ENDOCRINE SOCIETY
Hormone Science to Health

September 11, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Submitted via Regulations.gov

Dear Administrator Oz,

On behalf of the Endocrine Society, thank you for the opportunity to submit these comments on the Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies proposed rule.

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, pancreatic, pituitary) and thyroid disease. Many of the patients our members treat are Medicare beneficiaries. We also note that there is currently a shortage of adult endocrinologists across the country which has significantly impacted rural and underserved areas and will continue to rise.[1] As a result of this shortage, wait lists to see an endocrinologist can be many months long which negatively impacts Medicare beneficiaries.

Our members also experience some of the lowest salaries of medical subspecialists and often work outside of clinic time due to the complexity of diagnosis and treatment of endocrine conditions. Despite these challenges, endocrinologists have not seen significant increases in Medicare payments in decades. Consequently, the payment policies and other

[1] Romeo GR, Hirsch IB, Lash RW, Gabbay RA. Trends in the Endocrinology Fellowship Recruitment: Reasons for Concern and Possible Interventions. J Clin Endocrinol Metab. 2020 Jun 1;105(6):1701–6. doi: 10.1210/clinem/dgaa134. PMID: 32188983; PMCID: PMC7150610.

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revisions in the MPFS are of significant importance to our members. With this background, we provide comments on the following topics discussed in the proposed rule.

- Conversion Factor for 2026
- Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
- Proposed Efficiency Adjustment
- Potentially Misvalued Services Under the Physician Fee Schedule
    - Fine Needle Aspiration (FNA) CPT® Codes 10021, 10004, 10005, and 10006
- Payment for Medicare Telehealth Services under Section 1834(m) of the Act
    - Group Behavioral Counseling for Obesity
    - Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations
- Request for Information on Prevention and Management of Chronic Disease
- Medicare Diabetes Prevention Program (MDPP)
- MIPS Performance Category Measures and Activities: Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes

Conversion Factor for 2026:
2026 marks the first year that there are two separate conversion factors: one for practitioners working in a qualifying advanced alternative payment model (APM) and the other for those not participating in a qualifying APM. The conversion factor for the former will increase to $33.59, an increase of 3.83%, and the conversion factor for the latter will increase to $33.42, an increase of 3.62%. These increases reflect the 2.5% adjustment to the 2026 conversion factor included in the *One Big Beautiful Bill Act* recently adopted by Congress.

The Endocrine Society appreciates that the statutory update and other changes to the fee schedule result in a positive increase to the conversion factor. However, this increase is negated by the continued downward pressure on physician payment created by policies proposed in this rule, including the efficiency adjustment and the policy to reduce practice expense for services performed in the facility. These policies and resulting decreases in reimbursement threaten patient access to medically necessary services. Millions of Americans manage chronic conditions such as osteoporosis, obesity, and diabetes, and have little to no access to endocrinologists or face long wait times. One of the reasons for this shortage is that endocrinology continues to be one of the lowest paid specialties. Given that salary is a key consideration for aspiring physicians, we ask CMS to consider policies that encourage better pay for endocrinologists which will help address this ongoing shortage.

Since endocrinologists continue to face many challenges, it is not helpful to our members when reimbursement rates continue to decrease. Therefore, we urge the agency to adopt policies that increase, rather than cut, physician payment. After three decades of stagnant Medicare reimbursement rates and the proposed cuts in this rule, we believe this situation is unsustainable for endocrinologists and other physicians who continue to struggle, and the Medicare beneficiaries we treat.

We encourage the agency to work with Congress to develop solutions that provide certainty and stability to the MPFS. The Endocrine Society intends to continue congressional advocacy to help craft a legislative solution to create a sustainable reimbursement system for MPFS services that includes regular positive updates to the conversion factor.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
CMS proposes to change the methodology for the allocation of indirect PE within the physician payment formula. As described in the rule, CMS proposes "for each service valued in the facility setting under the PFS, we propose to reduce the portion of the facility PE relative value units (RVUs) allocated based on work RVUs to half the amount allocated to nonfacility PE RVUs beginning in CY 2026." According to the agency, this proposed change will reflect the current state of clinical practice given that there are fewer physicians working in private practice settings, and therefore, "the allocation of indirect costs for PE RVUs in the facility setting at the same rate as the non-facility setting may no longer reflect contemporary clinical practice."

The Endocrine Society disagrees with the CMS assumption that physicians providing services in the facility setting do not incur indirect PE costs at the same rate as for services provided in the non-facility setting. It is often assumed that physicians based at academic institutions or large health care systems do not incur indirect practice costs when providing services within the institution. Based on feedback from our members, we want you to know that this is not always the case. Some of our members in hospital-based practices still pay rent for office space and incur indirect costs associated with billing and scheduling. As written, the proposal would decrease indirect PE RVUs (e.g., rent, utilities, staff salaries) for both hospital-employed physicians and private practice physicians performing procedures in facility settings. The proposed cuts to indirect practice expense payments will have a direct and significant impact on the ability of endocrinologists to operate their practices, even when working for larger hospital institutions. This payment reduction will also affect patient access to care and may negatively affect the endocrinologist workforce. There is already a shortage of endocrinologists in the US, and further cuts to physician payment will only exacerbate this problem. We note that endocrinologists are critical to addressing chronic diseases because they manage some of the most common, complex, and costly conditions

affecting Americans. Their expertise goes beyond treating individual symptoms; endocrinologists coordinate long-term care for diseases that require continuous monitoring, medication adjustments, and patient education. Endocrinologists provide care, and monitor treatment for diabetes, obesity, osteoporosis, and thyroid diseases, all of which affect the Medicare population. Cutting physician payment is not prudent at a time when the administration is searching for ways to address the proliferation of chronic diseases.

The Endocrine Society acknowledges that physician practice ownership patterns have evolved since the inception of the Medicare PFS. However, reducing the indirect PE component of the physician payment formula without an evidence-based rationale is not an appropriate way to address concerns about consolidation. In fact, such cuts may accelerate consolidation by further lowering payment rates for physician services. The proposed 50% reduction to the indirect PE portion of the formula appears arbitrary, and we strongly urge CMS not to finalize this policy. Additionally, CMS has not shared the underlying data or methodology supporting this proposal, making it difficult to assess or provide informed comments. Based on our members' feedback, there is no consistent standard for how facility-based physicians incur indirect costs. It is not likely that all physicians will be affected equally, and therefore, we recommend CMS take a more measured approach and not use broad, sweeping policy to cut physician payments. We request CMS release the empirical data and methods used to justify this policy. If such data does not exist, we respectfully request that CMS first collect it and develop a proposal based upon it, providing stakeholders with the opportunity to review the underlying data and provide subsequent comments.

We urge CMS to not finalize this policy and to recognize that physicians, no matter the site of service of a procedure, still incur indirect practice expenses. Payment reductions not only harm physician practices but further undermine the value of the services being provided. Also, we recommend that at the very least the agency phases in the payment cut over four years as the agency has done with other impactful changes to the PE methodology to minimize the financial disruption to physician practices.

Proposed Efficiency Adjustment

For the first time, CMS proposes an efficiency adjustment to reduce the work RVUs and intraservice physician times for non-time-based services reducing reimbursement based on the rationale that physicians who perform these services become more efficient over time. Specifically, CMS proposes to apply an efficiency adjustment of -2.5% to the work RVUs and intraservice time for nearly all services on the MPFS, including procedures, radiology services, and diagnostic tests. The adjustment will not apply to time-based services,

including evaluation and management (E/M) visits, behavioral health services, maternity global codes, and care management services.

The agency has wrongly assumed that technology automatically improves efficiency, and the agency is using this flawed assumption to justify the 2.5% reduction in work RVUs and intraservice time. We argue the opposite. Prior to the development of Continuous Glucose Monitors (CGMs), real-time notifications, data downloads, and insulin pumps, endocrinologists reviewed a much more limited set of diabetes-related data at each patient visit. Now, and for endocrinologists in particular, technology has increased the amount of data available for physician review and to inform changes to the patient's treatment plan, which has resulted in better patient care, but not a reduction in time or efficiency. With CGM, insulin pumps, and other advanced technologies, physicians are inundated with *more* information than ever before. Even when technology, like the electronic health record is used, physicians must still spend considerable time reviewing the information, interpreting it, and discussing it with patients. Greater efficiencies in documentation or chart review do not reduce the cognitive work of data review, medical decision-making, preparing for a procedure, or other activities required for a medical intervention.

We also note that the complexity of endocrine patients has grown significantly. Physicians often need to address multiple chronic conditions within a single visit and prior to any procedural interventions, which lengthen encounters regardless of technological advances. In addition, for certain procedures such as thyroid ultrasound or fine needle aspiration (FNA), efficiency simply cannot replace precision and attention to patient safety. These services demand careful attention and technical accuracy, and there is no reasonable way to shorten the time to perform an FNA without compromising patient safety.

The assumption that efficiency reduces physician work is deeply flawed. It has brought benefits and optimized some aspects of practice. However, as mentioned before, patients are more complex, we have more data to analyze, and there is an increase in medications and lab reviews. We would argue that technology is not keeping pace with medical progress. The time, intensity, and expertise required in modern endocrine care have only increased, not decreased. We strongly recommend CMS reconsider policies that rely on arbitrary definitions of efficiency to justify reductions in physician reimbursement.

The Endocrine Society urges CMS not to finalize this policy. Instead, the agency must appropriately define efficiency, and how it may or may not translate to reduced work RVUs and intraservice time for every surgical procedure on the MPFS. The agency has also asked for information on the use of alternate data sources to support the valuation of a physician service, instead of the agency relying on the AMA RUC survey process.

The Endocrine Society has previously supported the development of a technical advisory panel to support the agency, and we again suggest that CMS consider this option. We reiterate our comments from on the CY2024 MPFS proposed rule "*Supporting 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.*[2] *This statement from Dr. Hsiao still holds true today despite recent efforts to redefine and revalue E/M 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*."

This cut to physician payment is ill-informed and comes at a time when the Medicare population needs endocrinologists more than ever. According to the Centers Disease Control and Prevention, diabetes is the most expensive chronic condition in the US.[3] Without a robust endocrinology workforce to manage and treat these patients, the costs will continue to climb. Additionally, the total Medicare costs of caring for complications associated with diabetes, including kidney disease, congestive heart failure, and stroke is approximately $37 billion annually.[4]

Potentially Misvalued Services Under the Physician Fee Schedule: Fine Needle Aspiration (FNA) CPT® Codes 10021, 10004, 10005, and 10006

Fine needle aspiration services represented by CPT codes 10021, 10004, 10005, and 10006 have been nominated as misvalued. CMS does not agree that the services are misvalued.

The Endocrine Society participated in the most recent resurvey of these services and was disappointed when CMS did not accept the RUC-recommended work values from that

[2] Hsiao, WC, Braun, P, Dunn DL et al. Med Care 1992;30 (11) Supplement: NS1-NS12.
[3] Centers for Disease Control and Prevention; Cost of Diabetes Complications for Medicare Beneficiaries. https://www.cdc.gov/diabetes/data-research/research/older-adults.html Accessed Aug. 29, 2025.
[4] Ibid.

survey. CMS double-counted the utilization for the new codes that had image guidance bundled, which resulted in the agency believing that the RUC recommended a 20% increase in physician work for the code family. **We do not believe that the codes need to be resurveyed but respectfully request that CMS correct the error with the following RUC recommended work RVUs:** 1.63 for CPT code 10005, 2.43 for CPT code 10009, and 1.20 for CPT code 10021.

Payment for Medicare Telehealth Services under Section 1834(m) of the Act

Group Behavioral Counseling for Obesity:
CMS received a request to add HCPCS code G0473 (*Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes)* to the Medicare Telehealth Services List. The agency believes that it meets the three steps for review and proposes adding the service to the Medicare Telehealth Services List. The Endocrine Society supports adding code G0473 to the Medicare Telehealth Services list. The ability to provide these services remotely will allow easier access to care for Medicare beneficiaries, while providing critical lifestyle interventions to help patients overcome their challenges with obesity.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations:
CMS proposes to permanently remove frequency limitations on furnishing services via telehealth for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services. The Endocrine Society supports this proposal.

Request for Information on Prevention and Management of Chronic Disease
We appreciate the agency's interest in supporting the prevention and management of chronic diseases and its request for feedback on how to enhance support for the prevention and management of chronic diseases. Endocrinologists are on the front lines of treating Medicare beneficiaries with diabetes and obesity – two of the most common chronic illnesses in the United States. Our members also treat other chronic conditions such as osteoporosis, thyroid disorders, adrenal, and pituitary conditions. Nearly every patient encounter with an endocrinologist involves management of a chronic disease.

We continue to be concerned about the obesity epidemic and the impact it has on the health of all Americans. Obesity is a direct link to hundreds of other chronic conditions. People living with obesity are at increased risk of developing over 230 complications including diabetes, heart disease, liver disease, and cancer. People living with obesity are nearly six

times more likely to develop type 2 diabetes.[5] There also continues to be a rising prevalence of obesity across the country. According to a recent study, between 1990 and 2021 the obesity rate doubled in adults to more than 40% and nearly tripled to 29% amongst girls and women aged 15 to 24.[6] Addressing this crisis has been a major priority for the Society and we urge CMS to consider ways to remove the barriers that Medicare beneficiaries face in accessing obesity treatment and care. Under Medicare Part B, Intensive Behavioral Therapy (IBT) is an effective lifestyle intervention that helps people living with obesity manage their disease through dietary and nutrition assessment. Unfortunately, IBT for Obesity is underutilized with only 2.16% of the more than 7.6 million Medicare FFS beneficiaries with obesity utilizing IBT.[7] CMS has limited coverage of IBT to primary care providers (PCP) in the primary care setting which is the primary reason for the underutilization of this benefit. We urge you to remove these restrictions to IBT and make it easier for PCPs to refer IBT to endocrinologists, registered dietitians, nutritional professionals, and community-based lifestyle programs.

Endocrinologists are often treating Medicare patients with multiple chronic conditions that interact in complex ways. For example, an older patient with diabetes, osteoporosis, and obesity requires medication adjustment, fall prevention planning, nutrition counseling, and sometimes coordination with surgeons or rehabilitation services. Endocrinologists routinely spend considerable time during these patient care interactions providing guidance, care coordination, and medication management; counseling on lifestyle interventions; and providing emotional support. The work of an endocrinologist directly supports CMS's priorities to reduce the health and economic burdens of chronic disease. To support the complex cognitive care necessary to prevent chronic disease, we need a robust workforce with endocrinologists, other specialists, and primary care physicians who support prevention and disease management. The policies in this proposed rule – namely the efficiency adjustment and change in calculation of the indirect practice expense – will only exacerbate the existing shortages of endocrinologists and other cognitive physicians. CMS must use the policy levers at its disposal to support better reimbursement for prevention and disease management services. Most of this work is represented by evaluation and management

[5] The American Journal of Managed Care. Obese Individuals Nearly 6 Times More Likely to Develop T2D, Study Finds. Accessed on January 22, 2025: https://www.ajmc.com/view/obese-individuals-nearly-6-times-more-likely-to-develop-t2d-study-finds

[6] The Lancet. National-level and state-level prevalence of overweight and obesity among children, adolescents, and adults in the USA, 1990–2021, and forecasts up to 2050. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)01548-4/fulltext

[7] Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF CY2019. Data.cms.gov. https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-otherpractitioners/medicare-physician-otherpractitioners-by-geography-and-service/data.

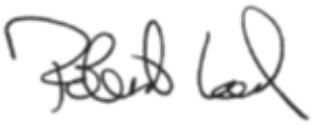
services, which continue to be undervalued despite recent improvements to their valuation. The Endocrine Society would welcome the opportunity to collaborate with agency to help create programs that support endocrinologists while also benefiting Medicare beneficiaries.

Medicare Diabetes Prevention Program (MDPP)
The Society supports the proposed changes to the Medicare Diabetes Prevention Program (MDPP) which will ensure that the program has the flexibility to expand the virtual care options that are available via online delivery for Medicare beneficiaries until 2029. As you know, the MDPP expanded model aims to prevent the onset of type 2 diabetes amongst Medicare beneficiaries using the proven clinical interventions from the CDC's National Diabetes Prevention Program. We support the proposed changes that will ensure that the Program's online services are consistent with the standards set by the Diabetes Prevention Recognition Program (DPRP). Given your Administration's commitment to addressing chronic disease prevention, we urge you to make the MDPP a permanent benefit in Medicare. Making the MDPP a permanent benefit would expand virtual access of the program which has proven to successfully delay the onset of type 2 diabetes.

MIPS Performance Category Measures and Activities: Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes
The Society supports the inclusion of the Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes measure to the MIPS. Our members participated in the development of this measure which is aligned with U.S. Preventative Services Taskforce recommendations on screening for prediabetes. Including this measure in the MIPS provides another tool for the providers to help patients delay the onset of type 2 diabetes.

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,



Robert Lash, MD
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