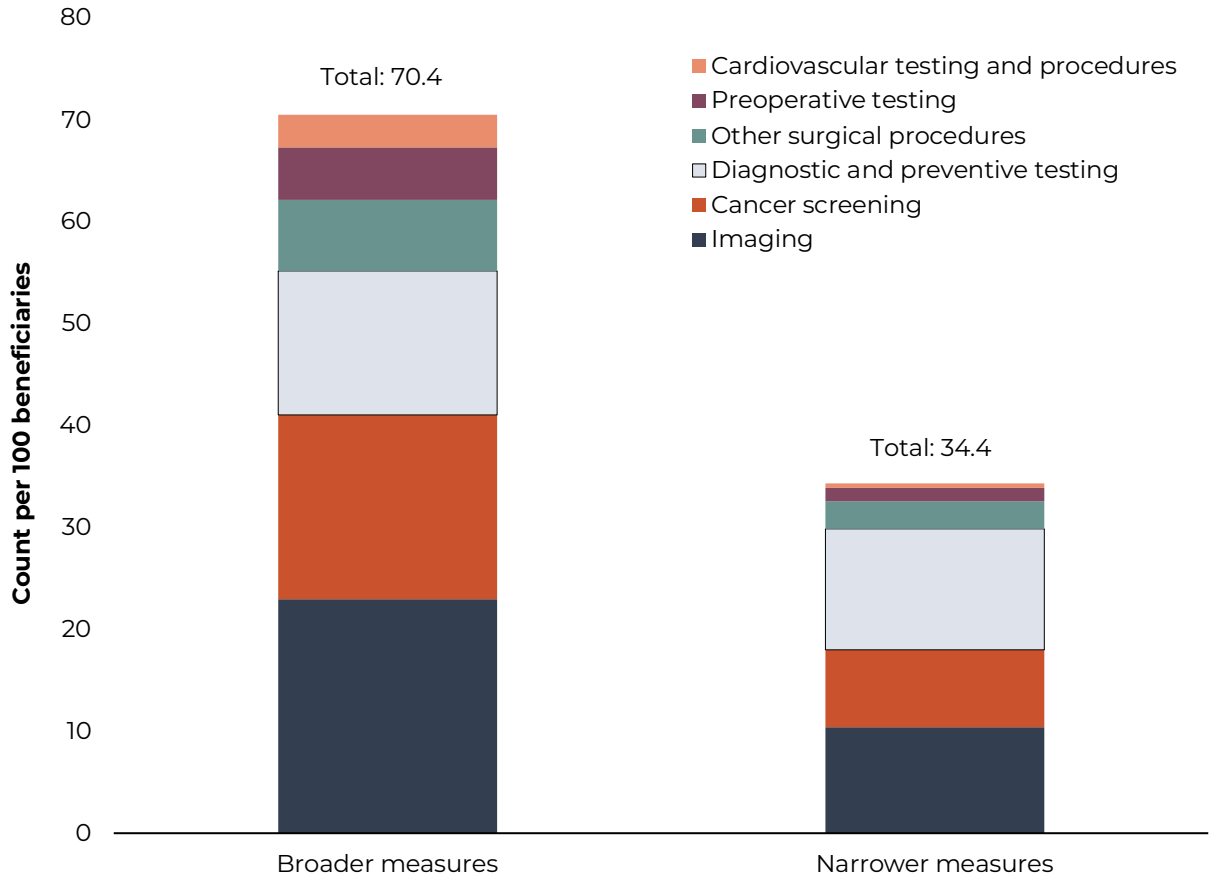
> Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.

> The 31 measures of low-value care in this chart were developed by a team of researchers. The measures are drawn from evidence-based lists—such as Choosing Wisely—and the medical literature. We applied these measures to 100 percent of Medicare claims data from 2022. These 31 measures do not represent all instances of low-value care; the actual number (and corresponding spending) may be much higher.

> The researchers developed two versions of each measure: a broader version (more sensitive, less specific) and a narrower version (less sensitive, more specific). Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure's specificity leads to less misclassification of appropriate use as inappropriate at the expense of potentially missing some instances of inappropriate use.

> Based on the broader versions of the measures, our analysis found about 71 instances of low-value care per 100 beneficiaries in 2022, with about 36 percent of beneficiaries receiving at least 1 low-value service that year. Medicare spending for these services was $5.8 billion. Based on the narrower versions of the measures, our analysis showed about 34 instances of low-value care per 100 beneficiaries, with 22 percent of beneficiaries receiving at least 1 low-value service. Medicare spending for these services totaled about $1.9 billion.

Chart 7-13 Imaging, cancer screening, and diagnostic and preventive testing accounted for most of the volume of low-value care in 2022



Note: "Count" refers to the number of unique services provided to fee-for-service Medicare beneficiaries.

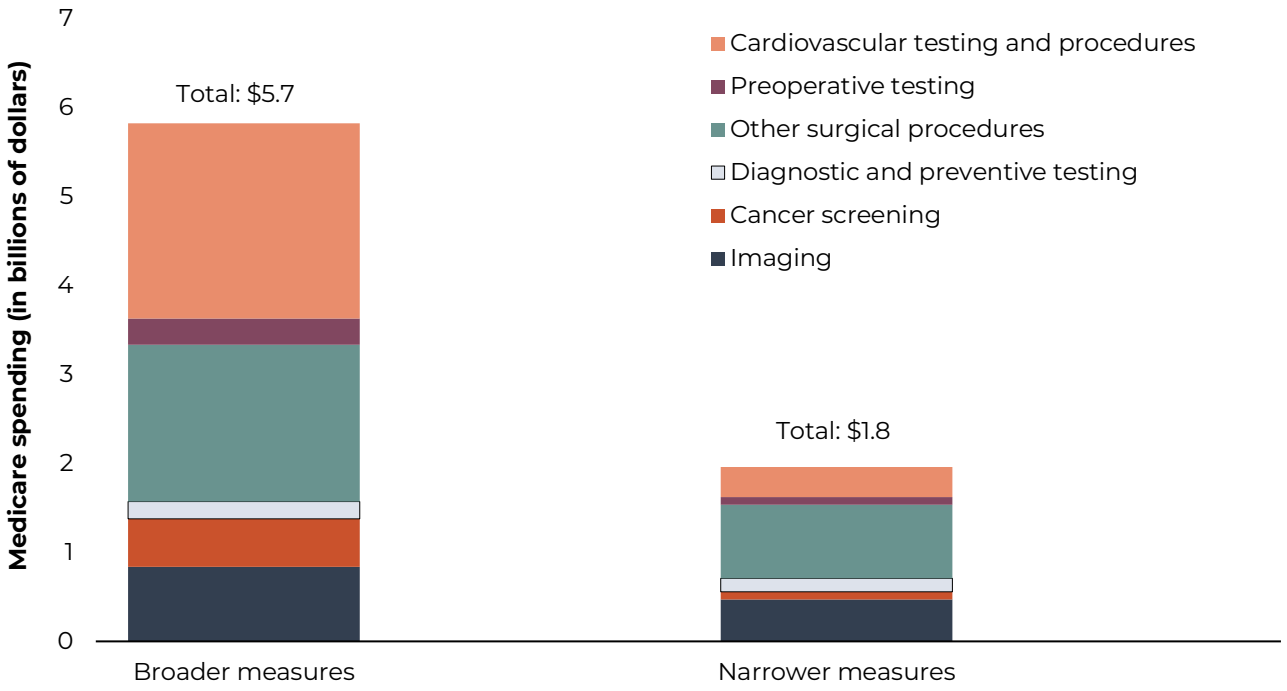
Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> We assigned each of the 31 measures of low-value care in Chart 7-12 to 1 of 6 clinical categories.

> Using the broader versions of the measures, imaging and cancer screening accounted for 58 percent of the volume of low-value care per 100 beneficiaries. The "imaging" category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults. The "cancer screening" category includes prostate-specific antigen testing for men ages 75 and older and colorectal cancer screening for older adults.

> Using the narrower versions of the measures, imaging and diagnostic and preventive testing accounted for 65 percent of the volume of low-value care per 100 beneficiaries.

Chart 7-14 Cardiovascular testing and procedures, other surgical procedures, and imaging accounted for most spending on low-value care in 2022



Note: "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2021. This method was developed by Schwartz et al. (2014).

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> Cardiovascular testing and procedures and other surgical procedures accounted for about 70 percent of total spending on low-value care using the broader measures. Other surgical procedures and imaging made up nearly two-thirds of spending on low-value care using the narrower measures.

> The "cardiovascular testing and procedures" category includes stress testing for stable coronary disease and percutaneous coronary intervention with balloon angioplasty or stent placement for stable coronary disease. The "other surgical procedures" category includes spinal injection for low back pain and arthroscopic surgery for knee osteoarthritis. The "imaging" category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults.

> The spending estimates probably understate actual spending on low-value care because they do not include the cost of downstream services (e.g., follow-up tests and procedures) that may result from the initial low-value service. Also, we are not capturing all low-value care through these 31 measures.

Chart 7-15 In MedPAC's 2023 survey, Medicare beneficiaries were more likely to report satisfaction with their access to care than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Received health care in past year: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"		
Yes	94%*	91%*
Providers that accept your insurance: Among those who received health care, "In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare / your insurance]?"		
Satisfied (net)	96*	91*
Very satisfied	80*	65*
Somewhat satisfied	16*	26*
Dissatisfied (net)	4*	9*
Somewhat dissatisfied	3*	7*
Very dissatisfied	1*	2*
Providers with timely appointments: Among those who received health care, "In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?"		
Satisfied (net)	87*	77*
Very satisfied	52*	38*
Somewhat satisfied	35*	39*
Dissatisfied (net)	13*	23*
Somewhat dissatisfied	10*	17*
Very dissatisfied	3*	6*

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. *Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> MedPAC surveys Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64 each year to compare these two groups' experiences accessing care in the prior 12 months.

> Our sample includes Medicare beneficiaries with any type of coverage, including Medicare Advantage plans, since it can be difficult to identify beneficiaries' type of Medicare coverage in a survey. Among the privately insured people we survey, most report having employer-sponsored health insurance. For example, in 2023, 85 percent were insured through their or their spouse's employer, and 15 percent were insured through an individual health insurance plan.

> In our 2023 survey, higher shares of Medicare beneficiaries reported receiving any health care in the past year (94 percent) compared to privately insured individuals (91 percent).

> Among those who received health care in the past year, higher shares of Medicare beneficiaries were satisfied with their ability to find health care providers that accepted their insurance (96 percent) compared with privately insured people (91 percent). Higher shares of Medicare beneficiaries were also satisfied with their ability to find providers that had appointments when needed (87 percent) compared with privately insured people (77 percent).

Chart 7-16 In MedPAC's 2023 survey, Medicare beneficiaries reported having slightly better access to primary care providers than did privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Have a primary care provider: "A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?"		
Yes	96%*	92%*
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"		
For none of my primary care (I always see a doctor)	41*	35*
For any of my primary care (net)	56*	61*
For some of my primary care	37	39
For all or most of my primary care	19*	22*
Don't know	3	4
Tried to get a new primary care provider: "In the past 12 months, have you tried to get a new primary care provider?"		
Yes	12%*	15%*
Reason looked for new primary care provider: Among those who tried to get a new primary care provider, "Which of the following best describes the main reason you tried to get a new primary care provider in the last 12 months?" (Overall share)		
My provider retired or stopped practicing	43 (5)	37 (5)
I wanted to change providers	34 (4)	31 (4)
I recently moved, so I needed to find a primary care provider in my area	15 (2)	13 (2)
I changed my health plan and had to find a new provider who participated in the new plan	5* (1*)	11* (2*)
My primary care provider was no longer accepting [Medicare / my insurance]	3* (0*)	8* (1*)

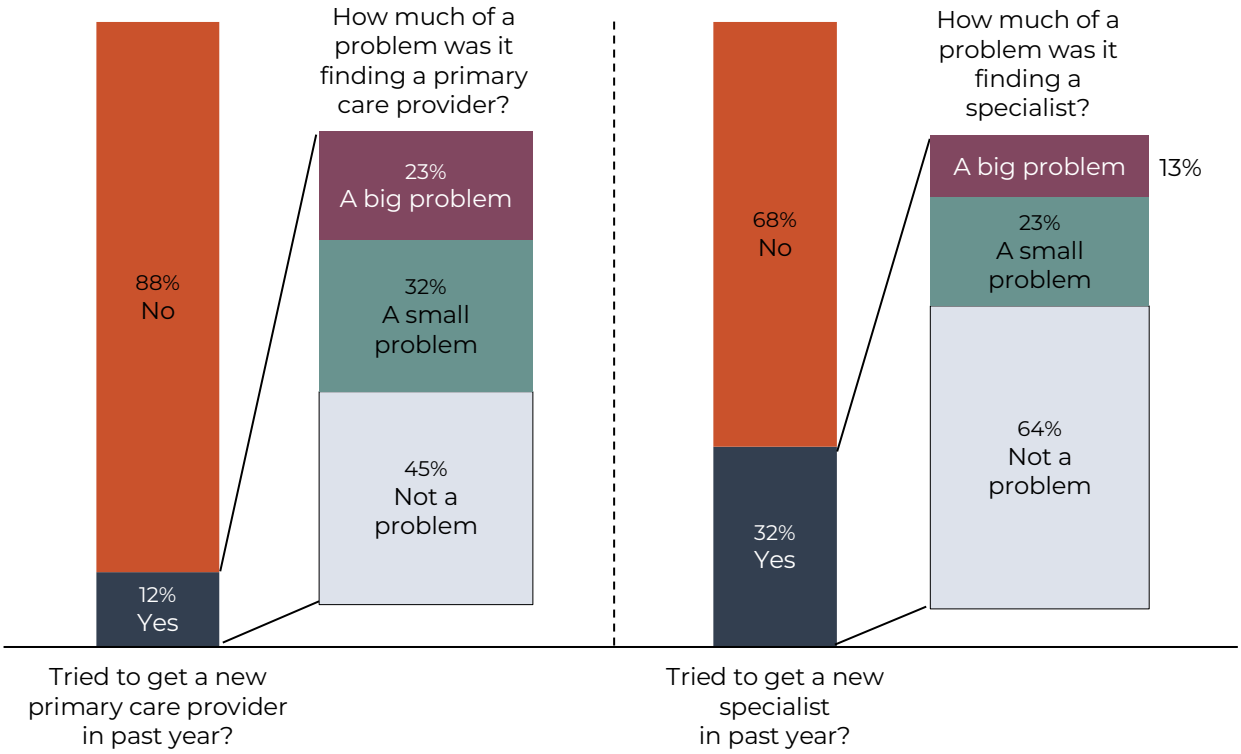
Note: NP (nurse practitioner), PA (physician assistant). We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Overall share" refers to the share of all respondents with this insurance. *Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, higher shares of Medicare beneficiaries reported having a primary care provider (96 percent) compared with privately insured people (92 percent).

> Among Medicare beneficiaries looking for a new primary care provider, only 3 percent did so because their existing primary care provider was no longer accepting Medicare (equivalent to slightly more than 0 percent of all Medicare beneficiaries). Among privately insured people looking for a new primary care provider, 8 percent did so because their existing primary care provider no longer accepted their insurance (equivalent to 1 percent of all privately insured people).

Chart 7-17 **In our 2023 survey, Medicare beneficiaries looking for a new primary care provider were more likely to report problems finding one compared with beneficiaries seeking a new specialist**



Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, among the 12 percent of Medicare beneficiaries who tried to get a new primary care provider in the past year, over half (55 percent) reported problems finding one: 23 percent reported a "big problem" finding a new one and another 32 percent reported a "small problem." These figures combined are equivalent to 7 percent of Medicare beneficiaries reporting problems finding a new primary care provider in the past year (data not shown).

> A larger share of patients look for a new specialist each year: In 2023, 32 percent of Medicare beneficiaries tried to get a new specialist. Among these beneficiaries, a little over a third (36 percent) reported problems finding a new specialist: 13 percent reported a "big problem" and 23 percent reported a "small problem" finding one. Combined, these figures are equivalent to 11 percent of Medicare beneficiaries reporting problems finding a new specialist in the past year (data not shown).

Chart 7-18 In our 2023 survey, Medicare beneficiaries were less likely to report problems finding a new clinician compared with privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Get a new primary care provider: "In the past 12 months, have you tried to get a new primary care provider?"		
Yes	12%*	15%*
Problems finding a primary care provider: Among those who tried to get a new primary care provider, "How much of a problem was it finding a primary care provider who would treat you?" (Overall share)		
A problem (net)	55* (7*)	68* (10*)
A big problem	23* (3*)	33* (5*)
A small problem	32 (4*)	35 (5*)
Not a problem	45* (5)	32* (5)
Primary care providers not accepting your insurance: Among those who had a problem finding a new primary care provider, "Did anyone from a doctor's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	15* (1*)	28* (3*)
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"		
Yes	32	33
Problems finding a specialist: Among those who tried to get a new specialist, "How much of a problem was it finding a specialist who would treat you?" (Overall share)		
A problem (net)	36* (11*)	46* (15*)
A big problem	13* (4*)	18* (6*)
A small problem	23 (7*)	28 (9*)
Not a problem	64* (20)	54* (18)
Specialists not accepting your insurance: Among those who had a problem finding a new specialist, "Did anyone from a doctor's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	15* (2*)	28* (4*)
Get a new mental health professional: "Some specialists and other clinicians focus on mental health. In the past 12 months, have you tried to get a new mental health professional?"**		
Yes	3*	7*
Problems finding a mental health professional: Among those who tried to get a mental health professional, "How much of a problem was it finding a mental health professional who would treat you?" (Overall share)		
A problem (net)	63 (2*)	70 (5*)
A big problem	38 (1*)	45 (3*)
A small problem	25 (1*)	25 (2*)
Not a problem	37 (1*)	30 (2*)
Mental health professionals not accepting your insurance: Among those who had a problem finding a new mental health professional, "Did anyone from a mental health professional's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	33* (1*)	54* (3*)

(Chart continued next page)

Chart 7-18 In our 2023 survey, Medicare beneficiaries were less likely to report problems finding a new clinician compared with privately insured people (continued)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Overall share" refers to the share of all respondents with this insurance.
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).
**Under this question, the following definition appeared: "Mental health professionals are clinicians like psychiatrists, psychologists, therapists, counselors, or clinical social workers you see to help treat conditions such as depression, anxiety, addiction, post-traumatic stress disorder, schizophrenia, or bipolar disorder."

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> Similar shares of Medicare beneficiaries and privately insured people looked for a new provider in 2023. Among Medicare beneficiaries, 12 percent reported looking for a new primary care provider in the past year and 32 percent reported looking for a new specialist. Among the privately insured, those shares were 15 percent and 33 percent, respectively.

> Among those looking for a new primary care provider (PCP), privately insured people were more likely than Medicare beneficiaries to report problems finding one. In 2023, 68 percent of the privately insured people who were looking for a new PCP reported problems (equivalent to 10 percent of all privately insured people), while 55 percent of Medicare beneficiaries who were looking for a new PCP reported problems (equivalent to 7 percent of all Medicare beneficiaries). Privately insured people also reported more problems finding specialists than did Medicare beneficiaries (46 percent vs. 36 percent, respectively, equivalent to 15 percent of privately insured people and 11 percent of Medicare beneficiaries).

> Privately insured people (7 percent) were more likely than Medicare beneficiaries (3 percent) to report looking for a new mental health professional in the last year. However, a majority of both groups reported problems finding such a provider: In our 2023 survey, 63 percent of Medicare beneficiaries who were looking for a mental health professional and 70 percent of privately insured people who were looking reported problems finding one.

> Whether they were looking for a new primary care provider, specialist, or mental health professional, privately insured people were more likely to encounter a clinician who did not accept their insurance compared with Medicare beneficiaries. For example, among those looking for a new primary care provider, 15 percent of these Medicare beneficiaries encountered a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries); in contrast, 28 percent of privately insured people looking for a new primary care provider had this experience (equivalent to 3 percent of all privately insured people).

Chart 7-19 In MedPAC's 2023 survey, Medicare beneficiaries ages 65 and over reported less interest in using telehealth in the future than did privately insured people ages 50 to 64

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Had a telehealth visit: "In the past 12 months, have you had a [video / telephone] visit . . . with any type of health care provider?"		
Telehealth visit (video or telephone) (net)	34%	34%
Video visit	17*	24*
Telephone visit (audio only)	26*	20*
Satisfaction with telehealth visit: Among those who had a [video / telephone] visit, "How satisfied were you with the [video / telephone] visit(s) you had in the past 12 months?"		
Video visit(s)		
Satisfied (net)	89	89
Very satisfied	55	53
Somewhat satisfied	34	36
Dissatisfied (net)	11	11
Somewhat dissatisfied	7	8
Very dissatisfied	4	3
Telephone visit(s)		
Satisfied (net)	93	89
Very satisfied	59*	49*
Somewhat satisfied	34*	40*
Dissatisfied (net)	7	11
Somewhat dissatisfied	5*	9*
Very dissatisfied	3	2
Interest in using telehealth in the future: "Would you be interested in having the option to use [video / telephone] visits to see health care providers in the future?"		
Interested in at least one type of telehealth visit (net)	35*	48*
Interested in video visits	26*	43*
Interested in telephone visits	26*	34*

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. In our questions about having had any telehealth visits in the past 12 months (the first set of questions shown above), video visits were defined as "using a smartphone, computer, or tablet" and telephone visits were defined as "a phone call with audio but no video."
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

(Chart continued next page)

Chart 7-19 In MedPAC's 2023 survey, Medicare beneficiaries ages 65 and over were less interested in using telehealth in the future than privately insured people ages 50 to 64 (continued)

> In our 2023 survey, about a third (34 percent) of Medicare beneficiaries and privately insured people each reported having had some type of telehealth visit in the past year. Medicare beneficiaries were somewhat more likely than privately insured people to have had an audio-only telephone visit (26 percent vs. 20 percent). Meanwhile, privately insured people were somewhat more likely to have had a video visit than Medicare beneficiaries (24 percent vs. 17 percent).

> About 90 percent of telehealth users reported being satisfied with their video visits or telephone visits in 2023.

> Fewer Medicare beneficiaries were interested in having the option to use telehealth in the future (35 percent) compared with privately insured people (48 percent). About one in four Medicare beneficiaries was interested in having the option to use video visits, and one in four was interested in having the option to use audio-only telephone visits.

> In analyses of Medicare beneficiary subgroups (not shown):

>> Video visits and telephone visits were more commonly used by Medicare beneficiaries who lived in urban areas and had higher household incomes (of at least $80,000). A lower share of Medicare beneficiaries ages 85 and over reported using video visits compared with younger beneficiaries.

>> Interest in continuing to have the option to use telehealth visits was higher among Medicare beneficiaries who were under the age of 75, had higher incomes, and lived in urban areas.

>> There were not statistically significant differences in the shares of White, Black, and Hispanic Medicare beneficiaries who used telehealth.

>> There were not statistically significant differences in the shares of different subgroups who were satisfied with their telehealth visits.

Chart 7-20 In 2023, Medicare beneficiaries were less likely than privately insured people to report waiting longer than they wanted to get appointments

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Long wait for 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 regular or routine care		
Never	49%*	37%*
Sometimes	39	40
Usually	9*	14*
Always	4*	8*
For an illness or injury		
Never	65*	55*
Sometimes	27*	30*
Usually	6*	10*
Always	2*	5*
Response to long wait: Among those who had to wait longer than they wanted for an appointment, "What did you do?" (Overall share)		
For regular or routine care		
Took the later appointment date	87* (42*)	82* (48*)
Went to a walk-in clinic	7* (3*)	10* (6*)
Decided not to schedule the appointment	4* (2*)	6* (4*)
Went to a hospital emergency room	2 (1)	2 (1)
For an illness or injury		
Took the later appointment date	68* (20)	58* (21)
Went to a walk-in clinic	16* (5*)	27* (10*)
Went to a hospital emergency room	9 (3)	8 (3)
Decided not to schedule the appointment	7 (2)	7 (3)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. Instructions for the questions shown above read: "For the next few questions, please think about the number of days or weeks you had to wait to get a doctor's appointment. Do not include time spent on hold or in the waiting room" and "Please count video visits and phone visits as appointments." "Overall share" refers to the share of all respondents with this insurance.
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In 2023, our survey found that Medicare beneficiaries were less likely than privately insured people to report having to wait longer than they wanted to get a doctor's appointment.

> About half (49 percent) of Medicare beneficiaries reported never waiting longer than they wanted to get an appointment for routine care, compared with 37 percent of privately insured people. For appointments for an illness or injury, about two-thirds (65 percent) of Medicare beneficiaries said they never had to wait longer than they wanted to get such an appointment, compared with 55 percent of privately insured people.

> Both Medicare beneficiaries and privately insured people were less likely to report waits for illness or injury appointments compared with regular or routine care appointments.

Chart 7-21 In our 2023 survey, Medicare beneficiaries were less likely than privately insured people to report forgoing care

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Forgoing care: "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?"		
Yes	20%*	27%*
Reason for forgoing care: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the **main reason** you did not see a doctor about this condition during the past 12 months?" (Overall share)		
I just put it off	27 (5)	22 (6)
I didn't think the problem was serious	25 (5)	21 (5)
I couldn't get an appointment soon enough	20 (4*)	22 (6*)
I thought it would cost too much	7* (1*)	22* (6*)
I couldn't find a doctor who would treat me	5 (1)	4 (1)
I had to put if off because of the COVID-19 pandemic	3 (1)	1 (0)
Other	12 (2)	9 (2)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. Components do not sum to 100 percent due to rounding. "Overall share" refers to the share of all respondents with this insurance.
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, 20 percent of Medicare beneficiaries and 27 percent of privately insured people reported forgoing care in the past year that they thought they should have gotten.

> About half of care-forgoers did so because they "didn't think the problem was serious" or "just put it off" (52 percent of Medicare beneficiaries and 43 percent of privately insured people reported one of these reasons).

> About one in five care-forgoers skipped care because they could not get an appointment soon enough: This was true for 20 percent of Medicare beneficiaries who reported forgoing care (equivalent to 4 percent of all Medicare beneficiaries) and 22 percent of privately insured people who reported forgoing care (equivalent to 6 percent of all privately insured people).

> Medicare beneficiaries were much less likely to forgo care due to concerns about cost compared with privately insured people: In 2023, only 7 percent of Medicare beneficiaries who reported forgoing care did so because they "thought it would cost too much" (equivalent to 1 percent of all Medicare beneficiaries), while 22 percent of privately insured people who reported forgoing care did so for this reason (equivalent to 6 percent of all privately insured people).

Chart 7-22 In our 2023 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
Received health care in past year: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	91%[a]	97%[ab]	97%[ab]	82%[a]	90%[ab]	93%[ab]
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"						
For all or most of my primary care	22[a]	18	14[ab]	28[a]	23	20[ab]
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"						
Yes	26	36[b]	38[b]	26	33[b]	35[b]
Forgoing care: "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?"						
Yes	23[a]	17[ab]	17[ab]	28[a]	31[a]	25[a]
Reason for forgoing care: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the **main reason** you did not see a doctor about this condition during the past 12 months?" (Overall share)						
I just put it off	26 (6)	31 (5)	26 (5)	20 (6)	23 (7)	23 (6)
I didn't think the problem was serious	23 (5)	28 (5)	29 (5)	15 (4)	19 (6)	24[b] (6)
I couldn't get an appointment soon enough	19 (4)	21 (4)	24 (4)	22 (6)	20 (6)	22 (5)
I thought it would cost too much	10[a] (2[a])	5[a] (1[a])	1[ab] (0[ab])	31[a] (9[a])	21[a] (6[a])	19[ab] (5[ab])
I couldn't find a doctor who would treat me	6 (1)	4 (1)	4 (1)	4 (1)	3 (1)	4 (1)
I had to put if off because of the COVID-19 pandemic	4 (1)	2 (0)	2 (0)	1 (0)	2 (1)	1 (0)
Other	12 (3)	8 (1[a])	13[a] (2)	8 (2)	12 (4[a])	7[a] (2)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Lower income" refers to respondents with household incomes of less than $50,000 per year, "middle income" refers to respondents with household incomes between $50,000 and $79,999, and "higher income" refers to respondents with household incomes of $80,000 or more. "Overall share" refers to the share of all respondents with this insurance.

[a]Statistically significant difference between Medicare beneficiaries and private insurance people within the same income category (at a 95 percent confidence level).

[b]Statistically significant difference between lower-income respondents and middle- or higher-income respondents within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

(Chart continued next page)

Chart 7-22 In our 2023 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries (continued)

> In 2023, we found a number of differences in access to care for lower-income Medicare beneficiaries (with household incomes below $50,000) and higher-income beneficiaries (with household incomes of $80,000 or more). For example:

>> Only 91 percent of lower-income beneficiaries reported receiving any health care in the past year, compared with 97 percent of middle- and higher-income beneficiaries.

>> Lower shares of lower-income beneficiaries reported looking for a new specialist in the past year (26 percent) compared with higher-income beneficiaries (38 percent).

>> Higher shares of lower-income beneficiaries reported forgoing care in the past year (23 percent) compared with higher-income beneficiaries (17 percent).

> Among lower-income respondents with private insurance who had forgone care, 31 percent reported cost as the main reason they had done so (equivalent to 9 percent of lower-income privately insured people). By contrast, among lower-income Medicare beneficiaries who had forgone care, 10 percent cited cost as the reason they had done so (equivalent to 2 percent of lower-income Medicare beneficiaries).

Chart 7-23 In our 2023 survey, lower shares of Black and Hispanic Medicare beneficiaries reported receiving any health care in the past year compared with White beneficiaries

	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	White	Black	Hispanic	White	Black	Hispanic
Received health care in past year: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	95%[a]	92%[b]	86%[b]	91%[a]	92%	85%[b]
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"						
Yes	33	23[b]	25	33	28	34

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "White" refers to non-Hispanic White respondents, "Black" refers to non-Hispanic Black respondents, and "Hispanic" refers to Hispanic respondents of any race.
[a]Statistically significant difference between Medicare beneficiaries and private insurance people within the same race/ethnicity category (at a 95 percent confidence level).
[b]Statistically significant difference between White and Black or Hispanic within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, Black and Hispanic Medicare beneficiaries generally reported care experiences comparable with those of White beneficiaries, with a few exceptions:

>> Lower shares of Hispanic and Black beneficiaries reported receiving any health care in the past year compared with White beneficiaries (86 percent and 92 percent vs. 95 percent). We also observed somewhat lower shares of Hispanic beneficiaries receiving care among the privately insured (85 percent) compared with White privately insured individuals (91 percent).

>> Lower shares of Black beneficiaries looked for a new specialist in the past year (23 percent) compared with White beneficiaries (33 percent).

> There were no statistically significant differences between the shares of White beneficiaries and Black or Hispanic beneficiaries who:

>> were satisfied with their ability to find health care providers who accepted their insurance,

>> were satisfied with their ability to find providers who had timely appointments available,

>> had a primary care provider,

>> saw a nurse practitioner or physician assistant for various shares of their primary care,

>> tried to get a new primary care provider,

>> tried to get a new mental health professional,

>> had to wait longer than they wanted to get an appointment, or

>> reported forgoing care that they thought they should have gotten.

Chart 7-24 In our 2023 survey, rural Medicare beneficiaries were more likely to receive most or all of their primary care from a nonphysician and were less likely to seek out specialty care compared with urban beneficiaries

	Medicare (ages 65 and older)		Private insurance (ages 50–64)	
Survey question	Urban	Rural	Urban	Rural
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"				
For none of my primary care (I always see a doctor)	42%[ab]	34%[b]	36%[ab]	26%[b]
For any of my primary care (net)	55[a]	61	60[ab]	69[b]
For some of my primary care	39	33	40	34
For all or most of my primary care	17[b]	29[b]	20[b]	36[b]
Don't know	3[ab]	5[b]	4[a]	4
Long wait for 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 regular or routine care				
Never	47[ab]	56[ab]	36[ab]	45[ab]
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"				
Yes	34[b]	23[b]	34[b]	27[b]
Problems finding a specialist: Among those who tried to get a new specialist, "How much of a problem was it finding a specialist who would treat you?" (Overall share)				
A small problem	21[ab]	33[b]	28[a]	27

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Urban" respondents live 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 live outside of an MSA.

[a]Statistically significant difference between Medicare beneficiaries and private insurance people within the same area type (at a 95 percent confidence level).

[b]Statistically significant difference between urban and rural respondents within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

(Chart continued next page)

Chart 7-24 In our 2023 survey, rural Medicare beneficiaries were more likely to receive most or all of their primary care from a nonphysician and were less likely to seek out specialty care compared with urban beneficiaries (continued)

> Our survey found a few differences related to the mix of clinicians whom rural and urban beneficiaries see:

>> More rural beneficiaries reported receiving all or most of their primary care from a nurse practitioner or physician assistant (29 percent) compared with urban beneficiaries (17 percent). This finding was also true among the privately insured.

>> More rural beneficiaries reported never having to wait longer than they wanted to get an appointment for regular or routine care (56 percent) compared with urban beneficiaries (47 percent), among those who needed this type of appointment.

>> Fewer rural beneficiaries reported looking for a new specialist in the past year (23 percent) compared with urban beneficiaries (34 percent).

>> Among those looking for a new specialist, a greater share of rural beneficiaries reported experiencing "a small problem" finding one (33 percent) compared with urban beneficiaries (21 percent).

> Among Medicare beneficiaries, there were no statistically significant differences between the shares of urban and rural residents who:

>> had received any health care in the past year,

>> were satisfied with their ability to find health care providers who accepted their insurance,

>> were satisfied with their ability to find health care providers who had appointments available when they needed them,

>> had a primary care provider,

>> tried to get a new primary care provider or a new mental health professional,

>> experienced a problem finding a new primary care provider,

>> waited longer than they wanted to get an appointment for an illness or injury,

>> reported forgoing care that they thought they should have gotten.