ENDOCRINE SOCIETY
Hormone Science to Health

September 11, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

Re: CMS-1784-P: Medicare Program; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Brooks-LaSure:

On behalf of the Endocrine Society, thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year (CY) 2024 (CMS-1784-P). Founded in 1916, the Endocrine Society represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, obesity, osteoporosis, endocrine cancers (i.e., thyroid, adrenal, ovarian, pituitary) and thyroid disease. Many of the patients our members treat are Medicare beneficiaries. We also note that there is a shortage of endocrinologists; wait lists to see an endocrinologist can be many months long; diagnosis and treatment can be extremely complex; the amount of work outside of clinic time is increasing; and endocrinologists have some of the lowest salaries of medical subspecialists, yet they have not seen significant increases in Medicare payments in decades. Consequently, the payment policies and other revisions in the MPFS are of great importance to our members.

We welcome the opportunity to work with CMS to address the ongoing needs of Medicare beneficiaries and ask you to consider our comments on the following sections of the proposed rule as you finalize your policies for CY 2024:

- Conversion Factor Update
- Complex Care Add-on Code G2211
- Request for Comment E/M Services

2055 L Street NW
Suite 600
Washington, DC
20036

T. 202.971.3636
F. 202.736.9705

endocrine.org

- Split/Shared Services
- Creation of New Services
- Caregiver Training Services
- Payment for Telehealth Services
- Diabetes Policies

Conversion Factor Update

The conversion factor is set to decrease by 3.36% as the result of a statutory 0 percent update, a negative 2.17 percent relative value unit budget neutrality adjustment, and the expiration of funding that Congress added to the MPFS for 2023. We would be remiss if we did not point out that the conversion factor for physician payments is only $2.00 higher than it was in 1992. That is thirty years of stagnant Medicare reimbursement rates that must be rectified moving forward to ensure robust participation of physicians across specialties in the program.

We understand that CMS, by lack of statutory authority, cannot update the conversion factor without an act of Congress. We continue to encourage CMS to work with Congress to develop a solution that allows for regular inflationary updates to the conversion factor, akin to the regular updates that other Medicare payment systems see every year. The Inpatient Prospective Payment System and the Outpatient Prospective Payment System receive inflationary updates every year, while physician payment levels remain stagnant. payments. Meanwhile, each year our members face the uncertainties of a payment system that does have a mechanism to update payments regularly. Physicians continue to see payment decreases, but at the same time are asked to do more—see additional patients, meet new Quality Payment Program (QPP) thresholds, and remain current on the latest drugs and biologics and their potential interactions with patients' existing medications. After three years of extremely difficult circumstances of delivering care during a global pandemic, many physicians are burning out. The uncertainty of Medicare payment updates each year certainly adds to the burnout.

We encourage the agency to work with Congress to develop solutions that provide stability and certainty to the MPFS. The Endocrine Society intends to meet and work with members of Congress to assist with this process and to encourage Congress to craft a legislative solution to mitigate cuts to the conversion factor and to improve physician payment in the Medicare program.

Complex Patient Care Add-on Code G2211

In this rule, CMS has notified stakeholders that payment will be made in CY 2024 for add-on code G2211, which is used to describe services associated with office/outpatient evaluation and management (E/M) services that are complex in nature and are related to a patient's single, serious, or complex condition. The code may be used with any level of E/M office/outpatient visit and cannot be billed when the modifier 25 is used. The Endocrine Society is pleased to see that Medicare will finally reimburse for this service, and we support the use of the code by our members. The Endocrine Society recommends that CMS finalize payment for G2211.

The Endocrine Society thanks CMS for revising the add on code's utilization assumptions and providing more detailed information about how this service can be billed. We believe that the code is applicable to the care delivered by endocrinologists, and while we supported the work of the CPT® Editorial Panel and the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC) in revising and revaluing E/M codes, the revisions did not go far enough to appropriately value the care we provide. The practice of endocrinology is constantly changing and is becoming increasingly complex. New medications are being approved and marketed for use to treat endocrinological conditions, including medications to treat diabetes, endocrine hypertension, infertility, and obesity. The complexity of navigating the use of these new drugs, coupled with the complex nature of our patients' conditions requires time, expertise and skill that may not be captured in the current values of E/M services. Additionally, members must assess how patients' social determinants of health affect their ability to access treatment and health outcomes. Furthermore, our members develop long term relationships with many of their patients, which are critical to understanding the outside factors that influence their health and inform their treatment recommendations. G2211 recognizes the value of these relationships to patients' health. Therefore, we believe in the value of the add-on code, G2211 to capture endocrinologists' complex work.

However, we do suggest that the agency provide guidance as to the documentation requirements, how often the code may be billed, and other guidance that may be helpful to ensure that the code is being used in the manner for which it is intended.

Request for Comment About Evaluating E/M Services More Regularly and Comprehensively

The agency is seeking information regarding alternative ways of valuing services under the MPFS, and for the first time, has asked if the AMA RUC is the entity best suited to do this work. In the proposed rule, the agency asks several questions of stakeholders, so that the agency may gain a better understanding of the valuation process and its potential. We are pleased to see that the agency has requested comments on this complex issue, particularly as it pertains to the valuation of E/M services.

Endocrinologists are non-procedural specialists. According to claims data, 77% of total services billed under the MPFS by endocrinologists are for E/M services (99202-99215 and 99221-99233) in the office/outpatient and inpatient settings.[1] Additionally, approximately 86% of E/M services billed by endocrinologists are provided in the office setting.[2] There is a shortage of adult endocrinologists in the United States, which is expected to increase to a shortage of approximately 2,700 endocrinologists by 2025.[3] We believe that the misvaluation of these services is a driver of this shortage.

The Endocrine Society has long advocated for improved payment to the services our members provide. While the Society participates in the RUC process, we believe that this process of valuing services is best suited for procedures, and as such, we recommend that the agency find alternative means to value E/M services. The Endocrine Society recognizes the significant commitment specialty societies, their RUC advisors, and RUC members make to participate in the process. However, most RUC members and participating societies are or represent proceduralists. Despite RUC members' commitment not to represent their specialty, there is a lack of expertise related to the delivery of E/M care delivered to patients with one or more complex conditions – the type of patients our members treat.

The Endocrine Society appreciates the work the CPT® Editorial Panel and the RUC did to redefine and value the outpatient E/M codes, yet they still fail to accurately reflect the work of our members. The RUC surveys are a useful tool to measure the

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[1] CMS 1740-P: *Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2024*. CY 2024 PFS Proposed Rule 2022 Utilization Data Crosswalked to 2024. https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-p Accessed Aug 24, 2023.
[2] Ibid.
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7150610/#:~:text=Never%20more%20so%20than%20today,2700%20by%202025%20(4).

work, time, and intensity for discrete procedures, but do not capture many of the aspects of high-quality E/M care, including physicians' expertise. The limitations of RUC surveys, which are essentially a convenience sample of members who perform the services, and the lack of expertise around the RUC table related to complex, non-procedural care means that these services will not accurately reflect the work of our members if this is the primary valuation methodology.

Our Society supports the creation of an expert panel to advise CMS that will have the sole purpose of valuing E/M services for payment under the MPFS. The Resource-based Relative Value Scale (RBRVS) was created to determine relative values for medical procedures but has failed to appropriately value E/M services since its inception. In fact, we note that the primary developer of the RBRVS, Dr. William Hsiao stated that the development of the E/M portion of the MPFS was not adequately supported, and that more refinement was needed, when the RBRVS was first launched.[4] This statement from Dr. Hsiao still holds true today despite recent efforts to redefine and revalue these services. We believe that an expert panel under the purview of CMS would be the best approach to studying and validating E/M services, and the expert panel, which should include physicians, patients, health economists, and billers and coders, would be responsible for establishing a permanent mechanism to ensure that the relative valuation of E/M services is data driven and reflects current practice. The Endocrine Society welcomes the opportunity to work with the agency in valuing E/M services and we stand ready to provide our input and expertise as needed.

Split/Shared Services

CMS has proposed, and delayed multiple times, that the "substantive portion" of a split/shared service in the inpatient setting is determined by the practitioner that spends "more than half the time" with the patient, and therefore should bill for the service. The Endocrine Society has never supported this definition of substantive portion, and we are pleased that the agency will again delay implementing this policy. As stated in our comment letter for the CY 2023 proposed rule, we support defining "substantive portion" as the practitioner who provides the medical decision making **or** spends the most time providing care to the patient. Using either of these means to determine substantive portion allows greater flexibility and aligns with the recent revisions of inpatient E/M services CPT® codes.

[4] Hsiao, WC, Braun, P, Dunn DL et al. Med Care 1992;30 (11) Supplement: NS1-NS12.

As we have noted in prior comments on this subject, endocrinologists often provide care using a team-based approach when treating patients with diabetes and other endocrine related disorders. For example, team-based care provides a diabetes patient with a well-rounded course of treatment that includes input and care from diabetes educators, nurse practitioners and physician assistants. The use of time to determine the substantive portion will likely erode team-based care and is counterintuitive to the current practice of endocrinology.

We suggest that in future rulemaking that the agency finalize the definition of substantive portion so that time or medical decision making may be used to determine the practitioner that bills for the service.

New Service for Administration of Social Determinants of Health Risk Assessment

The Biden Administration continues to develop policies that address healthcare equity and create fair access to government funded health care services and programs. With that in mind, the agency has proposed a new code to capture the time and resources required to perform a social determinants of health (SDOH) risk assessment.

These new services include the following:

- GXXX5: administration of a social determinants of health (SDOH) health risk assessment.

The Endocrine Society supports the creation of services that support the care we provide and improve the wellness of our patients. The services described by the new G code and caregiver training CPT® codes (discussed below) are services that we believe our members will utilize, and if finalized, we will provide our members with information on how to document and bill for these services. Having said that, the Endocrine Society urges the agency to first provide clarity on an issue with the provision of the SDOH assessment, and then if the code is finalized, we urge the agency to provide sub-regulatory guidance to clarify any remaining ambiguity.

Code GXXX5 describes the administration of a SDOH assessment not more than once every six months. It is unclear if this is service may be billed once every six months per patient or if the service is billable only once every six months per physician performing the assessment. That is, may an endocrinologist perform the

SDOH assessment, and one month later, may a surgeon perform the service before performing, for example, an amputation to better understand the needs of the patient pre- and post-surgery. We believe that it is possible that both the endocrinologist and the surgeon may want to perform the SDOH assessment based on the needs of the patient and the care plan set forth by both doctors. We seek clarity as to how the agency intended this code to be used and that the frequency be better defined.

Payment for Caregiving Training Services

With this rule, CMS has proposed to accept and make payment for new CPT® codes used to report caregiver training services that improve functional performance. Those services are described CPT® codes 9X015, 9X016, and 9X017. Additionally, CMS has proposed to provide payment for caregiver training services in a group setting. The codes associated with these services (CPT® codes 96202 and 96203) were previously not payable under Medicare.

We support the codes, and the payment as proposed by the agency. Caregivers are an important component of any successful course of treatment, and we believe caregivers can provide emotional and practical support to family members when that support is learned from specialists who provide caregiver training. We encourage the agency to finalize the codes and payment for caregiver training services.

Payment for Telehealth Services

With this proposed rule, CMS is implementing the extension of certain telehealth flexibilities including the waiver of the originating site requirement geographic restrictions, and coverage of audio-only services, through December 31, 2024. These flexibilities were authorized by Congress in the Consolidated Appropriations Act of 2023. We thank the agency for the continued flexibility associated with the provision of telehealth services, including audio-only services. We have found that the use of telehealth has greatly improved patient care, allowing patients to remain in their home for care, especially those who are immobile or unable to travel great distances has improved access to care.

As noted in our 2023 MPFS comment letter, Endocrine Society members are using telehealth services to treat patients and increase access to the specialized care we provide, potentially reducing the burden of health inequities and social determinants

of health. We also thank the agency for continuing to allow the use of virtual direct supervision, and for continuing to make payment at the non-facility rate for telehealth services provided to a Medicare beneficiary in their home. We believe that payment parity for telehealth services is important to support the continued delivery of virtual care. The setting under which a telehealth service is provided should have no bearing on the reimbursement level, as the costs and resources required are the same. We recognize that payment parity for services billed with POS 10 will not apply to many of the services our members provide unless Congress eliminates the originating site requirement beyond December 31, 2024. Since this flexibility is so important to our members, the Endocrine Society is advocating for Congress to make this change.

Diabetes Policies

The proposed rule contains several provisions to improve care for people living with diabetes and those at risk of developing diabetes. The rule would expand coverage of diabetes screening tests to include the Hemoglobin A1C (HbA1C) test. The Society supports this proposal, and we are pleased that CMS is following the recommendations of the U.S. Preventative Servies Taskforce (USPSTF) which recommends the use of the HbA1C test. The proposal would also expand and simplify the frequency limitations for diabetes screening. The Society supports these changes because it will make screenings easier to conduct and document which will reduce the burden for both physicians and beneficiaries.

The rule would also make changes to the Medicare Diabetes Prevention Program (MDPP) expanded model to improve utilization of the program. CMS has proposed creating a fee-for-service model which would allow beneficiaries to attend up to 22 sessions during the core services period of the program. The Society supports these changes and agrees with the agency that more needs to be done to improve beneficiary retention of this highly effective program. We also urge CMS to remove the once-per-lifetime limit on benefits which has restricted access to the program for beneficiaries who are most in need of MDPP services. The once-per-lifetime rule also does not align with other Medicare programs for behavior change, including smoking cessation and obesity counseling.

Thank you again for the opportunity to provide comments on this proposed rule. We are committed to working with you on the development of these payment policies. Should you have any questions or require additional information, please direct your

correspondence to Rob Goldsmith, Director of Advocacy and Policy, at rgoldsmith@endocrine.org.
Sincerely,

Stephen R Hammes, M.D., Ph.D.
President
Endocrine Society