SGIM and Its New Best Friends: The Cognitive Care Alliance

John D. Goodson, MD

Dr. Goodson is associate professor of medicine at Harvard Medical School and a physician at Massachusetts General Hospital in Boston, MA.

SGIM is the founding member of a new coalition of professional societies, the Cognitive Care Alliance (CCA), whose sole purpose is to champion the delivery of cognitive medical services. With the full backing of SGIM Council and leadership and the robust support of CRD Associates, the Alliance was formed to ensure a sustainable cognitive workforce committed to excellence in patient care. There are currently eight organizations in the Alliance: SGIM, the American Academy of Neurology, the American Association for the Study of Liver Diseases, the American College of Rheumatology, the American Gastroenterology Association, the Coalition of State Rheumatology Organizations, the Infectious Diseases Society of America, and the Endocrine Society.

The professional societies represented in the Alliance found common ground. The service codes as defined by the American Medical Association's Current Procedural Terminology (CPT) manual and valuated within the Medicare physician fee schedule fail to recognize the "complexity density" of modern cognitive care. This holds true for the sub-specialist dealing with the intense medical decision making around the introduction and management of modern therapeutics as well as the primary care physician who must manage multiple simultaneous conditions, many interacting medications, numerous consultation and test reports, and extensive laboratory data. We in primary care have watched for 20 years as our numbers have dwindled. Now our colleagues in other disciplines such as infectious disease, rheumatology, endocrinology, and neurology are experiencing the same decline.

The Alliance has three goals: 1) develop and implement new and appropriately defined outpatient evaluation and management (E/M) service codes, 2) ensure that E/M valuations capture the intense cognitive work provided, and 3) revise documentation expectations to represent the intensity of medical decision making and bring an end to mindless "cut and paste" charting.

Our efforts have taken us to Washington, DC, where we have met with senior staff members of the key House and Senate committees from both parties, as well as the Medicare Payment Advisory Commission (MedPAC) and senior leadership and staff within the Centers for Medicare and Medicaid Services (CMS) and the CMS Innovation Center (CMMI). We have carried the message that there will be an insufficient number of physicians in many cognitive specialties if there is not an immediate reworking of the existing fee schedule to bring about equitable compensation for equally intense clinical work.

The work of the Alliance comes at a particularly important moment. The grand goal of the Affordable Care Act (ACA) to extend health care will fail if there is an insufficient primary care workforce. Furthermore, expectations for "value-based" payment implicit within the new payment models conceived as a result of the Medicare Access and CHIP Reauthorization Act (MACRA)—the legislation that repealed the SGR—will never be achievable without a workforce of cognitive physicians who do not directly benefit from the procedures and interventions that drive high-cost and low-value health care expenditures. Importantly, the Comprehensive Primary Care Plus (CPC+) Project, proposed in April by CMMI, is built on the same CPT framework that vastly under-compensates the day-to-day work of modern primary care and unfortunately fails to recognize that it is not just primary care that is on the ropes.

The Alliance has argued that new service codes must be developed based on a new knowledge base. Our proposition, hardly revolutionary, is that payment policy should be based on solid and representative evidence. No one has made a substantial effort in the last 30 years to survey outpatient E/M activities across the specialties. Does a 99214 service code provided by an ophthalmologist really provide the same intensity of clinical work as the 99214 of a primary care internist, endocrinologist, or rheumatologist?

Unless we can create payment policy that provides primary care and other cognitive specialties the "respect" that we deserve, it's unlikely that the workforce of the future will have the balance necessary to sustain a thoughtful health care delivery system.

It is our hope and expectation that the logic of this approach will ultimately garner support from an even broader range of professional societies, within Congress, and across agencies and large health care enterprises. At my ACO, the primary care community continues to experience the same payment deficiencies as we have for the last three decades. The Alliance has communicated with the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP). The AAFP has a position similar to that of the Alliance. The ACP has lingered on the sidelines but recently has demonstrated increasing interest in joining the narrative.

As leaders in the formation of the Alliance, SGIM has distinguished itself among fellow professional

societies. SGIM has accomplished what has not been possible before. The strength of the Alliance derives from our ability to establish common themes that resonate across multiple specialties. Our credibility is rooted in our fundamental desire to improve health care and access, our academic base, our educational traditions, and our commitment to well-designed and peer-reviewed health services and clinical research.

Reference

1. Berenson RA, Goodson JD. Finding value in unexpected places. Fixing the Medicare fee schedule. New Eng J Med 2016; 374:1306-9.