

## HEALTH POLICY

# THE COGNITIVE CARE ALLIANCE: SGIM'S LEADERSHIP WITH PHYSICIAN PAYMENT REFORM

John D. Goodson, MD, Chair, Cognitive Care Alliance

*Dr. Goodson (jgoodson1@partners.org) is associate professor of medicine at Harvard Medical School and a physician at Massachusetts General Hospital in Boston, MA.*

**T**he Society of General Internal Medicine (SGIM) maintains a unique position among professional societies. In particular, we have spearheaded efforts to reform the Medicare Physician Fee Schedule (PFS) to achieve payment parity between proceduralists and cognates. All payment models based on the PFS depend on the existing pricing structure for physician services, even those enterprises who choose to participate in Alternative Payment Models (APMs) or practices that choose to remain in a fee-for-service arrangement and report quality information as required by the Merit-based Incentive Payment System (MIPS). In many salary models, productivity is calculated from the services submitted for billing. Even when compensation is unhooked from productivity, practice revenue and the revenue available for compensation depends on the service codes billed. Furthermore, there is an internal dynamic. Within large enterprises, the limited ability to generate revenue from purely cognitive services, no matter how intense, creates an environment where the non-proceduralists remain in a position of dependency.

### How Did the Pricing of Cognitive Services Become So Distorted?

In 1989, Congress declared that all Medicare professional payments would be based on a national fee schedule (now called the Medicare PFS) in which payments would be made only for specific services (i.e., that Medicare would not pay for any unrecognized service) and payments for professional services would be made relative to one another. In the model, relativity is based on the “resources” consumed on average, where resources are determined in large part by the “intensity” of the work. (Intensity includes mental stress, consequences, etc.) This has been the system of Medicare payment since 1992. All commercial carriers use the same pricing model. What Medicare does, all others follow.

The Medicare PFS is updated every January 1<sup>st</sup>. Physicians’ payments are made by multiplying the relative

value (listed in the Medicare PFS in relative value units, RVUs) of each service times an annual conversion factor. The MPFS lists thousands of codes that correspond to individual services. Congress empowered the AMA’s Current Procedural Terminology (CPT) committee to define services. The licensing fees from the manual that matches services to CPT codes has become an extraordinary source of revenue for the AMA, estimated to be around \$20 million per year!

**Certainly, more rational and more patient-centered payment models may evolve over time but the current reality demands immediate action. If there is to be a robust primary care workforce then the compensation for the complex work involved must be substantially improved.**

The definition of services and the assignment relative values based on the determinations of work “intensity” has had an enormous effect on physician compensation over the last three decades. Another and even more influential AMA committee, the Relative-Value Update Committee (RUC), “suggests” relative values for all CPT defined services. Since the beginning of the PFS, Medicare has accepted the vast majority of the RUC’s recommendations. In essence, the RUC largely determines what gets paid to every specialty. This committee is dominated by its majority of proceduralists (e.g., plastic surgery, radiology, pathology, several surgical specialties). Currently, there are some 6,500 codes in the CPT manual representing procedural services. There are roughly 50 codes that capture the entire range of cognitive, non-procedural services; these codes account for roughly half of Medicare’s physician payment—more than \$45 billion! These codes are also meant to capture all of inpatient care, outpatient care, consultative care, emergency room care, chronic care, and home care.

We in primary care depend on the evaluation and

*continued on page 2*



## HEALTH POLICY *(continued from page 1)*

management (E/M) service codes. The failure of these codes to adequately capture and provide relative values appropriate to the intensity of current clinical care has substantially contributed to the compensation disparities for physicians practicing primary care and to the declining numbers of primary care physicians. In addition, the documentation requirements that plague current clinical records arise directly from content stipulations that originated in the beginnings of the current payment schemes, during an era of manila folders and three ring binders. The E/M codes that capture all of our cognitive work have not been refined and updated for decades.

### **Enter the Cognitive Care Alliance (CCA)**

Recognizing a need for collaborative activism, SGIM took the lead in forming the Cognitive Care Alliance in 2015. The Alliance pulled together like-minded representatives from other professional organizations whose members depend on E/M services. The Alliance now includes rheumatology, endocrinology, gastroenterology, hepatology, infectious disease, and hematology. There are almost 100,000 physicians represented. SGIM convened the Alliance and currently holds the group's chairmanship.

Over the last year, the CCA's national lobbying efforts have involved several days of advocacy. Last May, we met with Patrick Conway, MD, then director of the Center for Medicare and Medicaid Innovation. SGIM's Hill Days for both 2017 and

2018 have carried the message that the distortions of the fee schedule must be corrected. The CCA was on the Hill in July, December, and January 2018, meeting with multiple staffers from both chambers and both sides of the aisle. Access for Medicare beneficiaries is non-partisan; shortages touch all districts and all states. In December and January, we met with Jeet Guram, MD, senior advisor to the Medicare administrator, Seema Verma. We have refined and focused our core messages and sent multiple letters to CMS and members of Congress. In September, the CCA participated in a national conference of experts convened at the Brookings Institute in Washington, DC.

The Alliance continues to seek out like-minded professional organizations as well as non-professional organizations. In January, the Alliance met with a representative from Families USA.

### **A Strategy for Change: Evidence-based Pricing of E/M Services**

The CCA believes that physician payment policy should be based on an accurate and reliable evidence-base. We have called on CMS to conduct the research necessary to redefine and appropriately value the E/M codes and correct any distortions in the pricing of physician services. In addition, we believe that as new service codes are developed, new documentation expectations can be created that will foster efficient and effective communication and end much of the drudgery inflicted by the existing EHRs, a major source of clinician exhaustion.

As new payment models are developed, pricing anomalies will have ongoing negative effects. Workforce shortages in primary care and other cognitive specialties will both deprive beneficiaries of needed services and hamper the evolution of efficient and thoughtful health care delivery models. MedPAC has repeatedly pointed out the deficiencies of existing E/M code definitions and valuations. However, getting the necessary research developed, completed and analyzed by CMS will take a sustained effort over many years. Many in Congress are sympathetic to the call for change. The advocacy efforts of SGIM, working in concert with the Alliance and complemented by the advocacy efforts of the other professional societies, has created forward momentum.

Certainly, more rational and more patient centered payment models may evolve over time but the current reality demands immediate action. If there is to be a robust primary care workforce then the compensation for the complex work involved must be substantially improved. Furthermore, any "Medicare for All" option will founder unless the workforce issues are addressed. There is a level of "complexity density" to cognitive work that is not captured by the existing physician payment system. The work of the cognates demands matrix thinking. Procedural work is fundamentally linear. The time has come to recognize these two realities of physician work and appropriately recognize that neither is inherently more important or more valuable. **SGIM**

*continued on page 3*