Implications of Changes in Medicare Payment and Documentation for Primary Care Spending and Time Use

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INTRODUCTION

Primary care is—ideally—accessible, timely, first-contact care that is comprehensive, coordinated, and longitudinal. To support primary care practices, several states have passed regulations or legislation to raise primary care spending to 7–12% of total healthcare spending.^{1, 2} The Centers for Medicare and Medicaid Services (CMS) has finalized the first major change to primary care payment in the Physician Fee Schedule in decades—raising fees for evaluation and management visits, and lowering documentation requirements (obviating rule-based review of systems and exam elements in favor of time-based or decision-complexity-based coding), beginning 2021.³

We sought to estimate the extent to which the new CMS rule may reach target primary care spending levels pursued in several states,^{1, 2} and the degree to which reduced documentation requirements may affect time use in primary care practices.

METHODS

We used a previously-validated model,⁴ which simulates the national population of primary care providers and their patients, reflecting current patterns of utilization, spending, and practice-level revenues and costs from all payers. Primary care spending was defined as the sum of all payments to practitioners in general practice, general internal medicine, or family practice, and included

geography-specific Medicare payments by visit code (data from $N=181,664$ primary care providers, Table 1).⁵ Reduced documentation time was estimated based on a prior practice time use study,⁶ and disaggregated into time spent during visits, outside of visits during practice hours, and after practice hours (Table 1). To estimate potential all-payer effects, we re-calculated the outcomes if commercial insurers and Medicaid adopted the same proportionate rate increase and documentation rules as Medicare. We also identified the implications of potential up-coding of visits to higher levels of complexity given the reduced documentation requirements.

RESULTS

Medicare Only. Based solely on the fee increases as applied to Medicare patients, we anticipate the CMS policy to increase gross revenues to primary care practices by \$20,176/full-time physician/year (95% CI \$1766 to \$90,261)—equivalent to an increase of 0.3 percentage points nationwide from the current average of 2.1% of total Medicare spending devoted to primary care. The increase would not be expected to achieve state targets for primary care spending (Table 2).

One-third of the usual time per practitioner note (~ 1.2 min/visit note) was estimated to be eliminated by the change in documentation requirements. Time saved from documentation would be expected to be 14.9 min/practitioner/day (95% CI 2.7 to 27.4), with 9.5 min/day saved from documentation during visits, 3.7 min outside of visits during practice hours, and 1.7 min outside of practice hours.

Table 1 Model Input Data and Sources

Parameter	Value	Source
Medicare payments		
2019 Schedule estimate (reference) by CPT code*		
99,201	\$46.49	Centers for Medicare and Medicaid Services ³ (based on relative value units listed in Table 125 of referenced rule)
99,202	\$77.12	
99,203	\$109.20	
99,204	\$166.86	
99,205	\$210.83	
99,211	\$23.43	
99,212	\$46.13	
99,213	\$76.04	
99,214	\$110.28	
99,215	\$148.12	
2021 Schedule estimate (updated rule) by CPT code*, including new primary care G code modifier (GPC1X)		
99,201	\$0 (to be discontinued)	National Ambulatory Medical Care Survey, details in ⁴
99,202	\$89.38	
99,203	\$128.30	
99,204	\$184.88	
99,205	\$233.53	
99,211	\$34.96	
99,212	\$60.55	
99,213	\$99.11	
99,214	\$133.34	
99,215	\$184.52	
Medicare patients as a proportion of primary care patients, at practices accepting Medicare	31.3% (95% CI 4.9%, 66.7%)	National Ambulatory Medical Care Survey, details in ⁴
Medicare patients as a proportion of primary care visits	24.7% (SD: 1.1)	
Documentation time (hours/visit/day)		Prior time study ⁶
During-visit	1.33 (SD: 0.86)	
Outside of visit, during practice hours	0.52 (SD: 0.72)	Medical Group Management Association, details in ⁴
Outside of practice hours	0.24 (SD: 0.73)	
Visits/provider/day	12.3 (SD: 5.3)	
Current fee-for-service payments to primary care, per full-time provider per year (all payers)	\$638,634 (SD: \$481,774; IQR: \$378,463, \$765,092)	

*Non-facility national average estimates are provided. Area-specific variations including work, practice expense, and malpractice geographic practice cost indices were taken accounted for in state-specific estimates (see Table 2). CPT: Current Procedural Terminology; 95% CI: 95% confidence intervals; SD: standard deviation; IQR: interquartile range

Additional Payers. If commercial insurers and Medicaid were to adopt the Medicare policy, the overall composite fee increases would be anticipated to increase gross revenues by \$156,071/full-time physician/year (95% CI \$62,028 to \$239,738)—an increase of 1.2 percentage points in the share of total national health care spending allocated to primary care, from the current share of 5.6% across all payers (including Medicare). This spending would approach state targets (Table 2). Time saved from documentation (including Medicare, Medicaid, and commercially insured patients) would be expected to be 41.8 min/practitioner/day (95% CI 39.4 to 44.2), with 26.6 min/day saved from documentation during visits, 10.4 min outside of visits during practice hours, and 4.8 min outside of practice hours.

Incorporating Potential Up-Coding Effects. If 5% of visits previously coded as level 3 or level 4 were up-coded by one level (to levels 4 and 5, respectively), we would expect the Medicare proportion of spending on primary care to increase by 0.4 percentage points, and—if other payers followed Medicare—total spending on primary care to increase by 1.5 percentage points.

DISCUSSION

Medicare payment changes that will take effect in 2021 will likely be insufficient to reach state target levels of primary care spending alone, but if all other payers follow Medicare, primary care spending levels may approach target levels.

Table 2 Results from Simulation of Medicare Payment Increase

	Current Medicare primary care spending as % of total Medicare spending	Future Medicare primary care spending as % of total Medicare spending (model estimates)	Current all-payer primary care spending as % of total healthcare spending	Future all-payer primary care spending as % of total healthcare spending (model estimates)*	Target primary care spending, as % of total healthcare spending (if legislation/regulation passed)†
National average	2.1%	2.4%	5.6%	6.8%	—
Alabama	2.3%	2.6%	6.2%	7.4%	—
Alaska	2.0%	2.3%	‡	‡	—
Arizona	2.5%	2.8%	5.2%	6.4%	—
Arkansas	2.1%	2.4%	‡	‡	—
California	2.2%	2.5%	6.1%	7.3%	Pending
Colorado	2.2%	2.5%	5.0%	6.2%	7.2% (commercial)
Connecticut	1.9%	2.2%	3.5%	4.7%	—
Delaware	2.3%	2.6%	‡	‡	Pending
District of Columbia	1.8%	2.1%	‡	‡	—
Florida	2.3%	2.6%	5.7%	6.9%	—
Georgia	2.2%	2.5%	5.7%	6.9%	—
Hawaii	3.2%	3.5%	‡	‡	Pending
Idaho	1.7%	2.0%	‡	‡	—
Illinois	2.1%	2.4%	5.0%	6.2%	—
Indiana	1.9%	2.2%	4.7%	5.9%	—
Iowa	2.1%	2.4%	‡	‡	—
Kansas	1.9%	2.2%	‡	‡	—
Kentucky	1.9%	2.2%	4.5%	5.7%	—
Louisiana	1.6%	1.9%	5.3%	6.5%	—
Maine	1.9%	2.2%	‡	‡	Pending
Maryland	2.2%	2.5%	5.5%	6.7%	—
Massachusetts	2.1%	2.4%	4.8%	6.0%	Pending
Michigan	2.1%	2.4%	4.7%	5.9%	—
Minnesota	1.9%	2.2%	7.6%	8.8%	—
Mississippi	1.7%	2.0%	‡	‡	—
Missouri	1.8%	2.1%	4.6%	5.8%	Pending
Montana	1.7%	2.0%	‡	‡	—
Nebraska	1.8%	2.1%	‡	‡	—
Nevada	2.0%	2.3%	‡	‡	—
New Hampshire	2.0%	2.3%	‡	‡	—
New Jersey	2.1%	2.4%	4.6%	5.8%	—
New Mexico	2.2%	2.5%	‡	‡	—
New York	2.1%	2.4%	5.0%	6.2%	—
North Carolina	2.4%	2.7%	5.9%	7.1%	—
North Dakota	1.6%	1.9%	‡	‡	—
Ohio	2.1%	2.4%	4.6%	5.8%	—
Oklahoma	2.0%	2.3%	6.7%	7.9%	—
Oregon	2.0%	2.3%	5.6%	6.8%	12.0%
Pennsylvania	2.2%	2.5%	4.2%	5.4%	—
Rhode Island	2.3%	2.6%	‡	‡	10.7% (commercial)
South Carolina	2.4%	2.7%	5.0%	6.2%	—
South Dakota	1.6%	1.9%	‡	‡	—
Tennessee	2.2%	2.5%	4.8%	6.0%	—
Texas	1.9%	2.2%	6.3%	7.5%	—
Utah	2.2%	2.5%	‡	‡	—
Vermont	2.4%	2.7%	‡	‡	Pending
Virginia	2.6%	2.9%	5.7%	6.9%	—
Washington	2.1%	2.4%	5.9%	7.1%	—
West Virginia	2.2%	2.5%	‡	‡	Pending
Wisconsin	2.0%	2.3%	6.2%	7.4%	—
Wyoming	1.7%	2.0%	‡	‡	—
International comparators					
Organization for Economic Cooperation and Development (OECD), mean of 23 countries			12.0%	—	—
United Kingdom, National Health Service			8.4%	—	—
Canada, Ontario province			8.1%	—	—

Estimates include adjustments for Geographic Practice Cost Indices, as well as work, practice expense, and malpractice relative value units.³ Current spending estimates and target spending levels from the Milbank Memorial Fund.¹ International comparisons from Koller et al.² The term “pending” in the last column indicates that legislation or regulation has passed state legislature, requiring the setting of a spending target, but that the department or committee charged with target setting has not yet agreed to or released a target publicly, to our knowledge.

*If other payers (commercial, Medicaid) adopt the same proportionate rate increase and documentation rules as Medicare

†As of October 2019

‡Insufficient data

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Compliance with Ethical Standards:

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