ENDOCRINE SOCIETY
Hormone Science to Health

August 28, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1612-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B Proposed Rule for CY 2016

Dear Mr. Slavitt:

On behalf of the Endocrine Society (Society), we appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed revisions to the payment policies under the Medicare physician fee schedule (PFS) for calendar year 2016. Founded in 1916, the Society represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as osteoporosis, diabetes, hypertension, infertility, obesity, and thyroid disease.

The Society looks forward to working closely with CMS as this proposed rule moves toward implementation and offers the following comments which focus on areas of particular importance to our members:

1. Improved Payment for the Professional Work of Care Management Services
2. Establishing Separate Payment for Collaborative Care
3. Complex Chronic Care Management Services
4. Physician Quality Reporting System
5. Clinical Improvement Activities under the Medicare Incentive Payment System (MIPS)
6. Physician Compare

Improved Payment for the Professional Work of Care Management Services

The Society applauds CMS for recognizing care management as a critical aspect of helping individuals achieve better health outcomes and reducing expenditure growth. We commend the

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agency for proposing to address the deficiencies in the existing evaluation and management (E/M) services, particularly as they relate to the delivery of comprehensive, coordinated care management.

We support CMS' proposal to create add-on codes to reimburse currently uncompensated physicians' work associated with E/M services as a practical and expedient, though limited, solution to the undervaluation of E/M services. We favor an initial focus on the outpatient new and established patient E/M code families, since these represent the most substantial of the many deficiencies in the existing codes.

The Society recommends two categories of new add-on codes be developed for use by all specialties: one for new and one for established patients. Each category should have two levels – the first for a high level of intensity and the second for even higher levels of intensity. Our members will suggest the corresponding vignettes.

These codes should follow the resource-based paradigm of resource-based relative value scale (RBRVS) using work intensity as the unit of resource use. For primary care, the levels of intensity would recognize both the complexity of multiple interactions of medications and health problems and the post-visit work intensity for patients with multiple chronic conditions. For the specialist, the levels of intensity would correspond to disease state complexity and medical decision making.

More Research Needed in Order to Understand E/M Services

While we appreciate CMS' current proposal to more fairly recognize physician work in providing E/M services, it is limited in scope by its very nature and will at best be only partially successful. New payment models being studied and implemented by CMS continue to rely on the RBRVS when determining physician compensation. Yet, the existing E/M codes continue to be inadequately defined and valued – a gap that has grown substantially in the 30+ years since their initial Harvard valuation.

In particular, the variability and intensity of the E/M work done by many specialties both within the face-to-face encounter as well as during the post-service period continues to evolve in complexity. Unfortunately, the existing E/M codes remain limited and fail to capture the diverse and growing efforts required within the current health care continuum.

Previously, the Society and 15 other cognitive specialties proposed that CMS improve the accuracy in the PFS by creating new outpatient E/M codes that would be developed from a research-based model. The model would be developed by studying the work done by physicians across the country before, during and after E/M services. If successful, this research-based model could then be used to address the deficiencies in the other E/M code families.

We urge CMS to commit to underwriting this research by hiring an expert contractor to work with stakeholders to develop a comprehensive understanding of the outpatient E/M work that physicians and their clinical staff currently perform. This research would: 1) describe in detail the full range of intensity for outpatient E/M services, 2) define discrete levels of service intensity based on this observational and electronically stored data combined with expert opinion, 3) develop documentation expectations for each service level that place a premium on the assessment of data and resulting medical decision making, 4) provide efficient and meaningful guidance for documentation and auditing, and 5) ensure accurate relative valuation as part of the PFS.

This research will be critical to identifying and valuing the uncompensated work associated with E/M services that the agency intends to support with the add-on code proposal, as well as for the development of new E/M codes. It will also help clarify what physician work should be attributed to the E/M services and allow a clear definition of what Medicare should expect from chronic care management (CCM) and transitional care management (TCM) services.

We applaud and fully support the commitment on the part of CMS to address the longstanding problem of inadequately defined and undervalued E/M services. We will gladly provide added support to any contractor hired to pursue the needed research and we will be pleased to serve as a resource for the agency in its efforts to ensure accurate service code definitions and valuations.

Establishing Separate Payment for Collaborative Care

Endocrinologists often work as part of a care team to provide optimal care for their patients. Chronic diseases, like diabetes, benefit from such team-based approaches that enable patients, their care givers, and their physicians to work in tandem to improve outcomes. Because of workforce shortages and the rapidly growing number of individuals with endocrine diseases, endocrinologists also serve as a consultant to primary care physicians and other specialists when the need for such expertise might arise. Endocrinologists spend a substantial portion of their time providing these collaborative services, including professional telephone consults, care coordination, and telemedicine. Through all of these arrangements, endocrinologists improve patient outcomes and provide additional expertise to the primary physician.

Given the extensive amount of time endocrinologists spend providing collaborative care, we support CMS' proposal to reimburse physicians for this care since the existing E/M services do not reimburse for the services provided in this context. While we understand that this proposed payment is not a replacement for the consultation codes, this proposal would address a gap in reimbursement that has existed since the elimination of those service codes. We envision that these payments will

reimburse physicians who may collaborate on a patient's case but never have face-to-face patient interactions.

As CMS considers how to operationalize this proposal, we are concerned about the imposition of potential health information technology requirements. If these requirements are too burdensome, they could prove to be too challenging for small practices and solo practitioners. We recommend that CMS remember this as the proposal is operationalized and not require full data transparency between collaborating physicians.

We also recommend that patient liability be waived for all physicians who provide collaborative care, extending beyond those participating in certain Innovation Center projects. Increasing access to specialty knowledge and to decision support will improve the accuracy of the primary physician's medical decision making and improve efficiency by eliminating the wait to incorporate specialized care recommendations as part of a patient's health plan.

Complex Chronic Care Management (CCM) Services

The Society commends CMS for looking for ways to improve beneficiary access to both the CCM and TCM services. We believe that this non-face-to-face care is critical to improving beneficiary health outcomes and lowering costs. However, we believe that the CCM code utilization will not increase unless specific changes to the service are made.

Endocrinologists provide care for many Medicare beneficiaries with chronic and complex conditions, like diabetes and thyroid disease, and often take on the role of the primary provider in disease management. We believe that our members and their patients will benefit if refinements are made to this code. The proposed work RVU of 0.61 and non-facility practice expense RVU of 0.54, which is approximately $42 in reimbursement for the service, undervalues the service. We remain concerned that the reimbursement level is so low that it does not support the costs of the staffing and technology requirements for the service, so physicians continue to do this work but do not bill for the service. We also recommend that CMS consider adopting the CPT code for more complex patients with its higher reimbursement level. This service would better reflect the complexity of many patients who require this type of care management.

The Society is also concerned about the time requirements for the service, which requires 20 minutes of care management services to be provided over a 30 day period. In the first eight months of use, this requirement has proven inefficient and impractical in practice. Patient care coordination needs may vary considerably from month to month. Over a year, the average time spent on non-face-to-face services may be 20 minutes per month. However, it could vary widely from month to month,

some months only a 5 minute phone call may be required and other months calls as long as 45 minutes may be required to manage a patient's condition. The requirement of 20 minutes per month will impose an unrealistic expectation that will challenge practices and potentially lead to unnecessary documentation. Documenting short phone calls or other interactions could interrupt the workflow of a practice and potentially disrupt the care delivered to patients. As such, the Society recommends that the reporting period be one year, and that the payment be based on a monthly average of 20 minutes across the year.

Physician Quality Reporting System

CMS has stated that it will implement two new measures groups: Diabetic Retinopathy and Multiple Chronic Conditions. The Society supports these new measures groups and thanks CMS for placing a greater emphasis on diabetes and other chronic conditions. With over 29 million people in the US with diagnosed or undiagnosed diabetes and approximately 25 percent of the population with multiple chronic diseases, the government must place its full support behind efforts to reduce these diseases and the resulting co-morbidities. Encouraging eligible providers (EPs) to focus on improving care for these patient populations will ultimately result in improved health and lower costs.

Despite these new measures groups, endocrinologists still lack a robust set of measures that reflect their practice patterns. The Society encourages CMS to work with the medical community to develop measures for those specialties who may lack a wide breadth of measures related to the work of their specialty. For example, many endocrinologists subspecialize in specific conditions, such as thyroid disease. For these physicians who see very few patients with diabetes, the number of measures from which they have to choose is very small. CMS must continue to work with specialty organizations to identify alternative methods for measure development and testing. Many small organizations lack the resources to undertake the time-intensive and costly process to develop measures specific to their specialty. We commend CMS for their willingness to accept measures outside of the NQF endorsement process, but urge even greater flexibility for those specialties with few measures specific to their work.

Clinical Improvement Activities under the Medicare Incentive Payment System (MIPS)

CMS has requested stakeholder input on activities that may qualify as Clinical Improvement Activities under the new MIPS program. The Society supports rewarding a practice's efforts to improve quality through the addition of clinical improvement activities to their services. The Society recommends that CMS consider recognition of tools and activities that allow the patient to play a greater role in their care, such as the use of shared decision making tools and transitions of care resources. These tools will encourage buy-in from patients for their care plans, and will ensure

that relevant information is shared with the other providers in the patient's care team, thereby leading to higher-quality of care, fewer complications, and reduced costs. The Society has developed resources to encourage shared decision making for patients starting on mealtime insulin (Accurate Insulin Decisions at www.accurateinsulin.org), and aid the transition for patients moving from the care of a pediatric endocrinologist to an adult endocrinologist (www.endocrinetransitions.org). We have also partnered with the American College of Physicians to develop toolkits to facilitate more effective, high value, patient-centered care coordination between primary care and specialty practices (hvc.acponline.org).

CMS should also consider diabetes self-management training (DSMT) as a clinical improvement activity. DSMT provides critical knowledge and skills training to patients with diabetes, helping them manage medications, address nutritional issues, facilitate diabetes-related problem solving, and make other critical lifestyle changes to effectively manage their diabetes. Evidence shows that individuals participating in DSMT programs are able to progress along the continuum necessary to make sustained behavioral changes in order to manage their diabetes. DSMT has been proven effective in helping to reduce the risks and complications of diabetes and is a vital component of an overall diabetes treatment regimen. Patients who have received training from a certified diabetes educator are better able to implement the treatment plan received from a physician skilled in diabetes treatment. Despite its effectiveness in reducing diabetes-related complications and associated costs, DSMT has been recognized by CMS as an underutilized Medicare benefit, even after more than a decade of coverage. Providing credit through the MIPS program for practices that offer DSMT to their patients may encourage more providers to offer this service.

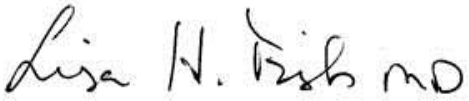
Physician Compare

CMS proposes to continue the Physician Compare program under the policies established in prior years, with the addition of two new proposals, including the reporting of group practices and EPs who receive a positive adjustment for the Value Modifier (VM). The VM program is new to most EPs, and is a relatively complicated program. The Society is concerned that reporting those who receive a positive adjustment will provide an inaccurate picture to patients who use the Physician Compare website to select a provider. Given that the VM program will sunset at the close of 2018 and Merit-Based Incentive Payment System (MIPS) will be implemented in 2019, we encourage CMS not to implement this proposal and instead wait to report the VM component of MIPS. Only when providers fully understand the program and how it affects their practice will the reporting of a positive adjustment provide meaningful information to consumers. We believe that the appropriate time will be when all providers are reporting under MIPS.

The Society is also concerned about the proposal to publicly report group Qualified Clinical Data Registry measures for individuals on Physician Compare. Attributing group practice data to an individual physician does not provide the necessary information to allow the consumer to determine how the individual physician performed on those measures. While an individual physician in the group could have provided high-quality care during the reporting period, another physician or physicians could bring the group's scores down with low-quality care. As such, the low-quality care provided by those physicians is negatively affecting other members of the group. We urge CMS to either report QCDR measures based on the individual physician's performance or eliminate this proposal.

The Society appreciates the opportunity to provide comments to CMS on the 2016 Medicare Physician Fee Schedule proposed rule and appreciates the hard work that went into drafting it. Please do not hesitate to contact Stephanie Kutler, Director, Quality Improvement at skutler@endocrine.org or Meredith Dyer, Associate Director, Health Policy, at mdyer@endocrine.org, if we may provide any additional information or assistance as CMS moves forward in developing this rule.

Sincerely,



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