CHAPTER 4

Physician and other health professional services

RECOMMENDATION

4 The Congress should:

- for calendar year 2026, replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point; and
- enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.

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

CHAPTER 4

Physician and other health professional services

Chapter summary

In 2023, traditional fee-for-service (FFS) Medicare's physician fee schedule paid for about 9,000 types of medical services provided across a variety of care settings. These services included office visits, surgical procedures, imaging, and tests delivered in physician offices, hospitals, skilled nursing facilities, and other settings. The clinicians who are paid to deliver these services include not only physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs), but also chiropractors, podiatrists, physical therapists, psychologists, and other types of health professionals. The Medicare program and its beneficiaries paid $92.4 billion in 2023 for fee schedule services billed by about 1.4 million clinicians and delivered to 28.2 million FFS beneficiaries, accounting for just under 17 percent of spending in FFS Medicare. Spending on clinician services by FFS Medicare and its beneficiaries was $0.7 billion higher in 2023 than in 2022, representing a 0.7 percent increase in total spending. This increase is largely attributable to a 3.3 percent decrease in the number of beneficiaries enrolled in FFS Medicare and 4.2 percent growth in spending per FFS beneficiary.

Assessment of payment adequacy

In 2023 and 2024, most clinician payment-adequacy indicators remained positive or improved, but clinicians' input costs are estimated to have grown faster than the historical trend.

In this chapter

Beneficiaries' access to care—In the Commission's 2024 survey, Medicare beneficiaries reported access to clinician services that was comparable to or, in most cases, better than that of privately insured people.

In response to a request from the House Committee on Appropriations, our survey began asking respondents to quantify wait times this year. We found that the number of weeks Medicare beneficiaries reported waiting for appointments with new clinicians was comparable to or better than the wait times reported by privately insured people. Our findings are consistent with those of other national surveys, which have found that people ages 65 and older (almost all of whom have Medicare coverage) report better access to care than younger adults and that Medicare beneficiaries of any age are more likely than privately insured people to rate their insurance coverage positively.

Other surveys also find that Medicare beneficiaries report having relatively good access to care. But some subgroups of beneficiaries report more access problems. In our analysis of CMS's 2022 Medicare Current Beneficiary Survey, we found that beneficiaries under age 65 and those with low incomes were more likely to report having trouble getting health care and to report delaying care due to cost compared with other Medicare beneficiaries.

Other surveys indicate that the share of clinicians accepting Medicare is comparable to the share accepting private insurance, despite private health insurers' higher payment rates. And almost all clinicians who bill Medicare accept physician fee schedule amounts as payment in full and do not seek higher payments from patients for fee schedule services.

The supply of most types of clinicians billing Medicare's physician fee schedule has been growing in recent years, although the composition of the clinician workforce continues to change. Over the last several years, the number of primary care physicians has slowly declined, the number of specialists has steadily increased, and the number of APRNs and PAs has climbed rapidly. The number of clinicians per FFS beneficiary has grown, partially attributable to a decline in the number of FFS beneficiaries.

Interest in becoming a clinician remains high. Over the last 40 years, the number of applicants to U.S. medical schools has grown, exceeding population growth, and has picked up in recent years. The number of APRNs and PAs has grown rapidly, suggesting robust interest in becoming these types of clinicians. In addition, for each year between 2016 and 2021, the number of clinicians who

began billing the fee schedule for the first time was larger than the number who stopped billing the fee schedule.

The number of clinician encounters per FFS beneficiary has increased over time, with faster growth from 2022 to 2023 (4.3 percent) compared with the average annual growth rate from 2018 to 2022 (0.5 percent). Growth rates varied by clinician specialty and type of service. From 2022 to 2023, the number of primary care physician encounters per FFS beneficiary declined by 0.1 percent, specialist physician encounters increased by 2.7 percent, and APRN and PA encounters increased by 10.1 percent.

Quality of care—We report three population-based measures of quality of clinician care: risk-adjusted ambulatory care–sensitive (ACS) hospitalization rates, risk-adjusted ACS emergency department (ED) visits, and patient-experience measures. In 2023, risk-adjusted rates of ACS hospitalizations and ED visits remained below (that is, better than) prepandemic levels and continued to vary across health care markets. Between 2022 and 2023, patient-experience scores in FFS Medicare were relatively stable.

Clinicians' revenues and costs—Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries or to their full panel of patients. Instead, we rely on indirect measures of how clinicians' payments compare with the costs of providing services.

To assess clinicians' incentives to treat Medicare beneficiaries versus patients with other types of insurance, we compare Medicare payment rates with private-insurance rates. In 2023, preferred provider organizations' (PPOs') payment rates for clinician services were, on average, 140 percent of FFS Medicare's payment rates—up from 136 percent in 2022. A 2022 survey by the American Medical Association suggests that providers are increasingly consolidating into larger organizations to improve their ability to negotiate higher payment rates from private insurers (and to gain access to costly resources and help complying with payers' regulatory and administrative requirements).

Since the Commission lacks data that would allow us to determine whether providers' revenues are greater than their costs and whether delivering clinician services is therefore profitable, we examine clinician compensation levels as a rough proxy for all-payer profitability. Clinician compensation levels

suggest that providing clinician services is profitable. In 2023, the median physician earned $352,000, according to SullivanCotter compensation data. Median compensation for advanced practice providers (e.g., nurse practitioners (NPs), PAs) was lower, at $138,000, but has been growing more quickly than physician compensation in recent years. From 2019 to 2023, advanced practice providers' compensation grew by 4.4 percent per year, on average, while physicians' compensation grew by 3.3 percent per year. (As a point of reference, inflation averaged 4.5 percent per year over this period.) We note, however, that Medicare constitutes only a portion of the revenue most clinicians receive since clinicians usually accept a variety of types of insurance and many employed physicians' compensation may not be directly tied to fee schedule payments—making clinician compensation an indirect measure of Medicare's payment adequacy. Compensation remained much lower for primary care physicians ($296,000) than for most specialists in 2023 (e.g., $496,000 for surgical specialties)—a disparity that may help explain why the share of physicians pursuing primary care in the U.S. has been declining.

Physician fee schedule spending per FFS beneficiary grew for most types of services in 2023, despite payment rates for many types of services declining from 2022 to 2023. Among broad service categories, growth rates were 4.2 percent for evaluation and management services, 4.2 percent for imaging, 3.7 percent for other (i.e., nonmajor) procedures, 7.2 percent for treatments, and 4.9 percent for tests. Spending per FFS beneficiary declined by 0.1 percent for major procedures.

Growth in clinicians' input costs as measured by the Medicare Economic Index (MEI) has moderated from recent highs during the coronavirus pandemic and is expected to moderate further in the coming years. Currently, MEI growth is projected to be 3.3 percent in 2024 and 2.8 percent in 2025. Nevertheless, we anticipate that increases in clinicians' input costs in 2024 and 2025 will be larger than the increases in FFS Medicare payment rates that are scheduled under current law. Although past updates have not kept pace with the growth in clinicians' input costs, the volume and intensity of clinician services per FFS beneficiary have increased substantially over time, suggesting (along with the Commission's broader findings on access to care) that below-MEI updates have not impeded access to date. Increased volume and intensity have also resulted in markedly higher physician fee schedule spending over time.

How should payment rates change in 2026?

Under current law, Medicare fee schedule payment rates are scheduled to increase by 0.75 percent for clinicians in advanced alternative payment models (e.g., accountable care organization models that involve some financial risk) and 0.25 percent for all other clinicians. Given recent inflation, input-cost increases in 2026—which are currently projected to be 2.3 percent—could be difficult for clinicians to absorb. Yet current payments to clinicians appear to be adequate, according to many of our indicators.

Given these mixed findings, the Commission recommends, for calendar year 2026, that the Congress replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the MEI minus 1 percentage point. Based on CMS's MEI projections at the time of this publication, the update recommendation for 2026 would be equivalent to 1.3 percent, which is above current-law updates of 0.75 percent or 0.25 percent. The recommendation would be a permanent update that would not expire at the end of 2026 and therefore would be built into subsequent years' payment rates. This approach differs from the temporary updates specified in current law for 2021 through 2024, which have each increased payment rates for one year only and then expired.

To promote adequate access to care for all Medicare beneficiaries, the Commission also recommends that the Congress enact our March 2023 recommendation to establish new, permanent safety-net add-on payments for clinician services furnished to FFS Medicare beneficiaries with low incomes. (We define "low-income" beneficiaries as those dually enrolled in Medicaid and Medicare or receiving the Part D low-income subsidy (LIS).) These add-on payments would increase Medicare payment rates by 15 percent for primary care clinicians and by 5 percent for all other clinicians for fee schedule services furnished to FFS Medicare beneficiaries with low incomes. The Commission has determined that providing this additional financial support is warranted since clinicians often receive less revenue for treating low-income beneficiaries because of how Medicare's cost-sharing policies interact with state Medicaid payment policies. Yet the cost to clinicians of treating low-income Medicare beneficiaries is likely to be at least as much as, if not higher than, the cost of caring for other beneficiaries. As a result of less revenue and potentially higher treatment costs, these beneficiaries are likely to be less profitable to care for and therefore could have difficulty accessing care.

All else being equal, we estimate that the Commission's recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by 1.7 percent. The increase for each clinician would vary by specialty and share of services furnished to beneficiaries with low incomes. Because primary care clinicians would receive higher add-on payments than non–primary care providers, safety-net payments would increase fee schedule revenue for primary care clinicians by an average of 4.4 percent and for non–primary care clinicians by an average of 1.2 percent. (These add-on payments would be paid entirely by the Medicare program; LIS beneficiaries would not owe higher cost sharing.)

We estimate that the combination of the recommended update and safety-net policies would increase fee schedule revenue for the average clinician by 3.0 percent. The effects would vary by provider specialty. We estimate that the combined effect of the two policies would increase fee schedule revenue by an average of 5.7 percent for primary care clinicians and by an average of 2.5 percent for other clinicians.

This recommendation would balance the need to provide adequate payments to clinicians with the need to limit growth in beneficiaries' cost sharing and premiums. ■

Background

To determine fee-for-service (FFS) Medicare payment rates under the physician fee schedule, CMS establishes relative values for a wide range of services. In 2023, Medicare's physician fee schedule paid for about 9,000 types of medical services.[1] Services' relative values are multiplied by the physician fee schedule's conversion factor (a fixed dollar amount equal to $32.35 in 2025) to produce a total payment amount for each service.[2] Medicare's physician fee schedule pays for a wide range of clinician services for FFS beneficiaries, including office visits, surgical procedures, imaging, and tests. When these services are delivered in certain facilities, such as hospitals or ambulatory surgical centers, CMS makes an additional payment through a separate facility payment system to pay for nonclinician costs like nursing services, medical supplies, equipment, and rooms (discussed in separate chapters of this report). In such instances, the physician fee schedule payment rate is reduced, but it is normally more than offset by the additional fee Medicare pays through the other payment system (e.g., through the hospital outpatient prospective payment system), resulting in higher spending than if the service were delivered in a nonfacility setting.

Physician fee schedule spending constituted just under 17 percent of spending in FFS Medicare (Boards of Trustees 2024).[3] In 2023, the FFS Medicare program and its beneficiaries paid $92.4 billion for physician fee schedule services, which is $0.7 billion more than in 2022. This figure represents a 0.7 percent increase in total spending, which is a function of a 3.3 percent decrease in the number of beneficiaries enrolled in FFS Medicare and 4.2 percent growth in spending per FFS beneficiary.

In 2023, just over 1.4 million clinicians, including physicians, advanced practice registered nurses (APRNs), physician assistants (PAs), chiropractors, podiatrists, physical therapists, psychologists, and other types of health professionals, billed the Medicare physician fee schedule for services. The number of clinicians billing the fee schedule in 2023 was higher than the previous year.

Are FFS Medicare payments adequate in 2025?

To assess whether FFS Medicare payments for clinician services are currently adequate, we examine indicators in three categories: beneficiaries' access to care, the quality of their care, and clinicians' revenues and costs. In 2023 and 2024, most indicators of physician payment adequacy remained positive or improved, but clinicians' input costs grew faster in this period than the historical trend.

Medicare beneficiaries' access to care is comparable to that of the privately insured

Although directly measuring access to care is challenging, most of our indicators suggest FFS Medicare beneficiaries have relatively good access to care. In the Commission's 2024 survey, Medicare beneficiaries continued to report access to care that is comparable to or, in most cases, better than that of privately insured people. The share of clinicians accepting Medicare is high and comparable to the share accepting private insurance. Almost all clinicians who treat FFS Medicare beneficiaries accept the physician fee schedule's payment rates as payment in full, although they have the option, as "nonparticipating" providers, to balance bill beneficiaries for higher amounts. If they elect to "opt out" of the program, clinicians treating FFS Medicare beneficiaries can also choose to forgo all FFS Medicare payments and set the price they charge patients—yet few choose to do this. The overall number of clinicians billing FFS Medicare has grown in recent years. The composition of the clinician workforce billing the fee schedule continues to change, with the number of primary care physicians slowly declining, the number of specialists growing at a modest rate, and the number of APRNs and PAs growing rapidly. The number of clinician encounters per beneficiary increased in 2023 for most types of services.

Most beneficiaries report relatively good access to clinician services in surveys and focus groups

One way we assess Medicare beneficiaries' access to care is by examining data from our annual survey of Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64. Our 2024 survey was

completed by over 10,000 respondents in the summer of 2024 and, as with prior years, was weighted to produce nationally representative results.[4] The Commission's survey includes Medicare beneficiaries in both FFS Medicare and in Medicare Advantage (MA) plans. We believe this group is representative of the experiences of FFS beneficiaries because in our and others' analyses of data from CMS's Medicare Current Beneficiary Survey, FFS beneficiaries and MA enrollees tend to report comparable experiences accessing care (Koma et al. 2023, Ochieng and Fuglesten Biniek 2022).

Consistent with last year, our 2024 survey found that Medicare beneficiaries reported access to care that was comparable to or, in most cases, better than that of privately insured people. (Throughout this section, the shares of Medicare beneficiaries and privately insured people who reported a given experience are statistically significantly different from each other at the 95 percent confidence level unless otherwise noted, consistent with prior years.) (See Table 4-A1, p. 135, in this chapter's appendix for some of our key findings for Medicare beneficiaries versus privately insured people.)

We also draw on findings from local focus groups that we conduct to ask beneficiaries and clinicians about their experiences with health care.[5] New in this year's focus groups, we held separate groups with beneficiaries enrolled in traditional FFS Medicare and those enrolled in MA plans and, where relevant, we highlight similarities or differences in experiences.

Relatively high satisfaction with overall access to care Our 2024 survey found that the vast majority of Medicare beneficiaries ages 65 and over (95 percent) and privately insured people ages 50 to 64 (91 percent) had received some kind of health care in the past 12 months. Among these survey respondents, a higher share of Medicare beneficiaries was satisfied with their ability to find health care providers who accepted their insurance (97 percent) compared with privately insured people (93 percent). In addition, among beneficiaries who had received health care, a higher share of Medicare beneficiaries was satisfied with their ability to find health care providers that had appointments when they needed them (88 percent) compared with privately insured people (79 percent). In our focus groups, Medicare beneficiaries in both FFS Medicare and MA plans reported high satisfaction with their insurance coverage, with the vast majority of participants rating their coverage as "excellent" or "good" (NORC at the University of Chicago 2024).

Nearly all Medicare beneficiaries have a primary care provider In our 2024 survey, 96 percent of Medicare beneficiaries reported having a primary care provider (PCP) compared with 91 percent of privately insured people. This finding is consistent with what we gathered from our focus groups, in which nearly all beneficiaries we spoke with reported having a regular source of primary care.

Our survey found that Medicare beneficiaries were slightly less likely to report receiving all or most of their primary care from a nurse practitioner (NP) or PA (19 percent) compared with privately insured people (23 percent). In our focus groups, beneficiaries reported a mix of physicians, NPs, and PAs as their designated PCP. Some beneficiaries reported that they go to practices that employ a mix of clinician types and said that they alternate their appointments among different clinicians or see whoever is available.

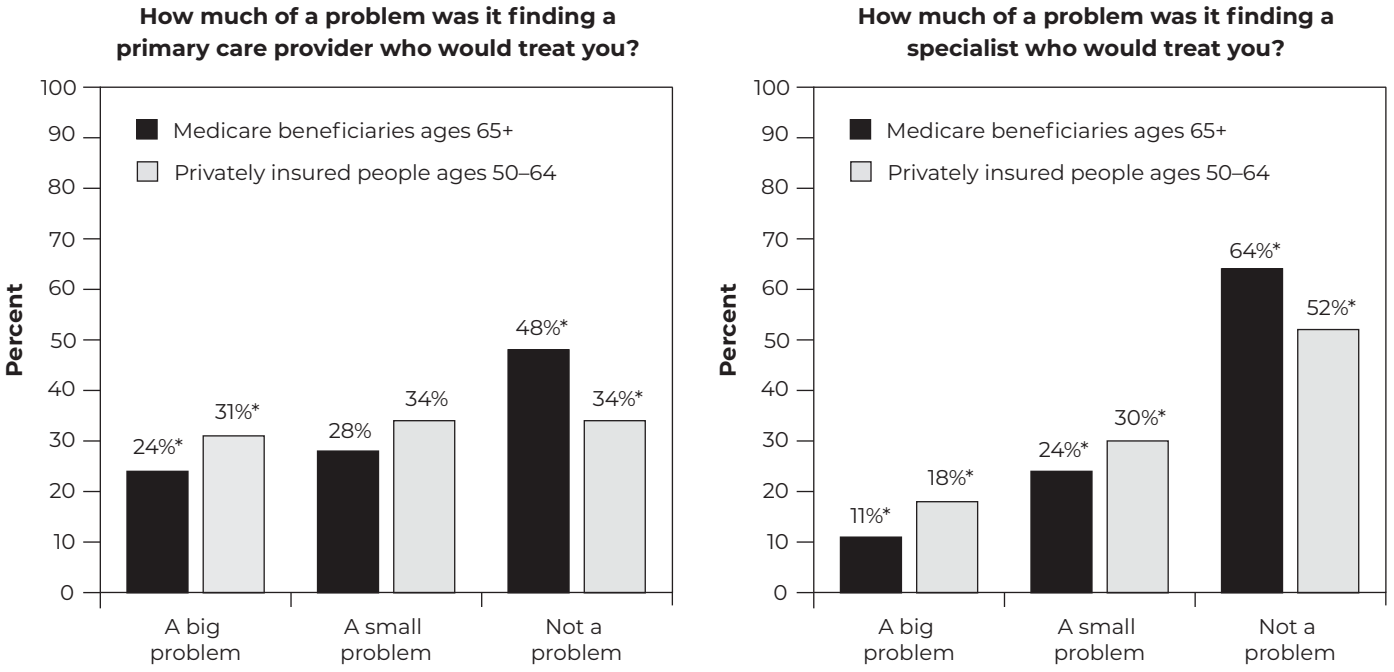
Medicare beneficiaries report fewer problems finding a new clinician than privately insured people In our 2024 survey, 11 percent of Medicare beneficiaries and 16 percent of privately insured people reported looking for a new primary care provider. Among those respondents, a smaller share of Medicare beneficiaries reported experiencing a "big" or "small" problem finding a new one (52 percent) compared with privately insured people (66 percent) (Figure 4-1). These amounts are equivalent to 5 percent of all Medicare beneficiaries and 10 percent of all privately insured people experiencing difficulty finding a new primary care provider. In our survey and focus groups, reasons beneficiaries cited for looking for a new PCP included that (1) their former PCP retired, stopped practicing, or moved away; (2) their PCP's practice had changed ownership and the beneficiary's experience of care had been negatively affected; (3) the beneficiary had moved; (4) a PCP was no longer in network; or (5) a PCP had switched to a concierge model.

About a third of respondents reported looking for a new specialist in the past 12 months, and among those looking, a smaller share of Medicare beneficiaries reported experiencing a "big" or "small" problem finding a new specialist (36 percent) compared with

FIGURE 4–1

Fewer Medicare beneficiaries reported problems finding a new clinician compared with privately insured people in MedPAC's 2024 survey

Among survey respondents who tried to get a new [primary care provider/specialist] in the past 12 months . . .



Note: We received completed surveys from 4,926 Medicare beneficiaries and 5,200 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 may not sum to 100 percent due to rounding.
* Statistically significant difference between Medicare and private-insurance groups (at a 95 percent confidence level).

Source: MedPAC's 2024 access-to-care survey, fielded by Gallup from July 25 to September 9, 2024.

privately insured people (48 percent) (Figure 4-1). These figures are equivalent to 11 percent of Medicare beneficiaries and 16 percent of privately insured people experiencing a problem finding a specialist, since more people look for a specialist than a PCP in a given year.

Most patients looking for a new mental health professional experience problems finding one In our 2024 survey, only a small share of people tried to get a new mental health professional in the past 12 months—3 percent of Medicare beneficiaries and 8 percent of privately insured people. However, among those looking for a new mental health professional, a majority experienced problems finding one (62 percent of Medicare beneficiaries and 74 percent of privately insured people—not a statistically significant difference, given how few people looked for this type of clinician). These figures are equivalent to an estimated 2 percent of Medicare beneficiaries and 6 percent of privately insured people experiencing a problem finding a mental health professional. Findings from our survey and other sources suggest that a sizable share of mental health professionals do not accept Medicare or private insurance (Ochieng et al. 2022). For example, a 2024 survey of psychologists found that 34 percent did not accept any type of insurance (American Psychological Association 2024). That survey also found that 53 percent of psychologists did not have openings for new patients.

Shorter waits for appointments for an illness or injury compared with routine care Among survey respondents who needed an appointment for regular or routine care, a smaller share of Medicare beneficiaries reported that they "usually" or "always" had to wait longer than they wanted to get such an appointment (13 percent) compared with privately insured people (22 percent). Survey respondents had less difficulty getting an appointment for an illness or injury: Among those needing this type of appointment, only 7 percent of Medicare beneficiaries reported "usually" or "always" waiting longer than they wanted, compared with 14 percent of privately insured people. One theory for our finding is that Medicare beneficiaries are more likely to be retired and thus may have more scheduling flexibility, which might allow them to be seen sooner than privately insured people who work full time.

In our focus groups, most beneficiaries described having timely access to primary care. For acute issues, beneficiaries reported that they could typically get in faster than they could for a routine visit. We asked beneficiaries about their experiences dealing with urgent medical issues or how they would handle one in the future. Some beneficiaries explained that their approach would depend on the severity of the issue, when it happened (i.e., during or outside of regular business hours), and the distance to different options for care.

For more findings about wait times for different types of appointments, see text box on Medicare beneficiaries' access to care.

Patients sometimes forgo care but not necessarily due to difficulties accessing it In our 2024 survey, a smaller share of Medicare beneficiaries reported forgoing care that they thought they should have received in the past 12 months (18 percent) compared with privately insured people (27 percent). The most common reasons Medicare beneficiaries did not obtain such care were that they did not think the problem was serious or they just put it off (cited by about half of those who reported forgoing care). Medicare beneficiaries were much less likely to report forgoing care because they thought it would cost too much (7 percent of those reporting forgoing care) compared with privately insured individuals (23 percent of those reporting forgoing care)—equivalent to 1 percent of all Medicare beneficiaries and 6 percent of all privately insured people. Among people who reported forgoing care, comparable shares of Medicare beneficiaries and privately insured people reported doing so because they could not get an appointment soon enough (22 percent of Medicare beneficiaries who reported forgoing care and 21 percent of privately insured people who reported forgoing care, equivalent to 4 percent of all Medicare beneficiaries and 6 percent of all privately insured people).

Few differences in access by race/ethnicity in our survey White, Black, and Hispanic Medicare beneficiaries reported similar experiences accessing care, according to most questions in our survey. We did, however, find differences on a few questions. Black beneficiaries were more likely to report "never" waiting longer than they wanted to get an appointment for regular or routine care (60 percent) compared with White beneficiaries (50 percent) and Hispanic beneficiaries (52 percent). And among beneficiaries who had tried to get a new primary care provider, Black beneficiaries were much more likely to report that the reason they did so was that they had switched health insurance plans (e.g., had switched into a new MA plan) and therefore needed to find a provider who participated in the new plan (26 percent) compared with White beneficiaries (7 percent) and Hispanic beneficiaries (5 percent). (See Table 4-A2 (p. 136) in the appendix for additional survey results for White, Black, and Hispanic beneficiaries.)

Few differences between rural and urban beneficiaries' reported access to care Urban and rural Medicare beneficiaries reported comparable experiences and satisfaction levels on most questions in our survey. That said, there were some differences between these two groups. A higher share of rural beneficiaries reported receiving all or most of their primary care from an NP or PA (30 percent) compared with urban beneficiaries (17 percent). A lower share of rural beneficiaries reported looking for a new specialist (26 percent) compared with urban beneficiaries (33 percent). Among those who needed an appointment for regular or routine care in the past year, rural beneficiaries were more likely to report "never" having to wait longer than they wanted to get an appointment (57 percent) compared with urban

Congressional request on Medicare beneficiaries' access to care

The House Committee on Appropriations requested that the Commission report on Medicare beneficiaries' access to care, including the share of primary care providers that refuse to accept or limit the acceptance of new Medicare patients and Medicare patients' wait times for visits with new primary care providers. We report findings on these key access-to-care indicators in this text box and discuss other access-to-care indicators elsewhere in this chapter (pp. 103-106 and pp. 112–120).

Committee report language

Medicare Beneficiaries' Access to Care.—The Committee is concerned that despite MedPAC's conclusion in its March 2024 Report to the Congress, Medicare and Medicare Advantage patients report longer wait times for routine health care appointments than patients with private health insurance plans. The Committee requests a report on Medicare beneficiaries' access to care, including the share of primary care providers that refuse to accept or limit the acceptance of new Medicare patients and data on Medicare patients' wait times for visits with new primary care providers.

Medicare beneficiaries' wait times for appointments

For many years, the Commission's annual survey has asked beneficiaries and privately insured people how often they experienced excessive waits for various types of appointments (see p. 106). In 2024, we added new questions to our survey that asked respondents to quantify how long their waits were for appointments. We found that among Medicare beneficiaries who tried to get a new primary care provider in the past year, 34 percent reported waiting two weeks or less for their first appointment, another 29 percent waited three to eight weeks, and 18 percent waited more than eight weeks (Figure 4-2, p. 108). Among Medicare beneficiaries who tried to get a new specialist, 33 percent reported waiting two weeks or less for their first appointment, 44 percent waited three to eight weeks, and 16 percent waited more than eight weeks (Figure 4-2).

Wait times reported by Medicare beneficiaries were comparable to or, in some cases, shorter than those reported by privately insured people. In Figure 4-2, asterisks identify statistically significant differences in the shares of Medicare beneficiaries and privately insured people who reported wait times of particular lengths. For example, Medicare beneficiaries were slightly more likely to be seen by a new primary care provider in one to two weeks and slightly less likely to be seen in three to five weeks compared with privately insured people. Medicare beneficiaries were also slightly more likely to be seen by a new specialist in less than one week and slightly less likely to wait six weeks or more for such an appointment.

These wait times suggest that a small but sizable minority of patients are experiencing substantial wait times for a first appointment with a new clinician. One way to free up time for clinicians to see more patients would be to reduce overly burdensome administrative tasks that consume clinicians' time, such as fee-for-service (FFS) Medicare's Merit-based Incentive Payment System (MIPS), which one study found consumed 202 hours of practice staff time (including 54 hours of physician time) per physician per year (Khullar et al. 2021). The Commission has recommended eliminating MIPS in part because it is overly burdensome and has not produced meaningful quality data for patients or the Medicare program (Medicare Payment Advisory Commission 2018b). MIPS is not the only burdensome quality measure–reporting program that clinicians face; one study estimated that physicians and their staff spend, on average, 785 hours per physician per year dealing with various payers' quality measure–reporting programs and that physicians could care for an additional nine patients per week if they did not have these obligations (Casalino et al. 2016).

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Congressional request on Medicare beneficiaries' access to care (cont.)

Figure 4-2 also shows that among Medicare beneficiaries who tried to get a new primary care provider, 15 percent had not yet scheduled an appointment with a new primary care provider. In contrast, among those looking for a new specialist, only 4 percent had not yet scheduled their first appointment. (A similar difference was observed among the privately insured.) As noted earlier,

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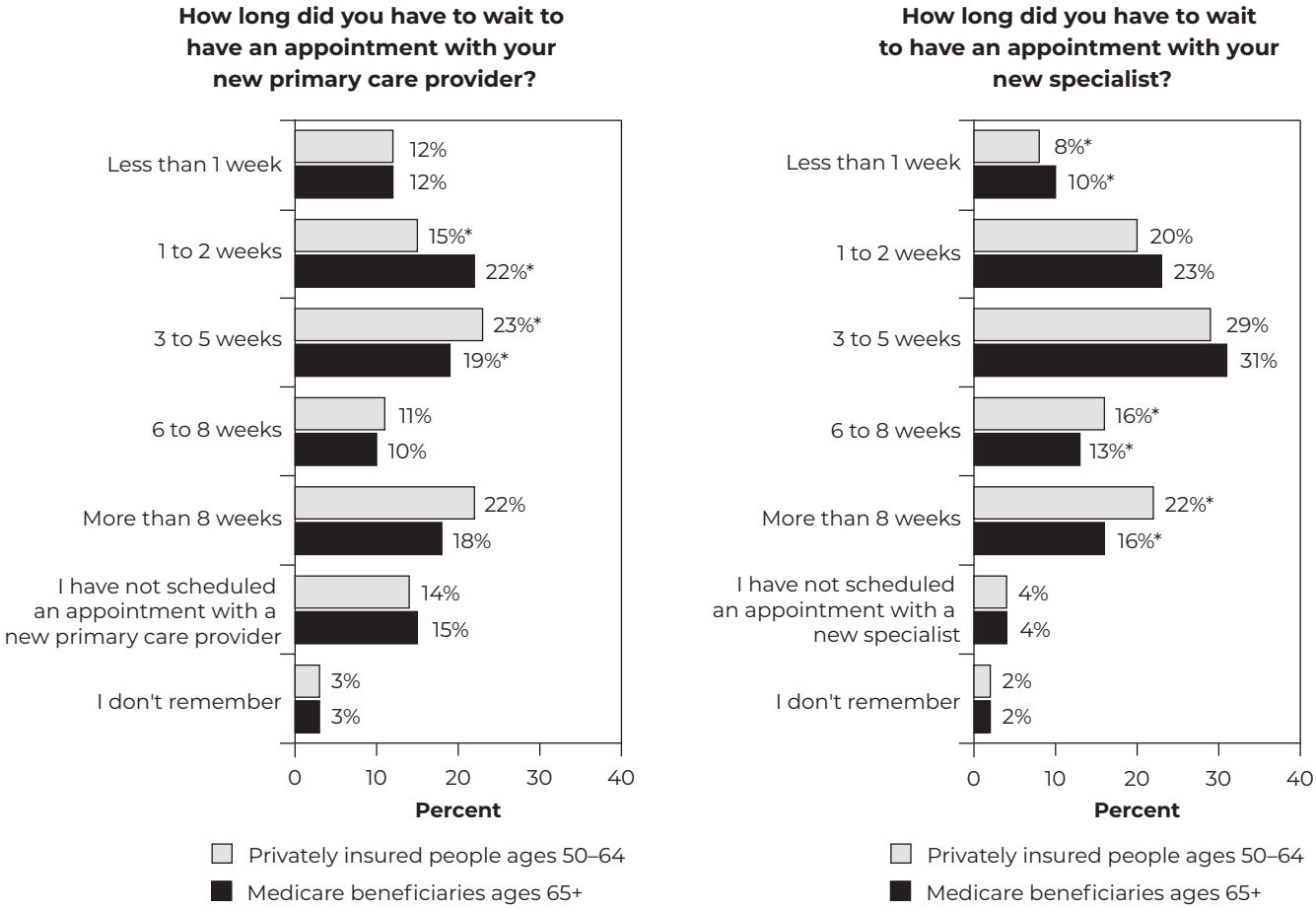
FIGURE 4–2

Medicare beneficiaries' reported wait times for a first appointment with a new clinician were comparable to or better than those of the privately insured, 2024

Among survey respondents who tried to get a new [primary care provider/specialist] in the past 12 months . . .



Note: These questions were asked of only the subsets of survey respondents who reported looking for a new primary care provider in the past 12 months (552 Medicare beneficiaries and 816 privately insured people) and who looked for a new specialist (1,657 Medicare beneficiaries and 1,913 privately insured people). 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. Medicare beneficiaries surveyed include both those with fee-for-service Medicare and those enrolled in Medicare Advantage plans since our analysis of the Medicare Current Beneficiary Survey finds that these two groups of beneficiaries report comparable wait times and MedPAC's survey does not differentiate between these two groups.
* Statistically significant difference between Medicare and private-insurance groups (at a 95 percent confidence level).

Source: MedPAC's 2024 access-to-care survey, fielded by Gallup from July 25 to September 9, 2024.

Congressional request on Medicare beneficiaries' access to care (cont.)

other questions in our survey find that a much higher share of Medicare beneficiaries report problems finding a new primary care provider (52 percent of those looking) than report problems finding a new specialist (36 percent of those looking) (see Figure 4-1, p. 105).

Once beneficiaries find a new clinician and establish a care relationship with them, subsequent appointments seem to be easier to schedule, according to our analysis of CMS's 2022 Medicare Current Beneficiary Survey (MCBS), which is a larger survey fielded among Medicare beneficiaries of all ages. The MCBS does not differentiate between appointments scheduled with new versus existing clinicians, and it finds that among Medicare beneficiaries who recently had a doctor's office visit scheduled after the beneficiary reached out to a doctor's office to set it up, 39 percent of these beneficiaries were seen in less than one week and 34 percent were seen in one to two weeks (Figure 4-3).[6] Another 14 percent reported waiting three to five weeks for their appointment, and 10 percent reported waiting six weeks or longer. These are much shorter wait times than those reported in our survey (shown in Figure 4-2), which focused only on wait times for a beneficiary's first appointment with a new clinician.

In our focus groups, beneficiaries' experiences accessing specialty care varied, with reported wait times as a new patient ranging from a couple

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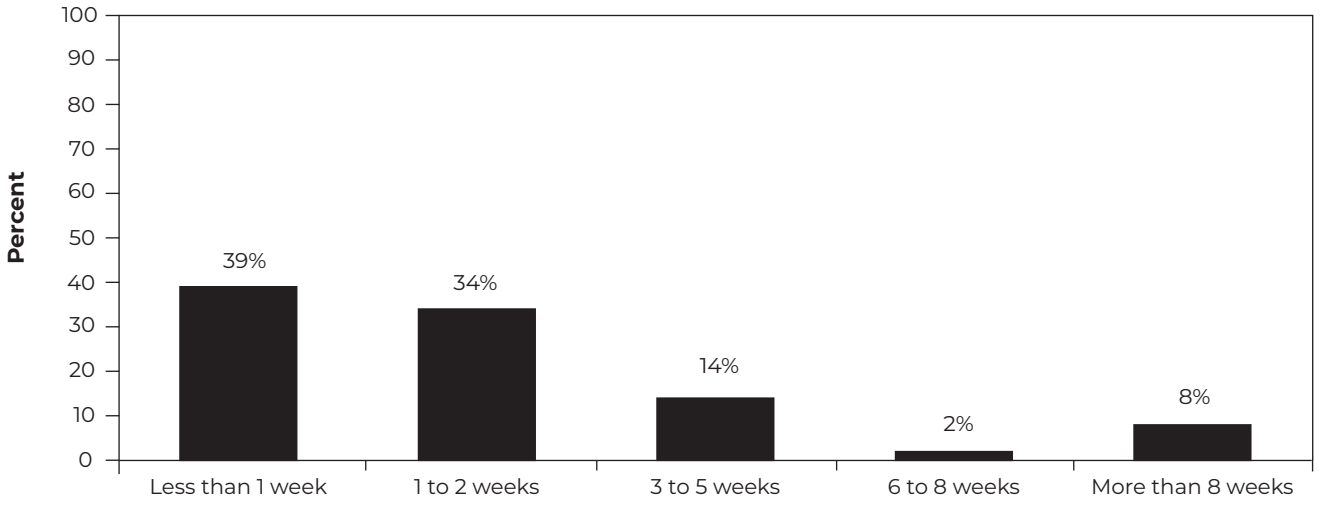
FIGURE 4–3

For doctors' office visits with all types of clinicians (new and existing), most Medicare beneficiaries reported wait times of two weeks or less for their most recent appointment, 2022



Note: The graph reflects the experiences of 3,281 Medicare beneficiaries of all ages (including those under the age of 65) who reported having a doctor's office visit that was scheduled after they contacted a doctor's office to set up an appointment; it does not include appointments scheduled after a provider reached out to a beneficiary to schedule a visit, visits scheduled at a prior visit, or standing appointments. Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries in 2022 (including both those with fee-for-service Medicare and those in Medicare Advantage plans, since our analysis of this survey finds that these two groups of beneficiaries report comparable wait times and MedPAC's survey groups together these two types of beneficiaries).

Source: MedPAC analysis of CMS's 2022 Medicare Current Beneficiary Survey.

Congressional request on Medicare beneficiaries' access to care (cont.)

of weeks to multiple months, with the longest wait times being between 6 and 12 months. Several beneficiaries reported long wait times for specialty care even when dealing with an acute medical issue. Consistent with the survey findings described above, many beneficiaries reported that wait times as a new patient tended to be much longer than as an established patient.

Our analysis of MCBS data also found that, among beneficiaries who had recently scheduled a doctor's office visit, a higher share of beneficiaries reported waiting less than one week for a visit with a primary care physician (44 percent) compared with those seen by a specialist (28 percent) (data not shown). This difference may reflect primary care providers' common practice of squeezing in existing patients for same- or next-day appointments when patients have an urgent health issue (since a core tenet of primary care is providing "first-contact" care to patients when they have a health issue (Starfield et al. 2005)). In contrast, when we looked at visits that had been booked at a prior appointment (which are, presumably, nonurgent), there was no difference by physician specialty in the shares of beneficiaries who reported being seen within one week (34 percent of beneficiaries were seen this quickly, whether they were seen by a primary care physician or a specialist) (data not shown).

Clinicians' Medicare acceptance rates

Several data sources suggest that the share of clinicians who accept Medicare is relatively high and comparable to the share who accept private health insurance, even though Medicare payment rates are usually lower than private insurers' payment rates.

In a 2022 survey by the American Medical Association (AMA), among nonpediatric physicians accepting new patients, 85 percent reported accepting all new Medicare patients and another 11 percent reported accepting some new Medicare patients; only 2 percent said they accepted only new privately insured patients (American Medical Association 2023b). The AMA survey found that the acceptance of Medicare varied by clinical setting and by medical specialty. Among those accepting new patients, larger shares of physicians in hospital-owned practices accepted Medicare (98.6 percent) compared with physicians in private practice (94.1 percent). And among those accepting new patients, larger shares of specialists accepted Medicare (e.g., 99.6 percent of internal medicine subspecialists, 99.4 percent of general surgeons, 98.7 percent of radiologists) compared with family medicine physicians (94 percent). (One specialty with notably low acceptance of Medicare was psychiatry: Among psychiatrists taking new patients, only 80.7 percent accepted new Medicare patients.)

A survey that focuses on the subset of physicians who work in office-based settings also found that comparable shares of physicians accepted Medicare and private insurance. In 2021, the National Ambulatory Medical Care Survey found that, among the 94 percent of nonpediatric office-based physicians who reported accepting new patients, 89 percent accepted new Medicare patients and 88 percent accepted new privately insured patients (Schappert and Santo 2023).

Looking from the perspective of patients trying to find a new provider, a 2023 KFF survey found that Medicare beneficiaries were less likely than privately insured people to encounter providers who did not accept their insurance. Specifically, the survey found that 83 percent of Medicare beneficiaries said they had not encountered a doctor or hospital that was not covered by their insurance in the past year. This figure compares favorably with the 73 percent of people with employer-sponsored insurance and the 57 percent of people with individual health insurance purchased through a Marketplace who

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Congressional request on Medicare beneficiaries' access to care (cont.)

reported not encountering this barrier. The KFF survey also found that 76 percent of Medicare beneficiaries said they had not encountered a doctor who was covered by their insurance but lacked available appointments in the past year; in contrast, only 61 percent of people with employer-sponsored insurance and 57 percent of people with Marketplace insurance reported not encountering this barrier (Pollitz et al. 2023).

Our own survey has found that Medicare beneficiaries are less likely to encounter a doctor's office that does not accept their insurance compared with privately insured people. In 2024, among Medicare beneficiaries who had problems finding a new primary care provider in the past year, 14 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries). In contrast, among privately insured people who had problems finding a primary care provider, 27 percent encountered a doctor's office that did not accept their insurance (equivalent to 3 percent of all privately insured people). A similar trend was observed for specialists: Among Medicare beneficiaries who had problems finding a new specialist, 13 percent reported encountering a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries), while among privately insured people who experienced a problem finding a new specialist, 27 percent encountered a doctor's office that did not accept their insurance (equivalent to 4 percent of all privately insured people).

CMS administrative data also confirm that a high share of clinicians accept Medicare. In 2023, 98 percent of clinicians billing the physician fee schedule were participating providers, meaning that they agreed to accept Medicare's fee schedule amount as payment in full. Clinicians who wish to collect somewhat higher payments (of up to 109.25 percent of Medicare's payment rates) can "balance bill" patients for additional cost sharing if they sign up as a nonparticipating provider and choose not to "take assignment" on a claim, but very few clinicians choose this option. In 2023, 99.7 percent of fee schedule claims were paid at Medicare's standard payment rate. If clinicians elect to opt out of the program, they can choose the price they charge patients and bill beneficiaries directly for their services but receive no payment from Medicare. The number of clinicians who opted out of Medicare as of September 2024 (46,400) was extremely low compared with the 1.4 million clinicians who participated in the program in 2023 (Centers for Medicare & Medicaid Services 2024c).[7]

There are many reasons that clinicians may choose to accept FFS Medicare despite payment rates that are usually lower than commercial rates. A sizable share of most clinicians' patients are covered by FFS Medicare, and if these clinicians opted to accept only commercially insured patients, they might not be able to fill their schedules. In addition, almost all hospitals accept FFS Medicare patients, and hospitals may expect their employed physicians to take FFS Medicare patients given the important role these patients play. And although commercial insurers' payment rates may be higher than FFS Medicare's rates, commercial insurers do not pay all claims submitted to them. In contrast, FFS Medicare pays all "clean" claims within 30 days of their receiving a claim (and owes providers interest on any late payments). Commercial insurers also often impose burdensome requirements on clinicians that take time to complete, such as requiring clinicians to complete prior-authorization paperwork. A 2023 survey by the AMA found that physicians complete an average of 43 prior authorization requests per week, requiring 12 hours per week, and 35 percent of physicians have dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2023a). In contrast, FFS Medicare generally does not require prior authorization. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates. ■

beneficiaries (49 percent). Rural beneficiaries were also more likely to report that they were able to be seen by a new primary care provider in one to two weeks (34 percent) compared with urban beneficiaries (among whom only 19 percent reported wait times of this length). (See Table 4-A3 (p. 137) in this chapter's appendix for additional survey results for rural and urban beneficiaries.)

Other surveys also find that Medicare beneficiaries report having relatively good access to care Our 2024 survey's overall finding that Medicare beneficiaries reported access to care that is comparable to or, in most cases, better than that of privately insured people is consistent with a 2023 KFF survey that compared the experiences of Medicare beneficiaries (of any age) with individuals who had employer-sponsored insurance, Marketplace plans, and other coverage. KFF's survey found that, compared with privately insured people, Medicare beneficiaries were more likely to rate their insurance positively, less likely to report having a problem with their health insurance, and less likely to report issues affording medical bills (Pollitz et al. 2023).

Our survey findings are also consistent with several federally funded surveys that find that Medicare-aged people report better access to care than younger adults—which could mean that gaining Medicare coverage makes it easier for some people to access health care. For example, data from the Medical Expenditure Panel Survey and the National Health Interview Survey have been combined to find that around age 65, when most people gain eligibility for Medicare, there are fewer reports of being unable to get necessary care and being unable to get necessary care because of cost (Jacobs 2021). Analysis of the National Health Interview Survey has also found that delaying or forgoing needed care due to cost was more common among adults under the age of 65 than adults over 65 (National Center for Health Statistics 2023). And analysis of the Behavioral Risk Factor Surveillance System survey has found that, compared with people with employer-sponsored or individually purchased private health insurance, Medicare beneficiaries are more likely to have a personal physician, less likely to have medical debt, and more likely to be very satisfied with their care (Wray et al. 2021).

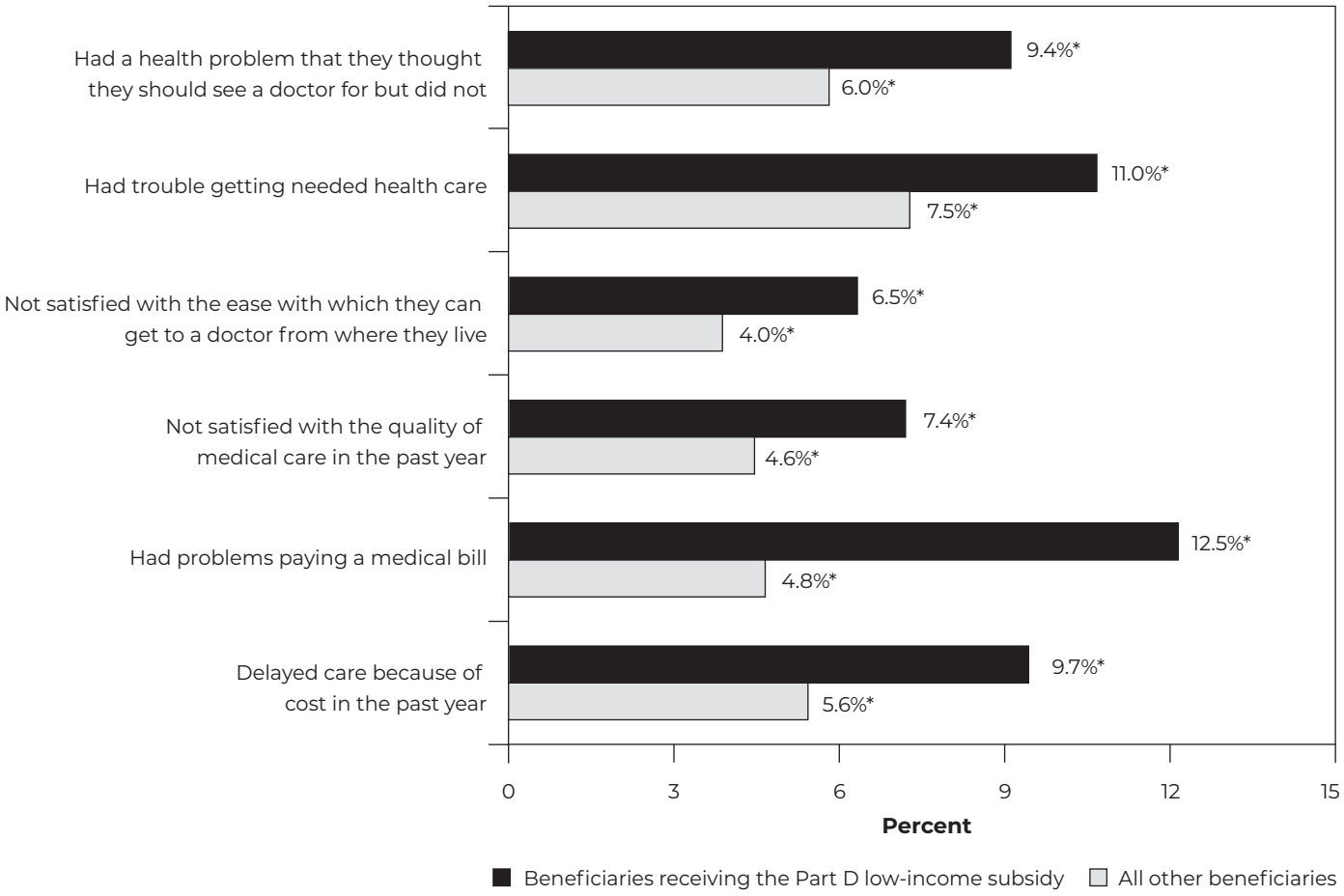
Our analysis of CMS's 2022 Medicare Current Beneficiary Survey (MCBS) also found that Medicare beneficiaries reported good access to care. Because the MCBS is an in-depth survey fielded among a large sample of Medicare beneficiaries, this data source allows us to isolate the experiences of FFS beneficiaries, specifically (in contrast to our own survey, which does not differentiate between FFS beneficiaries and MA enrollees). In 2022, the MCBS found that 93 percent of FFS beneficiaries (of all ages, not just those ages 65 and over) reported having a usual source of care that was not a hospital emergency department or an urgent care center, 95 percent felt their customary care provider usually or always spent enough time with them, and 90 percent were satisfied with the availability of care by specialists. A relatively small share (8 percent) reported experiencing trouble getting care in the past year—more often due to cost than to clinicians not accepting Medicare. Most beneficiaries (85 percent) said they were satisfied with their out-of-pocket costs for medical services, but a small share (4 percent) had a problem paying a medical bill.

Beneficiaries under age 65 report worse access to care than beneficiaries ages 65 and over One subgroup of Medicare beneficiaries that reports notably worse access to care in CMS's survey is beneficiaries under age 65 (most of whom have disabilities). For example, our analysis of 2022 MCBS data found that beneficiaries under the age of 65 were twice as likely as beneficiaries ages 65 and over to report having trouble getting health care (15 percent vs. 7 percent) and to report forgoing care that they thought they should have received (12 percent vs. 6 percent). They were over three times more likely to report having a problem paying a medical bill (18 percent vs. 5 percent) and to report delaying care due to cost in the past year (16 percent vs. 5 percent). Part of the reason for these difficulties may be that beneficiaries under age 65 tend to require more health care services than beneficiaries ages 65 and over yet have lower incomes than the older group (Cubanski et al. 2016, Medicare Payment Advisory Commission 2023a).

Beneficiaries with low incomes report obtaining less care In general, beneficiaries with low incomes report worse access to care than higher-income beneficiaries (Figure 4-4). Our analysis of 2022 MCBS data found that 9.4 percent of Medicare beneficiaries with incomes and assets low enough to qualify for the Part D low-income subsidy (LIS) reported forgoing care that they thought they should have received in the past year, compared

FIGURE 4–4

Low-income Medicare beneficiaries report worse access to care than higher-income beneficiaries, 2022



Note: Beneficiaries are eligible for the Part D low-income subsidy if (1) they have limited assets and incomes of 150 percent of the federal poverty level or less or (2) they are dually enrolled in Medicare and Medicaid. Survey results are weighted to be nationally representative of continuously enrolled Medicare beneficiaries (including both those with fee-for-service coverage and those enrolled in Medicare Advantage plans).
* Statistically significant difference between beneficiaries eligible and automatically receiving the Part D low-income subsidy versus all other beneficiaries (at a 95 percent confidence level).

Source: MedPAC analysis of CMS's 2022 Medicare Current Beneficiary Survey.

with 6.0 percent of higher-income beneficiaries. LIS beneficiaries were also more likely to report having trouble getting health care compared with higher-income beneficiaries (11.0 percent vs. 7.5 percent). A greater share of LIS beneficiaries was unsatisfied with the ease with which they could get to a doctor from where they live (6.5 percent vs. 4.0 percent) and unsatisfied with the quality of their medical care (7.4 percent vs. 4.6 percent). They were much more likely to report having problems paying a medical bill (12.5 percent vs. 4.8 percent) and more likely to delay care due to cost (9.7 percent vs. 5.6 percent).

Multiple factors may cause beneficiaries with low incomes to report worse access to care than higher-income beneficiaries, such as living in areas with fewer clinicians or being unable to access clinicians (e.g., due to cost concerns, transportation issues, local clinicians not taking new patients). For example, studies have

The Commission's recommendation to support clinicians when they care for low-income Medicare beneficiaries

In our March 2023 report to the Congress, the Commission recommended instituting a new Medicare safety-net (MSN) add-on payment for clinicians who treat low-income beneficiaries (Medicare Payment Advisory Commission 2023c). The Commission reaffirmed this recommendation in its March 2024 report to the Congress (Medicare Payment Advisory Commission 2024). Specifically, the Commission recommended that the Congress enact an add-on payment under the physician fee schedule for services provided to Medicare beneficiaries who are dually enrolled in Medicaid and Medicare and to beneficiaries who receive the Part D low-income subsidy (LIS) (as proxies for low income).[8] The add-on payments would equal the allowed charge amounts for physician fee schedule services furnished to these beneficiaries multiplied by 15 percent when provided by primary care clinicians and 5 percent for all other clinicians. The MSN add-on could be made as lump-sum payments to clinicians, rather than applied to individual claims, and should not be subject to beneficiary cost sharing.

The Commission contends that Medicare should provide additional financial support to clinicians who care for beneficiaries with low incomes because treating these beneficiaries can generate less revenue, even though the costs required to treat them are likely the same as for other beneficiaries, if not higher.

The revenue for treating beneficiaries with low incomes is often lower than the revenue clinicians collect for treating other beneficiaries because clinicians are prohibited from collecting cost-sharing amounts (either the annual Part B deductible or 20 percent coinsurance) from most beneficiaries who are dually enrolled in Medicaid and Medicare. In addition, state Medicaid programs are allowed to pay less than the full Medicare cost-sharing amount if paying the full amount would lead a provider to receive more than the state's Medicaid payment rate for the service.[9] One study found that 42 states limited Medicaid payments of Medicare cost sharing when Medicaid's fee schedule amount was lower than Medicare's rate (Roberts et al. 2020).

Using 2019 data, we estimate that providers were unable to collect about $3.6 billion in revenue due to these policies. Applying an MSN add-on to physician fee schedule payments would help to make up for a portion of clinicians' lost cost-sharing revenue when they treat these low-income beneficiaries, and it would thus reduce the financial penalty involved in treating these patients.

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found that the number of primary care physicians and PAs per capita tends to be lower in low-income counties compared with higher-income counties; in contrast, NPs are more evenly distributed across counties or even slightly more prevalent in counties with lower incomes (Davis et al. 2018, Liu and Wadhera 2022, Xue et al. 2019).

Concerns about access to care among low-income beneficiaries prompted the Commission to recommend in March 2023 that the Congress enact a safety-net add-on payment for fee schedule services delivered to these beneficiaries (see text box on supporting clinicians who furnish care to Medicare beneficiaries with low incomes).

The number of clinicians billing Medicare has increased, and the mix has changed

From 2018 to 2023, the total number of clinicians billing the fee schedule increased by an average of 2.2 percent per year, faster than FFS Medicare enrollment growth. The mix of clinicians has also changed over time.

The Commission's recommendation to support clinicians when they care for low-income Medicare beneficiaries (cont.)

Some clinicians treat a disproportionate share of low-income beneficiaries. Nine percent of primary care clinicians and 8 percent of non–primary care clinicians who billed the physician fee schedule in 2019 had more than 80 percent of their claims associated with beneficiaries receiving Part D's LIS. Across all primary care physicians, 28 percent of total allowed charges were associated with LIS beneficiaries. The share of allowed charges associated with LIS beneficiaries was slightly lower for non–primary care physicians (25 percent) but higher for nurse practitioners (41 percent). While the Commission recognizes that all clinicians who furnish care to beneficiaries with low incomes are at risk of lower revenue, we support providing a higher add-on rate for services furnished by primary care clinicians (including providers such as nurse practitioners and physician assistants) because they typically serve as a beneficiary's primary point of contact with the health care system. In addition, primary care clinicians generally receive less Medicare revenue and total compensation than specialists, and thus they have a greater need for safety-net payments (Neprash et al. 2023). Concerns have also been raised about the decline in the number of primary care physicians who serve fee-for-service beneficiaries and declining numbers of new physicians choosing to specialize in primary care, which safety-net payments could help address.

Using 2019 data, all else being equal, we estimate that a 15 percent safety-net add-on payment for primary care clinicians and a 5 percent add-on for other clinicians would have increased the average clinician's fee schedule revenue by 1.7 percent in 2019. The increase for each clinician would vary by their specialty and share of services furnished to low-income beneficiaries: Safety-net payments would increase total fee schedule revenue for primary care clinicians by 4.4 percent and for non–primary care clinicians by 1.2 percent. Because Medicare does not have an existing program to provide financial support to clinicians when they furnish care to beneficiaries with low incomes and because clinician payments are subject to relatively low statutory annual updates in the near term, the Commission asserts that the MSN add-on should be funded with new spending and not offset by reductions in fee schedule payment rates. The Commission emphasizes that MSN add-on payments should not be extended to Medicare Advantage (MA) plans or included in MA benchmarks because (1) many LIS beneficiaries are already enrolled in plans designed for enrollees who are dually eligible for Medicare and Medicaid and (2) plans can operate their own initiatives to support clinicians who serve low-income beneficiaries. ■

We limited this part of our analysis to clinicians who billed for more than 15 FFS Medicare beneficiaries in a given year. This minimum threshold helps us (1) better measure clinicians who substantially participate in Medicare and therefore are 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).[10] As a point of reference, studies suggest that primary care physicians' patient panels range from 1,200 to 2,500 patients per physician (Dai et al. 2019, Raffoul et al. 2016).

Table 4-1 (p. 116) provides both the absolute number of clinicians who billed the fee schedule for more than 15 beneficiaries and the number of clinicians who met that threshold per 1,000 FFS Medicare beneficiaries. In prior reports, when calculating clinician-to-beneficiary ratios, we have included the total number of Medicare Part B beneficiaries enrolled in either FFS Medicare or MA in the denominator (i.e., the total number of

TABLE 4–1

The number of clinicians billing Medicare's physician fee schedule has increased, and the mix of clinicians has changed, 2018–2023

	Number (in thousands)					Number per 1,000 FFS beneficiaries				
	Physicians					Physicians				
Year	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialty	Other specialties	APRNs and PAs	Other practitioners	Total
2018	139	462	237	174	1,012	4.2	13.9	7.1	5.2	30.4
2019	138	468	258	180	1,044	4.2	14.2	7.8	5.4	31.6
2020	135	468	268	172	1,043	4.2	14.5	8.3	5.3	32.3
2021	134	472	286	180	1,072	4.3	15.3	9.3	5.8	34.8
2022	133	477	308	184	1,102	4.5	16.1	10.4	6.2	37.2
2023	132	483	327	189	1,131	4.6	16.8	11.4	6.2	39.5

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialty" 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. This table includes only physicians with a caseload of more than 15 fee-for-service beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in fee-for-service Medicare Part B. 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 2024 annual report of the Boards of Trustees of the Medicare trust funds.

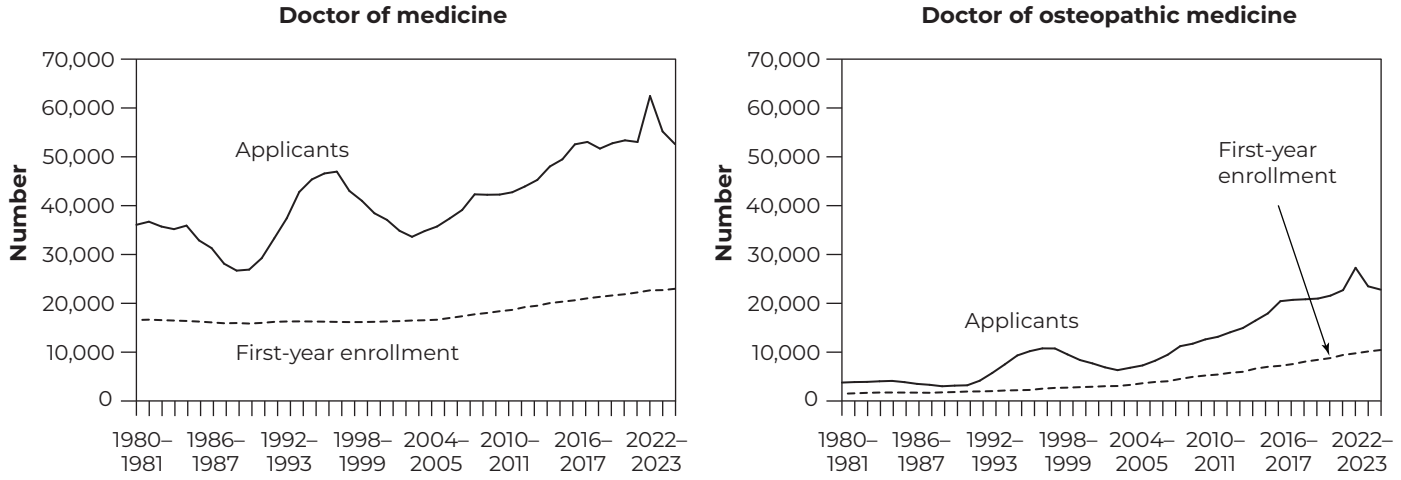
Medicare beneficiaries). We included both groups of beneficiaries because there was an assumption that all clinicians furnished services to both FFS and MA beneficiaries, so the clinician per beneficiary ratios should reflect that assumption by including all Part B beneficiaries. However, our analysis of MA encounter data indicates that a small but growing number of clinicians may see only MA beneficiaries and not beneficiaries enrolled in FFS Medicare. Since our count of clinicians is generated from FFS claims, MA-only clinicians would not be included in the numerator (i.e., count of clinicians). Including MA enrollees but not MA-only clinicians creates a mismatch between the numerator and denominator in our ratio calculation. Therefore, we have stopped including MA beneficiaries in the denominator for these calculations and now include only Part B beneficiaries enrolled in FFS Medicare. Although this measure has shortcomings because it does not provide the broadest view of how many clinicians are caring for Medicare beneficiaries, a FFS-only approach is consistent with the way we calculate encounters, service units, and allowed charges per 1,000 beneficiaries. In the future, we plan to continue analyzing MA encounter data to identify MA-only clinicians and possibly include them in future analyses of access to care.

Using our threshold, we found that the total number of clinicians billing the fee schedule between 2018 and 2023 grew from about 1.0 million to 1.1 million. Over the same period, the total number of clinicians per 1,000 FFS Medicare beneficiaries increased from 30.4 to 39.5.

While the total number of clinicians billing the fee schedule rose between 2018 and 2023, trends varied by type and specialty of clinician. Since 2018, the number of primary care physicians (which include physicians specializing in family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists) billing the fee schedule declined from 139,000 to 132,000—a net

FIGURE 4–5

First-year enrollment and the number of medical school applicants have increased over the last two decades



Note: Data were accessed on December 16, 2024. For the "doctor of medicine" figure, matriculants are referred to as "first-year enrollment" for comparability across figures.

Source: Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine.

loss of about 7,000 primary care physicians by 2023 (an average annual decline of 1.0 percent). However, the number of beneficiaries enrolled in FFS Medicare also declined over this period. As a result, the number of primary care physicians per 1,000 FFS Medicare beneficiaries increased over the period from 4.2 to 4.6. The total number of specialist physicians grew from 462,000 to 483,000, and the ratio of specialist physicians to every 1,000 beneficiaries increased from 13.9 to 16.8. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 237,000 to 327,000 (an average increase of 6.6 percent per year), or from 7.1 per 1,000 beneficiaries to 11.4 per 1,000 beneficiaries.[11] Meanwhile, the number of other practitioners, such as physical therapists and podiatrists, increased, as did the ratio of these practitioners per 1,000 beneficiaries.

Interest in becoming a clinician remains high

In the long term, access to health care also depends on new physicians and other types of clinicians entering the workforce. While less immediately related to the adequacy of fee schedule payment rates than some of our measures, we examine applications to medical school and first-year enrollment as proxies for students' interest in and ability to become a physician. To supplement this analysis, we also examine the growth of other clinician specialties, such as PAs, and the extent to which clinicians started and stopped billing FFS Medicare.

Physicians in the U.S. hold a degree as either a doctor of medicine (MD) or doctor of osteopathic medicine (DO). Despite year-to-year variations (e.g., an increase in medical school applications during the coronavirus pandemic), the long-term trend reflects an increasing number of applicants and first-year enrollees at both MD- and DO-granting educational institutions (Figure 4-5). For example, from the 1980–1981 academic year to the 2023–2024 academic year, the number of applicants to MD-granting institutions rose from about 36,000 to 53,000, an average increase of 0.9 percent per year, and the number of applicants to DO-granting institutions climbed from about 4,000 to 23,000, an average increase of 4.3 percent per year (Figure 4-5).

In addition, growth in applications and first-year enrollment has exceeded total U.S. population growth and has been faster in more recent years. For example, from the 1980–1981 academic year to the 2023–2024 academic year, first-year enrollment in MD or DO programs combined increased by an average of 1.4 percent per year compared with total U.S. population growth of 0.9 percent per year over the same period. In the most recent decade (from the 2013–2014 to the 2023–2024 academic years), first-year enrollment in MD or DO programs increased even faster (2.3 percent per year), while the total U.S. population grew more slowly (0.6 percent per year).

In addition to physicians, APRNs and PAs represent an increasingly large share of the clinician workforce, and the number of these clinicians has grown rapidly, suggesting robust interest in becoming an APRN or PA. For example, the number of certified PAs in the U.S. has quadrupled over the last two decades, increasing from about 43,500 in 2003 to 95,600 in 2013 to 178,7000 in 2023 (National Commission on Certification of Physician Assistants 2023, National Commission on Certification of Physician Assistants 2014).

After medical school, graduates complete a residency (often at a teaching hospital) where they gain additional practical training in delivering medical care. Data suggest that residency programs that train physicians to become specialists usually have an easy time filling all of their available positions, while lower-paid specialties—like family medicine, internal medicine, and pediatrics—and emergency medicine have a harder time filling all of their residency positions and end up filling many positions with international medical school graduates (Murphy 2024, National Resident Matching Program 2024).

The Commission has examined trends in the number of clinicians who stopped billing FFS Medicare, in addition to new clinicians entering the workforce. Annual changes in the number of clinicians who stop billing the fee schedule (exiting clinicians) and start billing the fee schedule (entering clinicians) could signal future access problems for beneficiaries if the number of exiting clinicians exceeds the number of entering clinicians or if there is a large increase in exiting clinicians. For each year between 2016 and 2021, the number of entering clinicians, as a share of all clinicians, was larger than the number of exiting clinicians (Medicare Payment Advisory Commission 2023c). These trends varied somewhat by specialty. In particular, the share of primary care physicians who exited was higher than the share who entered in multiple years. Nevertheless, in the aggregate, the net growth in the overall number of clinicians suggests that there is an adequate supply to treat beneficiaries.

Academic research suggests that Medicare payment rates have modest effects on physician retirements. For example, one paper found that, among 55- to 70-year-old physicians, a 10 percent increase in professional earnings driven by changes in payment rates leads to a 0.5 percentage point decline in the probability of retirement that year (Gottlieb et al. 2023).

The total number of clinician encounters per FFS beneficiary grew from 2018 to 2023

We use the quantity of beneficiaries' encounters with clinicians as another measure of access to care. We use a claims-based definition of encounters.[12] 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. In 2023, about 98 percent of beneficiaries enrolled in FFS Medicare had at least one encounter.[13]

The total number of encounters per FFS Medicare beneficiary grew from 21.8 in 2018 to 23.2 in 2023 (Table 4-2), and the average annual growth rate was 1.3 percent over that period.

The change in the number of encounters per FFS beneficiary varied by specialty and type of provider. For instance, the number of encounters per FFS beneficiary furnished by primary care physicians declined from 2018 to 2023, and the number of per beneficiary encounters provided by other types of clinicians was either stable or increased (Table 4-2).[14] Encounters with APRNs and PAs grew the fastest. Encounters with all types of clinicians declined from 2019 to 2020 due to the effects of the pandemic. These encounters started increasing in 2021, except for encounters with primary care physicians, which remained flat through 2023.

Encounters per beneficiary with primary care physicians fell by an average of 5.9 percent annually from 2018 to 2022. During this period, these

TABLE 4–2

Total encounters per FFS beneficiary were higher in 2023 compared with 2018, and the mix of clinicians furnishing them changed

	Encounters per FFS beneficiary						Percent change	
Specialty category	2018	2019	2020	2021	2022	2023	Average annual 2018–2022	2022–2023
Total (all clinicians)	21.8	22.3	19.8	21.6	22.3	23.2	0.5%	4.3%
Primary care physicians	4.0	3.5	3.1	3.1	3.1	3.1	–5.9	–0.1
Specialists	12.8	12.9	11.4	12.3	12.4	12.8	–0.6	2.7
APRNs/PAs	2.2	2.5	2.4	2.7	3.0	3.3	7.9	10.1
Other practitioners	3.3	3.4	2.9	3.5	3.7	4.0	3.1	8.6

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define an "encounter" as a unique combination of beneficiary identification number, claim identification number (for paid claims), and the national provider identifier of the clinician who billed for the service. We use the number of FFS Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. 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. 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 beneficiaries and 2024 annual report of the Boards of Trustees of the Medicare trust funds.

encounters declined by 12.7 percent from 2018 to 2019 and another 11.1 percent from 2019 to 2020; the decline has remained flat since then, falling by just 0.1 percent in 2023.

After declining 11.8 percent from 2019 to 2020 (from 12.9 to 11.4), encounters per beneficiary with specialists grew by 8 percent in 2021 (to 12.3). By 2023, encounters with specialist physicians had almost returned to prepandemic levels, after growing by 2.7 percent from 2022 to 2023.

The largest increase in encounters was among APRNs and PAs, which grew by an average of 7.9 percent from 2018 to 2022 and by 10.1 percent in 2023. There was broad growth across different types of services in APRN and PA encounters: From 2022 to 2023, APRNs and PAs delivered 10.6 percent more E&M services, 14.9 percent more "other procedures," 9.7 percent more treatment services, 12.4 percent more imaging, and 12.7 percent more tests (APRNs and PAs furnish services in both primary care and non–primary care practices) (data not shown).

The number of encounters with APRNs and PAs has grown rapidly, yet we are likely undercounting the number of fee schedule encounters provided by these clinicians due to "incident-to" billing. Medicare allows services furnished by APRNs and PAs to be indirectly billed as "incident-to" a physician visit, using the national provider identifier of a supervising physician if certain conditions are met. One study used Medicare claims data to estimate that in 2018, about 40 percent of office visits provided by APRNs and PAs were indirectly billed incident to a physician visit (Patel et al. 2022), which is consistent with the Commission's own research on this topic (Medicare Payment Advisory Commission 2019). The Commission has previously recommended that the Congress require APRNs and PAs to bill Medicare directly, eliminating incident-to billing for services they provide, which would allow a more accurate count of the number of beneficiary encounters with different types of clinicians (Medicare Payment Advisory Commission 2019). These changes would also enable policymakers to better understand whether services provided by APRNs and PAs are

TABLE 4–3

Encounters per FFS beneficiary across service types, 2018–2023

Type of service	Encounters per FFS beneficiary			Percent change	
	2018	2022	2023	Average annual 2018–2022	2022–2023
Total (all services)	21.8	22.3	23.2	0.5%	4.3%
Evaluation and management	12.9	13.0	13.5	0.2	3.4
Major procedures	0.2	0.2	0.2	–0.2	2.4
Other procedures	2.3	2.3	2.4	0.0	4.2
Treatments	2.5	2.9	3.2	3.5	9.0
Imaging	4.2	4.1	4.3	0.1	3.5
Tests	2.0	2.0	2.1	0.0	4.9
Anesthesia	0.5	0.5	0.6	–0.3	2.6

Note: FFS (fee-for-service). We define an "encounter" as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service. We use the number of FFS Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Values by type of service do not sum to totals 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 calculations were made on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

substituting for physician primary care visits or specialty care services.

After a period of relatively slow growth during the pandemic, beneficiaries experienced a return to rapid growth in the number of encounters for most types of medical services. From 2018 to 2022, the number of encounters per beneficiary increased for most types of services, but growth was restrained by the effects of the pandemic (Table 4-3). From 2022 to 2023, encounters grew more rapidly, with some differences across broad service categories. For example, the number of E&M encounters per beneficiary (which includes E&M office visits, hospital outpatient visits, and services provided during an inpatient stay) provided by all clinicians rose 3.4 percent, from 13.0 to 13.5. Over the same period, encounters for major procedures grew at the smallest rate (2.4 percent), while encounters involving treatment (such as physical therapy, treatment for cancer, and dialysis)[15] had the highest growth rate (9.0 percent).

Quality of clinician care is difficult to assess

The quality of care provided by individual clinicians is difficult to assess for a few reasons. First, Medicare does not collect clinical information (e.g., blood pressure, lab results) or patient-reported outcomes (e.g., improving or maintaining physical and mental health) at the FFS beneficiary level. Second, CMS measures the performance of clinicians using the Merit-based Incentive Payment System (MIPS), which, in March 2018, the Commission recommended eliminating because it is fundamentally flawed (Medicare Payment Advisory Commission 2018b). For example, MIPS allows clinicians to choose what measures to report from a catalog of hundreds of measures, which makes it harder to compare clinicians since only a few clinicians may report any given measure. Also, many clinicians are exempt from reporting quality data for MIPS (e.g., if they see 200 or fewer Medicare beneficiaries or bill Medicare for $90,000 worth of services or less), so there is

TABLE 4–4

Distribution of risk-adjusted rates of ambulatory care–sensitive hospitalizations and emergency department visits across hospital service areas, 2023

	Risk-adjusted 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	22.3	31.4	42.7	1.9
Ambulatory care–sensitive ED visits	38.2	60.5	89.6	2.3

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-adjusted 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 HSA with fewer than 1,000 FFS Medicare beneficiaries.

Source: Analysis of 2023 FFS Medicare claims data.

a sizable share of clinicians for whom CMS has no quality information. Third, for claims-based measures, Medicare's incident-to policies obscure the ability to determine who actually performed a service because a substantial portion of services performed by APRNs and PAs appear in claims data to have been performed by physicians. As noted above, in June 2019, the Commission recommended requiring APRNs and PAs to bill the Medicare program directly.

We report on the quality of the ambulatory care environment for beneficiaries in FFS Medicare using outcome measures that assess ambulatory care–sensitive (ACS) hospitalizations and emergency department (ED) visits, as well as patient-experience measures (using the Consumer Assessment of Healthcare Providers and Systems (CAHPS)). This approach is consistent with the Commission's principles for quality measurement (Medicare Payment Advisory Commission 2018a).

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

The Commission worked with a contractor to develop two claims-based outcome measures—ACS hospitalizations and ED visits—to compare quality of care within and across different populations (e.g., FFS Medicare in different local market areas), given the adverse impact on beneficiaries and high cost of these events (RTI International 2024). 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 entails hospital use that could have been prevented with timely, appropriate, high-quality care. For example, if a diabetic patient's primary care physician and overall care team work effectively to control the patient's condition, an ED visit for a diabetic crisis could be avoidable. However, measure results may also reflect differences in health care access, referral patterns, and specialist availability across markets areas. The measures also may not pinpoint the exact areas in ambulatory care where improvements are needed.

Consistent with previous years, in 2023, the distribution of risk-adjusted rates of avoidable hospitalizations and ED visits per 1,000 FFS Medicare beneficiaries varied widely across Dartmouth Atlas Project–defined hospital service areas (HSAs).[16] This variation signals opportunities to improve the quality of ambulatory care (Table 4-4). The HSA at the 90th percentile of ACS hospitalizations had a rate that was almost twice the HSA at the 10th percentile. The HSA at the 90th percentile of ACS–ED visits had a rate that was 2.3 times the HSA in the 10th percentile. Relatively poor

performance on a local market's ACS-hospitalization and ED-visit measures indicates opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can indicate best practices for ambulatory care systems.

The median risk-adjusted ACS-hospitalization and ED-visit rates per HSA increased (worsened) from 2021 to 2023 but remained below prepandemic rates (data not shown). For example, in 2019 the median ACS ED–visit rate per HSA was 75 per 1,000 FFS beneficiaries, which declined to 54.2 per 1,000 FFS beneficiaries in 2021 but rose in 2023 with a median rate of 60.5 per 1,000 FFS beneficiaries in 2023. During the coronavirus pandemic, there was a significant drop in overall ED visits due to people avoiding hospitals for noncritical issues, so we would expect some accompanying decline in ACS ED visits. ACS ED–visit rates remain below prepandemic levels, and it is difficult to untangle whether and how much of the decline in these visits is due to these and other changes in ED use or because of improved access to or quality of care.

Consistent with prior years, we have found differences in rates of ACS hospitalizations and ED visits across groups of Medicare beneficiaries, which could indicate differential access to high-quality ambulatory care (Medicare Payment Advisory Commission 2023b). In 2023, beneficiaries receiving the Part D low-income subsidy (a proxy for low income) had ACS hospitalization and ED visit rates that were 1.3 times higher than those of other beneficiaries. Black beneficiaries had a rate of ACS hospitalizations that was 1.6 times higher than that of Asian/Pacific Islander beneficiaries and a rate of ACS ED visits that was almost two times higher than that of Asian/Pacific Islander beneficiaries. Beneficiaries residing in rural areas had about the same ACS hospitalization rate as beneficiaries living in urban areas. However, beneficiaries in rural areas had ACS ED–visit rates that were 1.4 times higher than beneficiaries residing in urban areas.

Patient-experience scores

The Agency for Healthcare Research and Quality's CAHPS surveys generate standardized and validated measures of patient experience. 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 and how often it happened, from the patient's perspective. 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 to measure beneficiaries' experience of care with Medicare and their FFS providers.

Between 2022 and 2023, FFS–CAHPS scores were relatively stable. The 2023 FFS–CAHPS score for "getting needed care and seeing specialists" was 80 (score on a scale of 0 to 100), which was the same as in 2022, but the score has been trending downward over the past several years (Table 4-5). The score for "rating of health plan (FFS Medicare)" was 83, and the score for "rating of health care quality" was 85; both scores have been stable over the past few years. In 2023, 73 percent of surveyed beneficiaries reported receiving an annual flu vaccine, which was a decline of 4 percentage points from 2022. All 2023 FFS–CAHPS measure scores for urban residents were similar to the national average (Centers for Medicare & Medicaid Services 2024e). FFS–CAHPS measure scores for rural residents were similar to the national average, except for the annual flu vaccine rate, which was below the national average (data not shown).

Clinicians' revenues and compensation have increased, while inflation has been higher than usual

Clinicians do not submit annual cost reports to CMS, so we are unable to calculate their profit margins from delivering services to Medicare beneficiaries or to their full panel of patients more generally. Instead, we rely on indirect measures of how clinicians' payments compare with the costs of providing services. We find that clinician compensation has grown in recent years, but that Medicare payment-rate updates have grown more slowly than clinicians' input-cost growth, especially in the last few years. We also find that the volume and intensity of clinician services per FFS beneficiary have increased substantially over time, suggesting that below-MEI updates have not impeded access to date. Increased volume and intensity have also resulted in markedly higher physician fee schedule spending over time.

TABLE 4–5

Medicare FFS–CAHPS performance scores, 2019–2023

CAHPS composite measure	2020	2021	2022	2023	Score change, 2022–2023
Getting needed care and seeing specialists	83	81	80	80	0
Getting appointments and care quickly	78	76	75	82	N/A*
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	85	85	85	86	1
Rating of health plan (FFS Medicare)	84	83	83	83	0
Rating of health care quality	86	85	85	85	0
Annual flu vaccine	77	77	77	73	–4

Note: FFS (fee-for-service), CAHPS (Consumer Assessment of Healthcare Providers and Systems), N/A (not applicable). Questions in Rows 1 to 3 have response options of "never," "sometimes," "usually," and "always." CMS converts these responses to linear mean scores on a 0 to 100 scale. Questions in Rows 4 and 5 have responses of 1 to 10, which CMS also 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 FFS Medicare program. FFS–CAHPS response rates from 2019 to 2023 range from 28 percent to 29 percent. CMS halted collection of the 2019 beneficiary experience survey at the start of the coronavirus pandemic in 2020; thus we do not include 2019 scores.
* CMS revised which CAHPS survey items are scored in the "getting appointments and care quickly" composite measure, which may cause fluctuation in scores compared with prior years. Therefore, we do not report the change in scores over time.

Source: FFS–CAHPS mean scores reported by CMS.

Medicare's conversion factor has not grown in recent years, but payment rates for E&M visits have increased substantially

Payment rates are updated each year by updating the fee schedule's conversion factor.[17] (Increasing the conversion factor by 1 percent, for example, results in a 1 percent increase to payment rates.) In most years, the update to the conversion factor reflects two factors: (1) a percentage specified in statute (which may be zero) and (2) a budget-neutrality adjustment if necessary. The statutorily required budget-neutrality adjustment is a percentage calculated by CMS to ensure that any changes it has made to the relative values of specific billing codes in the fee schedule do not, in and of themselves, increase or decrease total fee schedule spending. During years in which the relative values for some services are increased, for example, and CMS anticipates these changes would result in an increase in total fee schedule spending, a negative budget-neutrality adjustment is made to offset those costs. The net effect of an increase in relative values for some services and an across-the-board downward adjustment in the conversion factor redistributes fee schedule spending among different services but does not increase or decrease expected total spending.

Statutory updates to the conversion factor are currently specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (shown in the "Update" rows of Table 4-6 (p. 124)). MACRA specified that clinicians' payment rates were to be updated by 0 percent from 2020 to 2025. Starting in 2026, payment rates will increase by 0.75 percent per year for qualifying clinicians in advanced alternative payment models (A–APMs) and by 0.25 percent per year for all other clinicians.[18] (Examples of A–APMs include accountable care organization models that require providers to take on some financial risk.)

In 2021, CMS increased the payment rates for many office and outpatient E&M visits upon the

TABLE 4–6

Physician fee schedule payment-rate updates, adjustments, and bonuses under current law

	2021	2022	2023	2024	2025	2026 and later
A–APM clinicians						
Update	0%	0%	0%	0%	0%	0.75%
A–APM bonus (not cumulative)	5%	5%	5%	5%	3.5%	1.88%*
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
MIPS adjustments (not cumulative)**	(–7% to +1.8%)	(–9% to +1.9%)	(–9% to +2.3%)	(–9% to +8.3%)	(–9% to TBD)	(–9% to TBD)
All clinicians						
Payment increase (not cumulative)	3.75%	3.0%	2.5%	1.25% and then 2.93%	N/A	N/A
Sequestration (not cumulative)	0%	0% (3 months), –1% (3 months), –2% (6 months)	–2%	–2%	–2%	–2%

Note: A–APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System), TBD (to be determined), N/A (not applicable). "Not cumulative" adjustments apply in a given year only and are not included in subsequent years' payment rates. A–APM bonuses and MIPS adjustments are based on clinicians' A–APM participation 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 (1) the updates specified in law (e.g., 0 percent plus a one-time increase of 2.93 percent in the latter part of 2024); (2) expiration of one-time increases (e.g., the one-time increase of 2.5 percent in 2023); (3) CMS's budget-neutrality adjustment (e.g., –2.2 percent in 2024), which ensures that changes to the relative values of particular billing codes in the fee schedule do not change total physician fee schedule spending by more than $20 million (not shown); and (4) the –2 percent sequester (which applies for one year at a time and is not built into subsequent years' payment rates). The fee schedule update in 2024 equaled 1.25 percent from January 1, 2024, through March 8, 2024, and was replaced by an update of 2.93 percent from March 9, 2024, through December 31, 2024, at which point the update expired.
* The A–APM bonus is worth 1.88 percent in 2026 and is then not available in subsequent years.
** The maximum positive MIPS adjustments shown for 2021 through 2024 are the highest adjustments actually made in those years, while the maximum adjustments for 2025 and 2026 are yet to be determined.

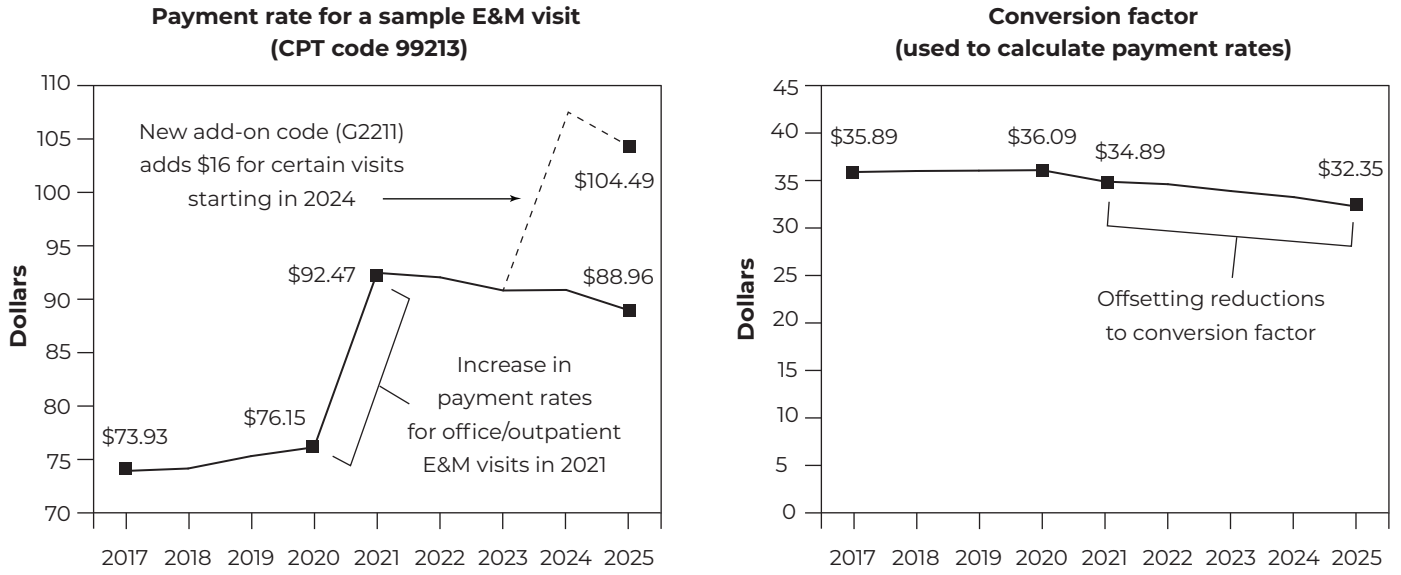
Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); the Coronavirus Aid, Relief, and Economic Security (CARES) Act; the Consolidated Appropriations Act, 2021; An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes; the Protecting Medicare and American Farmers from Sequester Cuts Act; and the Consolidated Appropriations Act, 2023; also CMS's final rules for the physician fee schedule for the payment years shown.

recommendation of the AMA/Specialty Society Relative Value Scale Update Committee. Increasing the payment rates for these billing codes required an offsetting –6.8 percent budget-neutrality adjustment to the fee schedule's conversion factor so that the change in payment rates for E&M visits did not increase expected spending under the fee schedule. To avoid a reduction of this size to the conversion factor (and, thus, to payment rates) in 2021, the Congress subsequently passed laws that provided a series of temporary increases to the conversion factor from 2021 through 2024 (shown in the "Payment increase (not cumulative)" row of Table 4-6). These increases effectively phased in the 6.8 percent reduction to the conversion factor over time. As a result, payment rates for office and outpatient E&M visits (which are provided by a wide variety of clinicians) have increased substantially (shown at left in Figure 4-6), while the conversion factor has gradually declined (shown at right in Figure 4-6).

In 2024, part of the 3.4 percent decline in the conversion factor that year (captured at right in Figure 4-6) is also offsetting the cost of a new add-on code that will add another $16 to the payment rate for office/outpatient E&M visits provided by clinicians

FIGURE 4–6

An increase to payment rates for office/outpatient E&M visits and a new add-on payment for certain office visits required offsetting decreases to the physician fee schedule's conversion factor



Note: E&M (evaluation and management), CPT (Current Procedural Terminology). The "office/outpatient E&M visit" code set refers to CPT codes 99202–99205 (new patients) and 99211–99215 (established patients). CPT code 99213 refers to a visit involving a low level of medical decision-making; if time is used for code selection, 20–29 minutes are spent on the date of the encounter. Payment rates shown for 99213 are nonfacility national payment rates. G2211 is an add-on code available to be billed with office/outpatient E&M visit codes when a clinician has a longitudinal relationship with a patient and meets other requirements.

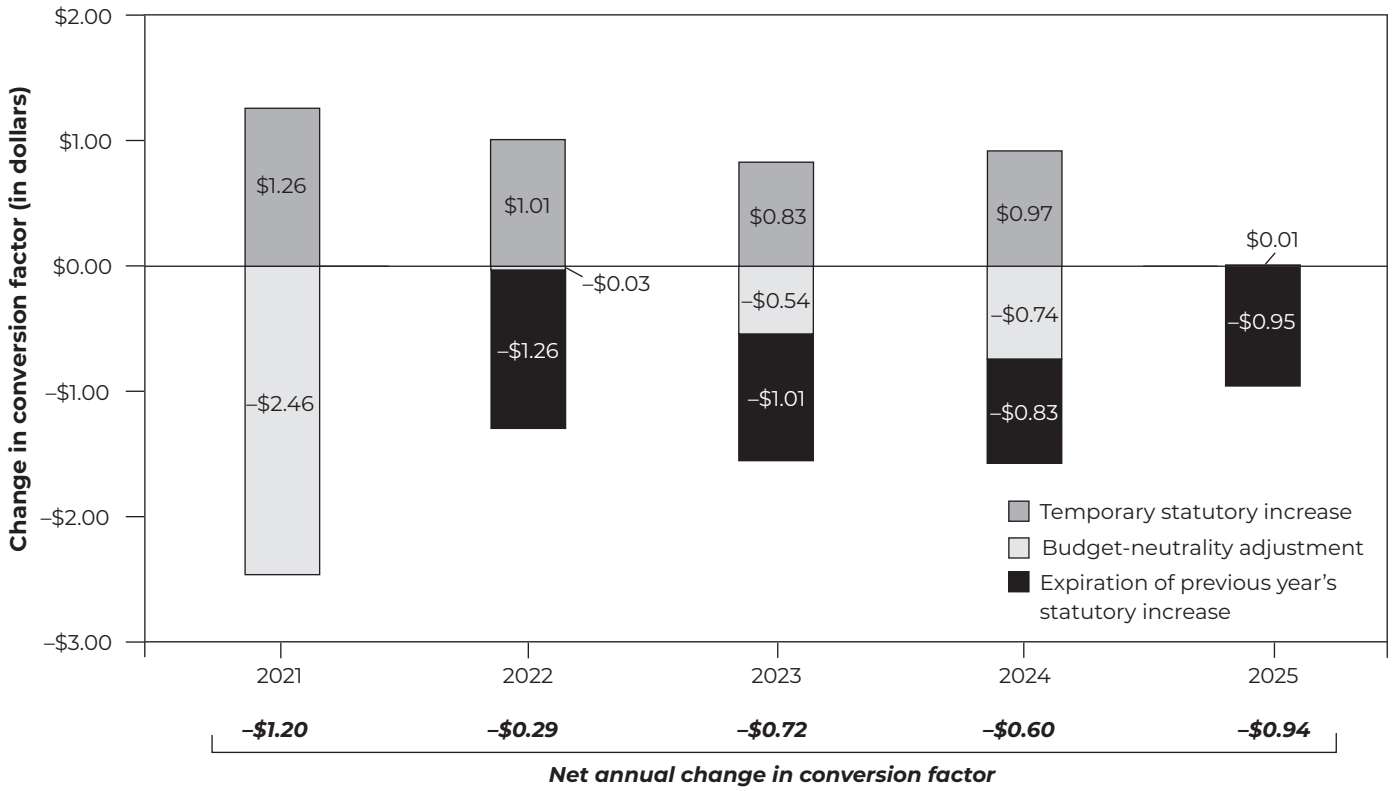
Source: CMS. Search the physician fee schedule (interactive billing code–payment rate look-up website), https://www.cms.gov/medicare/physician-fee-schedule/search/overview.

who have an ongoing relationship with a patient (shown as the dotted line in Figure 4-6). This add-on code is expected to be used by primary care clinicians and by specialists treating a patient's serious or complex medical condition (Centers for Medicare & Medicaid Services 2023b).

Figure 4-7 (p. 126) shows net annual changes in the conversion factor resulting from budget-neutrality adjustments, temporary one-year increases over the 2021 to 2025 period, and the expiration of those temporary increases.

Figure 4-7 (p. 126) shows that in 2021, when CMS substantially increased relative values for several commonly performed E&M services, the increase in payment rates for these services (combined with other adjustments) required a budget-neutrality adjustment of –$2.46. This adjustment was partially offset by an increase of $1.26, resulting from the Congress's temporary statutory increase of 3.75 percent in 2021, for a net change in the conversion factor of –$1.20 that year. In 2022, a net change in the conversion factor of –$0.29 was due to the combined effects of the expiration of the 2021 temporary increase (–$1.26), a small budget-neutrality adjustment (–$0.03), and the Congress's temporary statutory increase of 3 percent ($1.01). For 2023, a net change in the conversion factor of –$0.72 resulted from the combined effects of the expiration of the 2022 temporary increase (–$1.01), a budget-neutrality adjustment (–$0.54) from additional increases in E&M values, and the Congress's temporary statutory increase of 2.5 percent ($0.83). In 2024, the net $0.60 decline in the conversion factor resulted from the expiration of the previous year's temporary increase (–$0.83), another temporary increase ($0.97), and a budget-neutrality adjustment (–$0.74) to offset

FIGURE 4–7 **Recent declines in the conversion factor result from several countervailing effects**



Note: Changes shown for 2025 are based on information published in the final rule for the physician fee schedule for that payment year. Components may not sum to totals due to rounding.

Source: Centers for Medicare & Medicaid Services 2024b, Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2022, Centers for Medicare & Medicaid Services 2021, Centers for Medicare & Medicaid Services 2020.

the cost of a new add-on code that added $16 to the payment rate for office/outpatient E&M visits provided by clinicians who have an ongoing relationship with a patient.

Under current law, there is no scheduled update to the conversion factor for 2025. If there are no statutory changes, in 2025 the conversion factor will be reduced by $0.94, which would result from the expiration of the temporary 2.93 percent increase in the latter part of 2024 (–$0.95) and a very small positive budget-neutrality adjustment ($0.01). In 2025, the conversion factor will be $3.74 less than what it was in 2020 (data not shown).

Allowed charges per FFS beneficiary grew at a higher rate from 2022 to 2023 than during previous years

Despite the recent reduction in the conversion factor, the total payments that clinicians received per FFS beneficiary grew from 2022 to 2023, in part because of increases in the volume and/or intensity of services they deliver. We measure the total payments a clinician receives using allowed charges (which include Medicare payments and beneficiary cost-sharing liabilities) for services furnished to FFS beneficiaries that are paid under the physician fee schedule.[19]

From 2022 to 2023, across all services, allowed charges per beneficiary rose by 4.2 percent (Table 4-7).

TABLE 4–7 **Growth in allowed charges per FFS beneficiary varied by type of service, 2018–2023**

Type of service	Change in units of service per FFS beneficiary		Change in allowed charges per FFS beneficiary		Share of allowed charges, 2023
	Annual average 2018–2022	2022–2023	Annual average 2018–2022	2022–2023	
All services	**1.3%**	**5.4%**	**2.2%**	**4.2%**	**100.0%**
Evaluation and management	0.3	3.5	2.8	4.2	51.7
Imaging	0.5	3.8	1.3	4.2	10.8
Major procedures	–0.5	2.1	–0.5	–0.1	6.9
Other procedures	0.7	5.1	1.5	3.7	12.7
Treatments	5.8	11.5	4.4	7.2	10.2
Tests	0.3	5.2	1.1	4.9	4.8
Anesthesia	–0.5	2.3	–0.9	0.3	2.5

Note: FFS (fee-for-service). We use the number of FFS Medicare beneficiaries enrolled in Part B to define units of service and allowed charges per beneficiary. The Restructured BETOS Classification System (RBCS) is used to group clinically similar services into categories and subcategories.

Source: MedPAC analysis of Medicare claims data for 100 percent of FFS beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

Among broad service categories, growth rates were 4.2 percent for E&M services, 4.2 percent for imaging services, 3.7 percent for other procedures (i.e., procedures that are not considered major procedures), 7.2 percent for treatments, 4.9 percent for tests, and 0.3 percent for anesthesia. Allowed charges per beneficiary for major procedures fell by 0.1 percent. Growth in all categories was higher in 2023 than it was during the 2018 to 2022 period. This period included slow or negative growth during the pandemic, but spending largely rebounded in 2021 and 2022. For most categories, the growth in allowed charges in 2023 was also higher than the average annual rate of growth in the years immediately prior to the pandemic, which averaged 2.0 percent from 2015 to 2019 (data not shown). The exceptions were major procedures and anesthesia, which declined or grew more slowly from 2022 to 2023 than they did over the 2015 to 2019 period.

We also present data on changes in units of service per beneficiary. For most types of service, a unit represents one individual service, such as an office visit, surgical procedure, or imaging scan. As measured by units of service per beneficiary, the volume of clinician services grew more quickly over the 2022 to 2023 period (5.4 percent) than it did in 2018 to 2022 (1.3 percent per year), which included the pandemic, during which volume for various types of services experienced relatively slow growth or declined (Table 4-7). Volume growth during both periods varied by type of service, but growth rates for all types of service were higher in 2023 than during the 2018 to 2022 period.

The similarity of overall volume and spending growth in 2023 suggests that much of the growth that year was driven by increased volume. Spending can also be affected by increased intensity of the services being delivered, which often does not result in changes in volume. For example, if providers substitute computed tomography (CT) scans with contrast for CT scans without contrast, the allowed charges for imaging services would increase at a higher rate than would units of service for imaging. Differences in allowed charges from volume may also be partly attributable to increases or decreases in Medicare's payment rates for

certain services, such as the recent increases in rates for E&M services. Decreases in allowed charges relative to service volume can also be related to the shift of services from freestanding offices to the outpatient hospital setting, where fee schedule payments are generally still made but payment rates are lower.

Among the broad service categories shown in Table 4-7 (p. 127), treatments had the highest rate of growth in allowed charges and units of service. The treatments category includes services such as administration of dialysis and cancer treatments, physical therapy, and spinal manipulation. Increases in physical, occupational, and speech therapy services were the primary drivers of growth: Spending per beneficiary on these types of treatments rose by 13.5 percent from 2022 to 2023 and grew by more than 60 percent over the 2018 to 2023 period (data not shown). The increase in allowed charges in the treatment category is mirrored by increases in service units for these types of services. The growth in volume and spending may be related to provisions in the Bipartisan Budget Act of 2018, which eliminated annual caps on spending for therapy services for each beneficiary unless a medical exemption was granted. Providers that exceed a specified spending threshold are now permitted to attest to medical necessity by including a modifier on the claims.

Over the same five-year period, spending per beneficiary for major procedures decreased. The decline in spending among major procedures was largely driven by changes in major digestive/gastrointestinal procedures and vascular procedures (average of –4.6 percent and –1.0 percent, respectively). There was also a decline in spending per beneficiary for other (i.e., nonmajor) vascular procedures (average of –3.6 percent). The number of services per beneficiary and payment rates for many of these procedures have declined since 2018, but the number of gastroenterologists and vascular surgeons billing FFS Medicare has been stable.

Average payment rates of private-insurance PPOs grew faster than, and remained 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 and avoid those with FFS Medicare coverage. For this analysis, we used data on paid claims for enrollees of preferred provider organization (PPO) health plans that are part of a large national insurer that covers a wide geographic area across the U.S.[20] In 2023, the average PPO payment rate for clinician services was 140 percent of FFS Medicare's average payment rate, up from 136 percent in 2022.

The ratio in 2023, as in prior years, varied by type of service. For example, private-insurance rates were 109 percent of Medicare rates for care-management and coordination E&M visits but 203 percent of Medicare rates for CT scans.

The gap between private-insurance rates and Medicare rates has grown over time as Medicare rates have increased more modestly than private-insurance rates: In 2011, private-insurance rates were 122 percent of Medicare rates. However, as we noted earlier, clinicians accept Medicare at rates similar to those of private insurance, and some academic research suggests that increasing Medicare fee schedule rates might not necessarily narrow the gap between Medicare and private-insurance rates. Specifically, one paper found that a $1.00 increase in Medicare rates led to a corresponding $1.16 increase in private-insurance rates (Clemens and Gottlieb 2017).

The growth in private-insurance rates may result in part from 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 (Medicare Payment Advisory Commission 2020). In recent years, the share of physicians in larger groups and employed by hospitals has risen substantially (Kane 2023). For example, according to an AMA survey, from 2012 to 2022, the share of physicians who were either directly employed by a hospital or part of a practice with hospital ownership increased from about 29 percent to 41 percent (Kane 2023).

Studies have found that private-insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation (Capps et al. 2018, Clemens and Gottlieb 2017, Neprash et al. 2015). Similarly, the Commission has found that independent practices with larger market shares and hospital-owned practices have received higher private-

insurance rates for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). The AMA survey found that the most cited reason physicians gave for selling their practice to a hospital was to enhance their ability to negotiate higher payment rates with payers (cited by 80 percent of physicians working in practices acquired by hospitals); other commonly cited reasons were to improve access to costly resources and get help complying with payers' regulatory and administrative requirements (cited by about 70 percent of respondents in these practices) (Kane 2023).[21]

Compensation and productivity data indicate that clinicians who work in hospital-owned practices do not necessarily earn higher compensation, but they do tend to see fewer patients and bill for fewer services than clinicians in physician-owned practices (Medical Group Management Association 2024, Medical Group Management Association 2023, Medical Group Management Association 2022, Whaley et al. 2021). A Medscape survey of employed physicians found that the most appealing aspects of working as an employed physician were not having to run a small business, having stable income, not having to pay for malpractice insurance, good work–life balance, working with large teams and staff, and having to spend less time on rules and regulations. The top drawbacks cited were having less autonomy, having to comply with more workplace rules, having less income potential, having to meet mandatory performance targets, lack of job security, and not being as productive as they would like (McKenna 2022).

Clinician compensation is increasing

Since the Commission lacks data that would allow us to calculate clinicians' all-payer profit margins from delivering services, we use clinician compensation data as a rough proxy for all-payer profitability. Clinician compensation levels indicate that total revenues are greater than costs and that providing clinician services is therefore profitable. These compensation levels also give some assurance that there is an incentive for individuals to pursue careers as clinicians. We note, however, that Medicare constitutes only a portion of the revenue most clinicians receive since clinicians usually accept a variety of types of insurance and many employed physicians' compensation may not be directly tied to fee schedule payments—making clinician compensation an indirect measure of Medicare's payment adequacy. That said, academic research suggests that changes in Medicare fee schedule payment rates directly affect physician earnings. One study found that a 10 percent increase in Medicare payment rates led to a 2.4 percent increase in professional earnings of 40- to 55-year-old physicians (Gottlieb et al. 2023).

According to SullivanCotter's latest clinician compensation and productivity surveys, after the high rate of growth observed in median physician compensation from 2021 to 2022 (9 percent), physician compensation grew at a more typical rate from 2022 to 2023 (3 percent).[22,23]

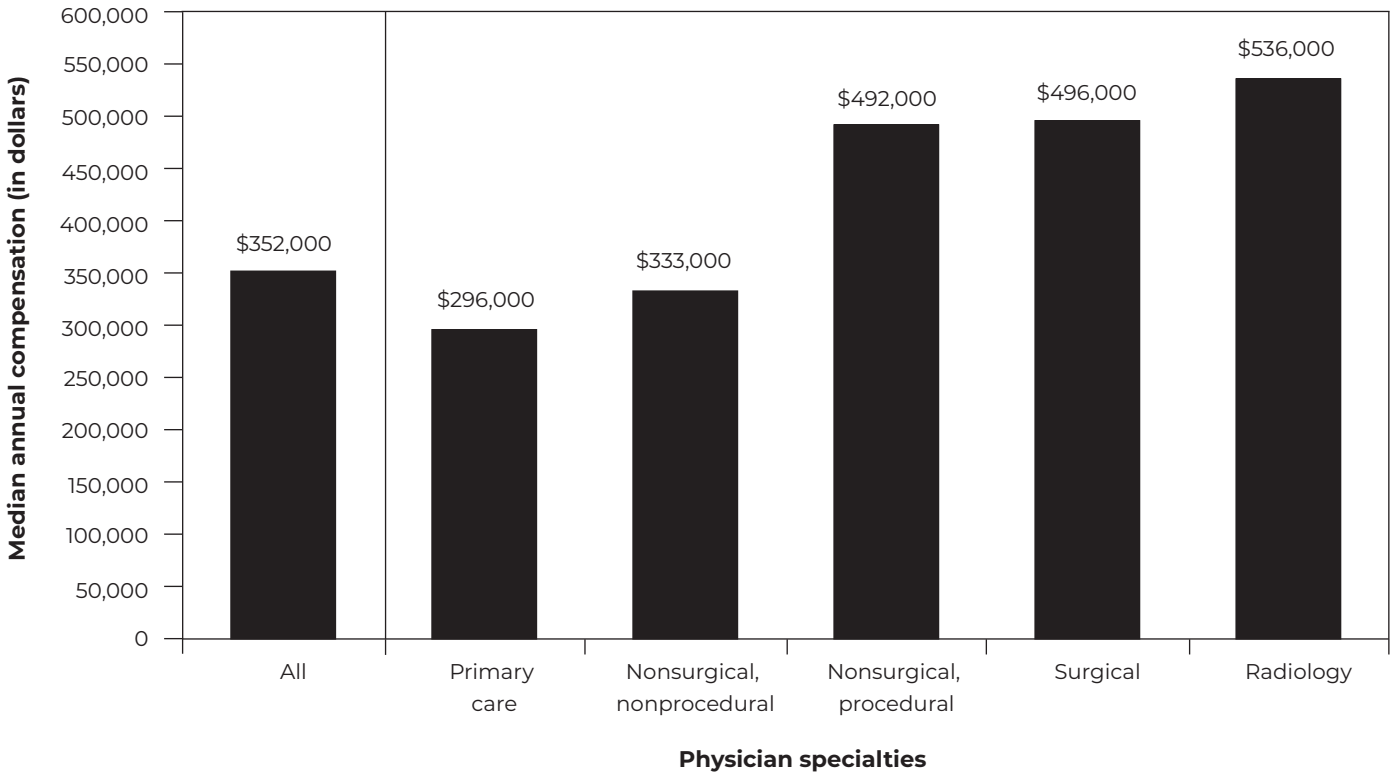
Over a longer, four-year period from 2019 to 2023, physician compensation grew by an average of 3.3 percent per year. (As a point of reference, inflation averaged 4.5 percent per year over this period.) There was substantial variation across physician specialties over this period: Compensation grew more quickly for a number of specialties that mainly provide E&M office visits, such as family medicine (5.0 percent per year, on average), rheumatology (4.8 percent), internal medicine (4.7 percent), and neurology (4.6 percent). Compensation grew more slowly for specialties like pulmonology (1.2 percent), ophthalmology (2.2 percent), nephrology (2.4 percent), radiology (2.5 percent), and dermatology (2.5 percent).[24]

Median compensation for advanced practice providers (e.g., NPs, PAs) grew twice as fast as physician compensation from 2022 to 2023 (6 percent), in line with the growth rate observed from 2021 to 2022 (5 percent). From 2019 to 2023, compensation for advanced practice providers grew by an average of 4.4 percent per year (keeping pace with inflation).

By 2023, compensation for the median physician was $352,000, and compensation for the median advanced practice provider was $138,000.[25] As shown in Figure 4-8 (p. 130), physician compensation varied substantially by specialty, with the median primary care physician earning much less ($296,000) than the median physician in a surgical specialty ($496,000). In contrast, compensation differences for advanced practice providers in different specialties were much smaller, with only about $25,000 separating the median clinician in the highest- and lowest-paid specialties (data not shown).

FIGURE 4–8

Compensation for primary care physicians is lower than for most specialists, 2023



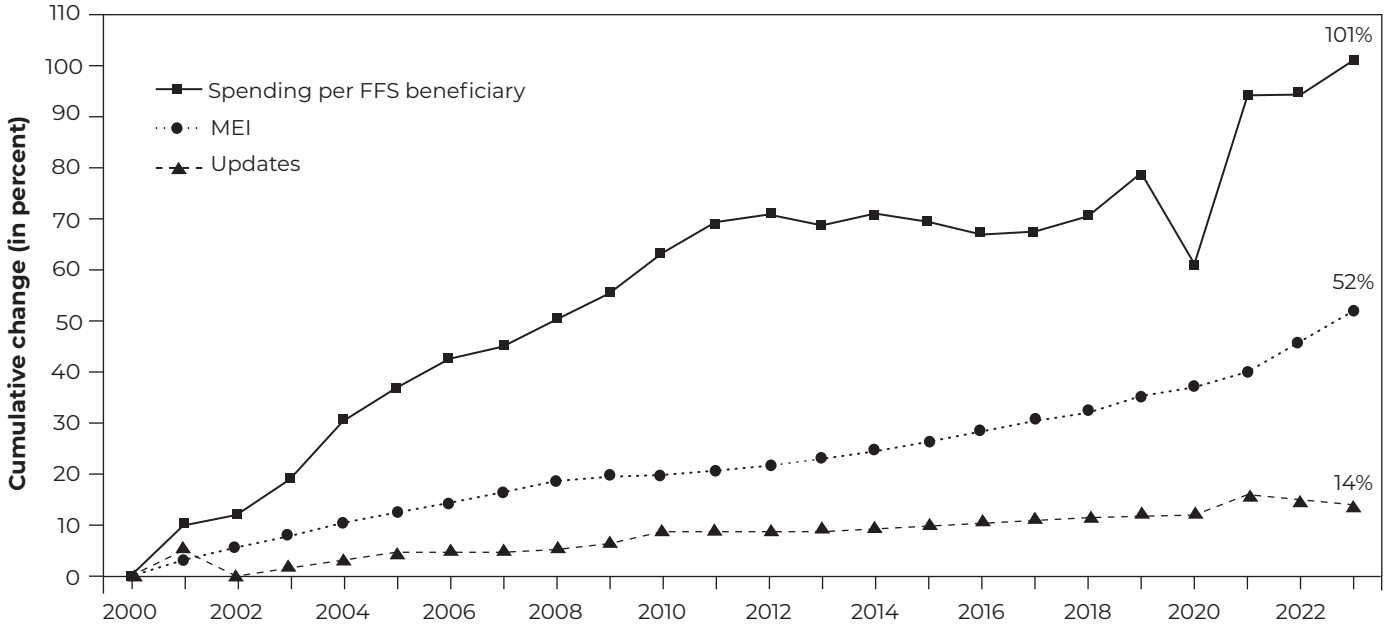
Note: Figure includes all physicians who reported their 2023 annual compensation in the survey (*n* = 115,610). All numbers are rounded to the nearest thousand. "Compensation" refers to median total cash compensation adjusted to reflect full-time work and does not include employer retirement contributions or payments for benefits. The "primary care" group includes family medicine, internal medicine, and general pediatrics. The "nonsurgical nonprocedural" group includes psychiatry, emergency medicine, hospital medicine, endocrinology and metabolism, nephrology and hypertension, neurology, physical medicine and rehabilitation, rheumatology, and other internal medicine/pediatrics. The "nonsurgical procedural" group includes cardiology, dermatology, gastroenterology, pulmonology, and hematology/oncology. The "surgical" group includes general surgery, orthopedic surgery, cardiovascular and cardiothoracic surgery, neurological surgery, ophthalmology, otolaryngology, urology, obstetrics/gynecology, and other surgical specialties. Certain nonsurgical nonprocedural specialties (endocrinologists, rheumatologists, psychiatrists) had lower median compensation than primary care physicians.

Source: SullivanCotter's Physician Compensation and Productivity Survey, 2024.

The large compensation disparity between primary care physicians and most specialists may help explain why a declining share of physicians are pursuing careers in primary care. However, primary care physicians' incomes have been increasing more quickly than other specialties over the past few years, perhaps due in part to recent increases to payment rates for some billing codes commonly used by primary care providers and new codes that have been added to the Medicare physician fee schedule that are geared toward primary care providers. Primary care physicians' compensation has the potential to continue to increase in 2025, when new per beneficiary payments will become available to pay for a wide variety of advanced primary care management services such as coordinating care transitions and communicating with patients by email. These new payments will range from $15 to $110 per beneficiary per month, depending on a patient's number of chronic conditions and whether they are dually enrolled in Medicare and Medicaid as a qualified Medicare beneficiary. We will monitor the uptake of these new codes.

FIGURE 4–9

Physician fee schedule spending per FFS beneficiary grew substantially faster than the MEI or fee schedule payment updates, 2000–2023



Note: FFS (fee-for-service), MEI (Medicare Economic Index). The MEI measures the change in clinician input prices. MEI data are from the new version of the MEI (based on data from 2017) and include updated total-factor productivity data that CMS released as part of the second quarter of 2024 market basket data. Spending per FFS beneficiary is based on incurred spending under the physician fee schedule. The graph shows updates to payment rates in nominal terms. Fee schedule updates do not include Merit-based Incentive Payment System adjustments or bonuses for participating in advanced alternative payment models. One-time payment increases of 3.75 percent in 2021, 3.0 percent in 2022, and 2.5 percent in 2023 are included.

Source: MedPAC analysis of Medicare regulations, CMS market basket data, and reports from the Boards of Trustees of the Medicare trust funds.

Growth in input costs accelerated in recent years but is moderating

We report the growth in clinicians' input costs because it helps us understand the extent to which Medicare payment-rate updates and clinician revenues are keeping pace with increases in the costs associated with running a practice. The Medicare Economic Index (MEI) measures the average annual price change for the market basket of inputs used by clinicians to furnish services. Unlike many other market baskets, the MEI has long been adjusted for a measure of productivity growth. Therefore, reported MEI growth figures include a built-in adjustment for total-factor productivity. 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).

MEI growth was 1 percent to 2 percent per year for several years before the coronavirus pandemic and was 2.1 percent in 2020.[26] MEI growth then increased to 2.3 percent in 2021 and 4.4 percent in 2022. MEI growth slowed slightly to 4.0 percent in 2023 and is projected to moderate further in the coming years—to 3.3 percent in 2024, 2.8 percent in 2025, and 2.3 percent in 2026.[27]

From 2000 to 2023, cumulative MEI growth has far exceeded updates to physician fee schedule payment rates (Figure 4-9). Over that period, the MEI increased cumulatively by 52 percent compared with 14 percent for fee schedule updates. However, the volume and intensity of clinician services delivered each year has increased, which has resulted in fee schedule spending per FFS beneficiary growing by 101 percent over the same time period.[28] The substantial growth in volume and intensity (and the Commission's broader finding

that Medicare beneficiaries report relatively good access to care) suggests that below-MEI updates have not impeded access and that simply comparing changes in fee schedule updates with MEI growth is insufficient to capture changes over time in clinicians' ability to provide services to Medicare beneficiaries.

In the past, some research has found that increasing fee schedule payment rates led to reductions in the volume and intensity of fee schedule services and, conversely, that declining payment rates led to increased volume and intensity (Congressional Budget Office 2007, Office of the Actuary 1998). Using this logic, some stakeholders have suggested that the large increases in volume and intensity that have driven the growth in fee schedule spending per beneficiary over more than two decades represent clinicians' responses to fee schedule payment rates that declined (after adjusting for inflation) over that period. However, more recent research suggests a positive relationship between payment rates and volume and intensity: That is, volume and intensity increase as payment rates increase. For example, one study found that, among 40- to 55-year-old physicians, a 10 percent increase in payment rates led physicians to bill 4.4 percent more relative value units (RVUs)—3.9 percent more procedures (nearly all of which is driven by performing procedures on additional patients rather than doing procedures more frequently for the same number of patients) and additional shifts to relatively higher-paid procedures (Gottlieb et al. 2023).[29] Other research has found that the relationship between payment rates and the volume of care is greater for elective procedures, such as cataract surgery, than less discretionary services (Clemens and Gottlieb 2014). This evolving body of research suggests that increasing fee schedule rates will likely lead to an increased provision of care, and it could increase Medicare and beneficiary spending.

How should FFS Medicare payments change in 2026?

Under current law, Medicare fee schedule payment rates are expected to grow by 0.75 percent for clinicians in advanced alternative payment models (e.g., accountable care organization models that involve some financial risk) and 0.25 percent for all other clinicians in 2026. Based on many of our indicators, current payments to clinicians appear to be adequate to ensure access to care. But given recent inflation, ongoing cost increases that exceed payment updates could be difficult for clinicians to absorb.

In addition, as discussed in our March 2023 report to the Congress, the Commission is concerned that clinicians often receive less revenue when treating low-income beneficiaries because of the way Medicare's cost-sharing policies interact with state Medicaid payment policies. Since these lower payments could put clinicians who furnish care to low-income beneficiaries at greater financial risk and reduce access to care for low-income beneficiaries, Medicare should provide additional support to clinicians who serve this population.

RECOMMENDATION 4

The Congress should:

- **for calendar year 2026, replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the Medicare Economic Index minus 1 percentage point; and**
- **enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries.**

RATIONALE 4

Overall, access to clinician services for Medicare beneficiaries appears to be comparable to, or better than, that of privately insured individuals, though quality of care is difficult to assess. Clinicians' fee schedule payments per FFS beneficiary and their all-payer compensation have continued to rise, but input costs are projected to continue to grow faster than Medicare's payment rates in coming years.

Current law calls for payment rates to increase by 0.25 percent or 0.75 percent in 2026. The Commission is concerned that these relatively low payment increases may make it difficult for clinicians to absorb recent and continued cost increases. Then again, aggregate payments appear adequate on the basis of many of our indicators. Therefore, given these mixed findings, the recommendation is that the Congress replace the

updates set to take effect in 2026 with the projected increase in the MEI for 2026 minus 1 percentage point.

The MEI is currently projected to grow by 2.3 percent in 2026, so this recommendation would yield an estimated increase in payment rates of 1.3 percent (2.3 percent minus 1 percentage point = 1.3 percent) from 2025. These MEI growth figures are projections, are subject to uncertainty, and could be larger or smaller than actual MEI growth.

In addition to the recommendation for an across-the-board increase, the Commission contends that, for reasons set forth in previous years' physician update chapters, it is important to provide additional financial support to clinicians who furnish care to low-income beneficiaries (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023c) (see text box, pp. 114–115). The recommendation therefore calls for the Congress to enact add-on payments to clinicians for physician fee schedule services furnished to low-income Medicare beneficiaries. The add-on payments would equal the allowed charge amounts for physician fee schedule services furnished to low-income beneficiaries multiplied by 15 percent when provided by primary care clinicians and 5 percent for all other clinicians. These new add-on payments would be consistent with the safety-net clinician recommendation in our March 2023 and March 2024 reports.

We estimate that the Commission's recommended safety-net add-on policy would increase the average clinician's fee schedule revenue by 1.7 percent. The increase for each clinician would vary by their specialty and share of services furnished to low-income beneficiaries. Because primary care clinicians would receive higher add-on payments than non–primary care providers, safety-net payments would increase fee schedule revenue for primary care clinicians by an average of 4.4 percent and for non–primary care clinicians by an average of 1.2 percent. (These add-on payments would be paid entirely by the Medicare program; low-income beneficiaries would not owe higher cost sharing.)

We estimate that relative to payment rates in 2025, the combination of our MEI minus 1 percentage point update and our safety-net add-on payments would increase the average clinician's Medicare fee schedule revenue by 3.0 percent in 2026, with revenue increasing by an average of 5.7 percent for primary care clinicians and by an average of 2.5 percent for other clinicians.

IMPLICATIONS 4

Spending

- Current law is expected to increase payment rates by 0.75 percent for clinicians in advanced alternative payment models and by 0.25 percent for all other clinicians in 2026. This recommendation would increase program spending relative to current law by $2 billion to $5 billion in 2026 and by $10 billion to $25 billion over five years.

Beneficiaries and providers

- We expect that this recommendation will help ensure FFS Medicare beneficiaries' access to care by maintaining clinicians' willingness and ability to treat them. This recommendation may increase clinicians' willingness and ability to treat beneficiaries with low incomes. ■

APPENDIX 4–A

Key findings from the Commission's 2024 access-to-care survey

TABLE 4–A1

Medicare beneficiaries reported access to care that is comparable to or, in most cases, better than that of privately insured people, 2022–2024

Survey question	Medicare beneficiaries (ages 65 and older) 2022	2023	2024	Privately insured (ages 50–64) 2022	2023	2024
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 ("very" or "somewhat")	–	96%[a]	97%[ab]	–	91%[a]	93%[ab]
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 ("very" or "somewhat")	–	87[a]	88[a]	–	77[a]	79[a]
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 routine care						
Never	55[ab]	49[a]	51[a]	40[ab]	37[a]	36[a]
Sometimes	32[ab]	39	37[a]	40[a]	40	42[a]
Usually	8[a]	9[a]	9[a]	12[a]	14[a]	14[a]
Always	4[a]	4[a]	4[a]	8[a]	8[a]	8[a]
For illness or injury						
Never	67[a]	65[a]	65[a]	58[ab]	55[a]	54[a]
Sometimes	26[a]	27[a]	28[a]	29[a]	30[a]	32[a]
Usually	4[a]	6[a]	5[a]	8[a]	10[a]	9[a]
Always	3[a]	2[a]	2[a]	5[a]	5[a]	5[a]
Tried to get a new provider: "In the past 12 months, have you tried to get a new . . . ?" (Share answering "yes")						
Primary care provider	11[a]	12[a]	11[a]	14[a]	15[a]	16[a]
Specialist	26[b]	32	31	29[b]	33	34
Problems finding 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?" (Percentages in parentheses are the overall share of all respondents with this insurance.)						
Primary care provider						
Not a problem	46 (5)	45[a] (5)	48[a] (5)	38 (5)	32[a] (5)	34[a] (5)
Small problem	32 (4)	32 (4[a])	28 (3[a])	33 (5)	35 (5[a])	34 (5[a])
Big problem	22 (2[a])	23[a] (3[a])	24[a] (2[a])	29 (4[a])	33[a] (5[a])	31[a] (5[a])
Specialist						
Not a problem	68[a] (18)	64[a] (20[a])	64[a] (20[a])	59[ab] (17)	54[a] (18[a])	52[a] (17[a])
Small problem	22 (6[ab])	23[a] (7[a])	24[a] (8[a])	26 (7[ab])	28[a] (9[a])	30[a] (10[a])
Big problem	10[a] (3[a])	13[a] (4[a])	11[a] (3[a])	15[a] (4[ab])	18[a] (6[a])	18[a] (6[a])
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	18[a]	20[a]	18[a]	24[ab]	27[a]	27[a]

Note: Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "don't know" and "refused." Survey sample sizes are approximately 4,000 Medicare beneficiaries and 4,000 privately insured people in 2022, approximately 5,000 of each group in 2023, and approximately 5,000 of each group in 2024; sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. To account for the longitudinal nature of the data, all comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.
[a] Statistically significant difference between Medicare beneficiaries and the privately insured in a given year (at a 95 percent confidence level).
[b] Statistically significant difference between 2024 and 2023 or between 2024 and 2022 within the same insurance group (at a 95 percent confidence level).

Source: MedPAC's access-to-care surveys conducted in the summers of 2022, 2023, and 2024.

TABLE 4–A2

Few statistically significant differences in White, Black, and Hispanic Medicare beneficiaries' access to care in 2024

	Medicare beneficiaries (ages 65 and older)			Privately insured (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]	94%	95%[a]	92%[a]	89%	87%[ab]
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 ("very" or "somewhat")	97[a]	97	95	92[a]	95	95
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 ("very" or "somewhat")	88[a]	92	89	79[a]	85	81
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[a]	97	97[a]	91[a]	92	90[a]
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 routine care						
Never	50[a]	60[ab]	52[a]	36[a]	44[a]	32[a]
Sometimes	37[a]	34	36	42[a]	39	48
Usually	10[a]	3[ab]	8	14[a]	12[a]	13
Always	4[a]	4	3	8[a]	5	8
For illness or injury						
Never	65[a]	66	61	55[a]	62	46
Sometimes	28	29	31	31	28	38
Usually	5[a]	3	6	9[a]	6	12
Always	2[a]	2	2	5[a]	4	4
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	18[a]	18	21	27[a]	23	32

Note: "White" refers to non-Hispanic White respondents, "Black" refers to non-Hispanic Black respondents, and "Hispanic" refers to Hispanic respondents of any race. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "don't know" and "refused." Sample consists of approximately 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. To account for the longitudinal nature of the data, all comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.
[a] Statistically significant difference between Medicare beneficiaries and the privately insured within the same race/ethnicity category (at a 95 percent confidence level).
[b] Statistically significant difference between White and Black or White and Hispanic respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC's access-to-care survey conducted in summer 2024.

TABLE 4–A3

Few statistically significant differences between urban and rural Medicare beneficiaries' access to care in 2024

	Medicare beneficiaries (ages 65 and older)		Privately insured (ages 50–64)	
Survey question	**Urban**	**Rural**	**Urban**	**Rural**
Tried to get a new provider: "In the past 12 months, have you tried to get a new . . . ?" (Share answering "yes")				
Primary care provider	11%[a]	10%	16%[a]	14%
Specialist	33[b]	26[b]	35[b]	28[b]
Problems finding 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?" (Percentages in parentheses are the overall share of all respondents with this insurance in this type of geographic area.)				
Primary care provider				
Not a problem	47[a] (5)	53 (5)	34[a] (5)	36 (5)
Small problem	29 (3[a])	23 (2[a])	34 (5[a])	40 (6[a])
Big problem	24 (3[a])	24 (2)	33 (5[a])	23 (3)
Specialist				
Not a problem	65[a] (21[ab])	62[a] (16[b])	52[a] (18[ab])	49[a] (13[b])
Small problem	24 (8[a])	25 (6)	30 (10[a])	34 (9)
Big problem	11[a] (3[a])	13 (3)	18[a] (6[a])	18 (5)
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 routine care				
Never	49[ab]	57[ab]	34[ab]	45[ab]
Sometimes	38[a]	33	43[a]	37
Usually	9[a]	8	15[a]	10
Always	4[a]	3[a]	8[a]	7[a]
For illness or injury				
Never	64[a]	67	53[ab]	60[b]
Sometimes	29[a]	26	33[a]	27
Usually	5[a]	5[a]	9[a]	10[a]
Always	2[a]	2	5[a]	4
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	18[a]	20[a]	27[a]	28[a]

Note: "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. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "don't know" and "refused." Sample consists of approximately 5,000 Medicare beneficiaries and 5,000 privately insured people, but sample sizes for particular questions varied. Surveyed Medicare beneficiaries include those enrolled in fee-for-service Medicare or Medicare Advantage. To account for the longitudinal nature of the data, all comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.

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

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

Source: MedPAC's access-to-care survey conducted in the summer 2024.

Endnotes

1 Our count includes unique Healthcare Common Procedure Coding System codes for which Medicare made at least one payment during the year. We treat codes that have modifiers as a single code, and we do not include codes that clinicians could have billed for but did not.

2 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf.

3 Although most clinician services are paid under the physician fee schedule, some are paid through federally qualified health centers, rural health clinics, and critical access hospital Method II billing.

4 Our survey is fielded among a sample drawn from the Gallup Panel. The Gallup Panel is a probability-based panel generated by random-digit-dial and address-based sampling. Approximately 8 percent of people invited to join the Gallup Panel do so. When they join, they specify which language they would like to receive surveys in and through what mode they would like to receive surveys. Our survey was fielded via web or mail in English or Spanish, depending on panelists' preferences. We paid respondents a $5 incentive to complete the survey or $10 if they were a member of a subgroup whose response rate we were trying to increase. Among eligible individuals invited to participate in our survey, 48 percent completed it. Questions asked of all Medicare beneficiaries ages 65 and over (n = 4,926) have a margin of error of +/− 1.74 percentage points at the 95 percent confidence level, and questions asked of all privately insured people ages 50 to 64 (n = 5,200) have a margin of error of +/− 1.75 percent.

5 We annually conduct focus groups with beneficiaries and clinicians in different parts of the country to provide more qualitative descriptions of beneficiary and clinician experiences with the Medicare program. During these discussions, we hear from beneficiaries and providers about variation in experiences accessing care. In summer 2024, we conducted four focus groups with Medicare beneficiaries in each of three urban markets. Two of the groups in each market were composed of beneficiaries dually eligible for Medicare and Medicaid. New for this year, we held separate groups with beneficiaries enrolled in FFS Medicare and those enrolled in MA for both the Medicare-only and dually eligible beneficiary groups. We also conducted three virtual focus groups with beneficiaries residing in rural areas. In addition, we conducted three focus groups with clinicians in each of the three urban markets: primary care physicians, specialist physicians, and primary care nurse practitioners and PAs.

6 Other types of doctor's office appointments asked about in the MCBS are appointments scheduled after a provider contacted a patient to schedule a visit, appointments scheduled at a prior visit, and standing appointments.

7 Clinicians who opted out of Medicare were concentrated in the specialties of behavioral and mental health (58 percent), oral health (19 percent), and primary care (9 percent) (Centers for Medicare & Medicaid Services 2024c).

8 The Commission's definition of "low-income Medicare beneficiaries" includes all beneficiaries who receive full or partial Medicaid benefits and beneficiaries who do not qualify for Medicaid benefits in their states but receive the Part D LIS because they have limited assets and an income below 150 percent of the federal poverty level. Collectively, we refer to this population as "LIS beneficiaries" because nearly all Medicare beneficiaries who receive full or partial Medicaid benefits are also automatically eligible to receive the LIS. About 19 percent of Medicare FFS beneficiaries with Part B coverage are LIS beneficiaries, but they account for roughly 25 percent of all allowed charges billed under the physician fee schedule.

9 These policies are referred to as "lesser-of" policies because state Medicaid programs pay the lesser of (1) Medicare's cost-sharing amount or (2) the difference between the state Medicaid fee schedule and the Medicare program's payment for a service.

10 A substantial number of clinicians bill for 15 or fewer beneficiaries in a given year, but they account for a small share of services and allowed charges. For example, in 2023, about 19 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. Further, we note that this threshold does not account for whether clinicians are practicing on a full- or part-time basis.

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

12 We define an "encounter" as a unique combination of beneficiary identification number, claim identification number (for paid claims), and national provider identifier of the clinician who billed for the service.

13 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 is found in the 2024 Medicare Trustees' report.

14 Practitioners can submit claims under more than one specialty. For those practitioners, we use the specialty associated with the plurality of allowed charges billed to the physician fee schedule.

15 Physical therapy includes stretching, strength training (with or without weights), and heat or cold therapy. Medicare beneficiaries are also eligible to receive occupational therapy to treat hand and arm disorders and to help with activities of daily living (such as getting dressed and bathing), and speech therapy, which provides treatment to regain and strengthen speech and language skills.

16 The roughly 3,400 Dartmouth Atlas Project–defined HSAs are a collection of ZIP codes whose residents are hospitalized chiefly in that area's hospitals.

17 Payment rates for a service can also change because of adjustments to the relative value units for that service.

18 MACRA also specified two types of additional payments for clinicians: (1) an annual bonus for clinicians with a sufficient share of patients or payments in A–APMs, and (2) for clinicians not qualifying for the A–APM bonus, payment adjustments through the Merit-based Incentive Payment System (MIPS), which can be positive, neutral, or negative depending on a clinician's performance on measures of quality, cost, participation in clinical-improvement activities, and use of health information technology. Beginning in 2027, the A–APM bonus will no longer be available, but MIPS payment adjustments will continue for clinicians not in A–APMs. In 2024, about 386,000 clinicians (roughly 27 percent of the clinicians who bill Medicare) received MACRA's A–APM participation bonus (Centers for Medicare & Medicaid Services 2024a). Another 493,000 clinicians received a positive MIPS adjustment to their physician fee schedule payments from Medicare, of up to 8.26 percent (about four times the maximum in past years) (Centers for Medicare & Medicaid Services 2024d). About 87,000 clinicians received a negative MIPS adjustment to their payment rates, up to –9 percent (Centers for Medicare & Medicaid Services 2024d). Another 44,000 clinicians received a neutral (0 percent) MIPS adjustment because their MIPS score was the same as the MIPS performance threshold. We estimate that roughly 430,000 clinicians were ineligible for A–APM bonuses or MIPS adjustments (e.g., because they saw a low volume of Medicare beneficiaries).

19 Allowed charges are a function of the physician fee schedule's relative value units and conversion factor plus other payment adjustments, such as those determined by geographic practice cost indexes.

20 The private insurer's 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. Data do not include MA claims.

21 Less commonly selected reasons for selling a practice to a hospital in the AMA's survey were to better compete for employees, to increase availability of additional services that patients need, and to make it easier to participate in risk-based payment models.

22 The SullivanCotter compensation data are limited in that a majority of the provider organizations that contributed compensation data for this survey are affiliated with a hospital or health system.

23 The growth rates reported in this statement were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2022 and 2023.

24 The growth rates reported in this paragraph were calculated using a sample restricted to staff clinicians who were in SullivanCotter's sample in both 2019 and 2023.

25 The dollar amounts reported in this sentence were calculated using all staff clinicians in SullivanCotter's 2023 sample.

26 MEI-growth data included in this chapter differ from data published in physician fee schedule rules because of methodological differences. MEI-growth data included in this chapter reflect the MEI growth that occurred or is projected to occur in a given year. In contrast, MEI-growth data in fee schedule rules reflect the most recently available actual historical data at the time of publication. For example, the final rule for payment year 2025 uses MEI growth from the second quarter of 2024 (i.e., actual historical MEI growth from the third quarter of 2023 to the second quarter of 2024). MEI growth reported in this chapter for 2025 is based on projected MEI growth from the fourth quarter of 2025 (i.e., projected MEI growth from the first quarter of 2025 to the fourth quarter of 2025). We also incorporate a productivity adjustment to match the period from which MEI growth was analyzed.

27 MEI-growth projections in this chapter are as of the third quarter of 2024 and are subject to change.

28 The growth in fee schedule spending per beneficiary, especially during the second half of this period, was restrained by the shift of services from clinician offices to hospital outpatient departments. For example, the Commission found that from 2012 to 2017, had shifts in site of service not occurred, average annual growth in the total number of RVUs billed (RVU values multiplied by units of service) would have been 1.5 percent per year instead of 1.1 percent, with larger differences for imaging services and tests (Medicare Payment Advisory Commission 2019). These figures represent lower-bound estimates of the effects of site-of-service shifts for fee schedule services because we were unable to adjust for shifts among certain types of services, such as radiation therapy, chemotherapy injections, and other tests. While this trend lowers fee schedule spending (because fee schedule payment rates are lower when a service is furnished in a facility), it increases Medicare's total spending generated by fee schedule services (fee schedule spending plus associated hospital outpatient spending).

29 Research conclusions on the relationship between prices and volume may vary for several reasons, such as the permanence of the price increase and the population studied. For example, the literature studying the effects of price on utilization for Medicaid beneficiaries is mixed (Medicaid and CHIP Payment and Access Commission 2025).

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