THE ENDOCRINE SOCIETY

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August 30, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1524–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Proposed Rule; CMS-1524-P

Dear Dr. Berwick,

On behalf of The Endocrine Society (Society), representing more than 14,000 physicians and scientists in the field of endocrinology, we appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed revisions to the payment policies under the Physician Fee Schedule for calendar year 2012. The Society looks forward to working closely with CMS as this proposed rule moves toward implementation.

Founded in 1916, the Society represents physicians and scientists engaged in the treatment and research of endocrine disorders, such as osteoporosis, diabetes, hypertension, infertility, obesity, and thyroid disease. The following comments focus on five areas of particular importance to our members:

1) CY 2012 Identification and Review of Potentially Misvalued Services
2) Payment for Bone Density Tests
3) Diabetes Self-Management Training (DSMT) Services (HCPCS Code G 0109)
4) Value-based Payment Modifier
5) Quality Reporting Initiatives

CY 2012 Identification and Review of Potentially Misvalued Services

In the proposed rule, CMS recommends that the American Medical Association Resource-based Relative Value Scale Update Committee (RUC) conduct a comprehensive review of all evaluation and management (E/M) codes by 2013. CMS notes that these services consistently appear in the top 20 physician fee schedule expenditures and that a comprehensive review of these services has not occurred since 2006. The Society welcomes this review as current values for E/M services do not adequately account for the time and expertise that cognitive specialists, like endocrinologists, provide in managing chronic conditions or in coordinating care.

Endocrinologists, like other cognitive specialists, primarily provide E/M services to patients with chronic and complex conditions that require a level of expertise that the referring physician is not

always trained to diagnose or qualified to treat. Significant time and resources are expended to develop an expertise that enables endocrinologists to treat complex and challenging cases. Studies have shown that patients with diabetes and thyroid disorders have lower morbidity rates, fewer readmissions, and lower healthcare costs when treated by an endocrinologist.[1] Endocrinologists provide cost-effective treatment that has shown to significantly reduce complications without the use of unnecessary diagnostic testing and procedures.[2] However, patients are often forced to wait up to 3 to 6 months for an appointment, as there are fewer than 4,000 clinical endocrinologists to care for the 25-100 million potential patients with conditions like diabetes and obesity in the United States.[3]

Patient access problems caused by workforce shortages can be partially attributed to current compensation for the E/M services these physicians primarily provide. Recent research shows that endocrinologists are one of the lowest paid specialties.[4] In contrast, procedural specialties such as orthopedic surgeons, radiologists, anesthesiologists, and cardiologists earned more than twice the average income of endocrinologists. The low compensation coupled with the increasing strain on endocrinologists' time due to the increasing patient load makes it difficult to attract physicians to the specialty, particularly when they have the option to go into a higher paying specialty.

As rates of conditions like diabetes continue to skyrocket, significant complications stemming from a shortage of endocrinologists can be expected in the future. CMS currently recognizes workforce shortages and the non-procedural work that is conducted by primary care physicians by providing a 10 percent incentive payment. This payment offsets the undervaluation of evaluation and management services and makes primary care more attractive to medical students. Due to the nature of the work that cognitive specialists provide, the Society requests that CMS expand this incentive payment to physicians who provide primarily E/M services to patients with chronic conditions. This payment would account for the additional training and expertise that cognitive specialists have in treating patients with chronic conditions, while making the field of endocrinology a more attractive option.

While the Society hopes the comprehensive E/M review will revalue and redefine these codes to improve care coordination and patient outcomes, it should be noted that these codes are not currently designed to account for chronic care management. The Society believes that these codes need to be restructured, rather than simply revalued, to properly address these factors and the shift from episodic to chronic care. In order to truly change healthcare delivery and accomplish the goals laid out in the proposed rule, CMS must develop a new system to code for chronic care management that accounts for varying complexity of cases and care coordination.

Furthermore, a comprehensive review of 91 E/M codes by 2013 – half by July 2012 – will be challenging. Significant work goes into the review of these codes and many organizations must work together to address ways in which these codes are utilized by various specialties in order to reach consensus. As such, the Society recommends that CMS extend the deadline for this review

[1] Levatan C., The Value of the Clinical Endocrinologist in the New Millennium. The Endocrinologist. 2001 11: 137-145.
[2] Levatan C., 2001.
[3] Dall TM, Zhang Y, Chen Y et al. The economic burden of diabetes. *Health Affairs*. 2010;29:297-303.
[4] Kane, L., 2011 Medscape Physician Compensation Report. MedScape. 2011. (http://www.medscape.com/features/slideshow/compensation/2011/)

until 2015 so that a workgroup can be formed to address underlying problems with the way in which these codes are structured, rather than simply revaluing these codes.

Extending this review to 2015 will also provide additional time for the healthcare delivery system to transition towards the value-based care that is necessary to address problems with current E/M values. Currently, this review would be restricted to calculating values based on resource inputs alone and cannot account for the value these services provide on a broader scale. Under these criteria, it will be difficult, if not impossible, to achieve better care coordination, to account for workforce shortages, or to adequately reimburse physicians who treat patients with chronic conditions without restructuring E/M codes altogether.

Payment for Bone Density Tests

The Society continues to be concerned with inadequate reimbursement for Dual Energy X-Ray Absorptiometry (DXA) scans and the negative impact this will have on patient access to bone density tests. A short-term fee fix was included in the Affordable Care Act to increase payments for these services to 70 percent of the 2006 rate. However, this provision is scheduled to expire at the end of 2011 and will result in a 50 percent reduction in reimbursement for these tests. Should this occur, fewer physicians will provide bone density tests and patient access to these services will be jeopardized.

It is essential that these services are appropriately reimbursed as more than half of women aged 50 or older have osteoporosis or low bone mass. This condition often goes un-diagnosed and untreated, leading to serious complications at a cost of $18 billion each year. Osteoporosis-related fractures are projected to increase by 50% over the next decade, which will only further strain the Medicare budget.

In the proposed rule, CMS recommends that the AMA RUC review CPT codes 77080 "Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)" and 77082 "Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment" during CY 2012. To avoid unintended and negative consequences that would stem from a 50 percent reduction in reimbursement for these services, the Society recommends that CMS extend rates for DXA at 70 percent of the 2006 rate until the AMA RUC has been able to review these codes. The Society further recommends that CMS reassess the effect that the Deficit Reduction Act of 2005 has had on patient access to these services.

Diabetes Self-Management Training (DSMT) Services (HCPCS G0109)

In the proposed rule, CMS notes an anomaly regarding the physician time allotted to a diabetes self-management training (DSMT) for a group session (HCPCS G0109) and recommends an adjusted time for these services that is based on 6 patients. As a result, the relative value units (RVUs) for G0109 would be decreased from 0.55 to 0.46. The Society is concerned that the decreased reimbursement for this service will negatively impact access to DSMT programs. With the drastic rise in rates of diabetes, the Society underscores the importance of these programs in reducing severe complications that result from the improper management of this disease. The Society recommends that CMS maintain the 2011 RVU's of 0.55 for G0109 because of the

growing number of Medicare beneficiaries with diabetes and the increasing need for DSMT services.

Value-based Payment Modifier

The Society welcomes a shift towards a healthcare delivery system that focuses on improving quality, reducing costs, and providing patient-centered and coordinated care. The Society has been active in the development of the Patient-Centered Medical Home and the Patient-Centered Medical Home-Neighbor care models that aim to achieve these goals and supports future innovation in these areas.

Under the Affordable Care Act, CMS is required to begin implementing a value-based payment modifier during 2013 so that it can be applied to specific physicians under the PFS in 2015, and to all physicians by 2017. CMS has proposed that physician feedback reports would serve as a testing basis to develop and implement the value-modifier and is currently testing these reports in several states. While the Medicare Administrative Contractor is able to assist CMS in disseminating these reports in these four states, there is concern about the ability to provide this information on a national level in the future without additional resources. The Society believes that these reports must be received by physicians in a timely manner in order to provide meaningful and actionable information to improve quality or reduce costs. As such, the Society recommends a reallocation of resources at CMS to better ensure that these reports are provided to physicians as soon as possible.

While the Society appreciates the fact that CMS is proposing to use quality measures already included in the Physician Quality Reporting System (PQRS) to streamline these programs, there is concern that if physicians fail to achieve the requirements for PQRS, they will also be subject to the penalty from the value-based payment modifier. The use of incentives and penalties for the adoption of health information technology is meant to aid in a physician's transition to the use of these systems. However, the numerous programs that have been developed over the past several years have contributed to a great deal of confusion and redundant penalties. The Society reiterates its support of CMS' recent efforts to align these programs but is concerned about the lack of time for physician education on these requirements.

The Society is also concerned about the way CMS intends to use this information in peer group comparisons. It will be difficult to compare value within specialties as many physicians work within different sub-specialties and treat patients with different conditions. For example, endocrinologists often have an expertise in diabetes, thyroid disease, or bone conditions. Because of this expertise, they are often referred the most complex and severe cases that would be difficult to compare because of a variety of co-morbidities that are found in these diseases. Therefore, conducting a comparative analysis of patients, even within an endocrine sub-specialty, would not provide actionable information because of varying complexities and complications of multi-system chronic conditions.

Because of these factors, it is important to make a risk-adjusted comparison regarding what condition is being treated, while factoring in issues such as complexity and co-morbidity in order to ascertain actionable data that can be used to improve value and reduce costs. The Society supports CMS' plan to investigate stratifying physicians by specialty and by the conditions they

treat to allow "both cost and clinical measures to reflect the procedures and services that best portray physician practice patterns" and would caution CMS against applying the modifier until it does so.

CMS proposes to use the year 2013 as the initial performance period to serve as the basis for the value-based modifier, which will be applied in 2015. The Society opposes this recommendation as many of the programmatic requirements have yet to be determined. The Society recommends that CMS delay the performance period until 2014 so that it can finalize details such as which physicians the modifier will be applied to in 2015 and the manner in which peer groups will be compared.

The Society believes that attribution is also highly problematic when assessing the quality and cost that will be used in the payment modifier. CMS must determine which physician is responsible for improved outcomes and reduced costs. Endocrinologists often treat the most severe patients, who are generally referred from a primary care physician. These patients often have multiple chronic conditions and much of the outcome is dependent on the patient's management of his or her disease. Because of this, endocrinologists can take steps to improve quality but it is often the patient's responsibility to effectively manage their disease. The Society hopes that CMS will take these factors into account so that physicians are not unfairly punished for lower quality due to a patient's failure to self-manage his or her disease.

Quality Reporting Initiatives

The Society appreciates CMS's efforts to streamline the quality incentive programs to provide clarity on reporting requirements and to reduce administrative burdens. While there continues to be significant confusion regarding programmatic components and deadlines among the physician community, the Society believes that efforts to align the Physician Quality Reporting System, the Electronic Health Record, and the e-Prescribing (eRx) programs are a step in the right direction.

It is critical that health information technology is easily adoptable and that significant physician education is provided so that physicians are not unfairly penalized for failing to meet these requirements. The Society actively educates its members on these programs but it is challenging because of the continually evolving requirements. The Society appreciates CMS' efforts to align the PQRS and EHR incentive programs so that certified EHR technology could be used to satisfy requirements for both programs in the future. However, with these changes there will also be additional confusion on the part of the provider. CMS should make significant efforts to provide education to physicians on these programmatic changes prior to implementing any payment adjustments.

The Society supports CMS' recent modifications of the eRx incentive program that provide additional significant hardship exemptions to better enable eligible professionals to avoid a pay adjustment. Furthermore, in the proposed rule, CMS recommends allowing eligible providers to report the eRx numerator 10 times without the denominator to avoid the pay adjustment, and 25 times with at least one of the denominator codes to receive the incentive payment. The Society supports this proposal, as physicians may not have an applicable denominator code to report with the numerator that would enable them to avoid the pay adjustment. However, the Society would like to reiterate the need for CMS to delay the 2012 payment adjustment because of failures to

provide adequate exemptions during the six month reporting period as well mid-year modifications to the program that did not allow for enough time to educate physicians on how to avoid this penalty.

The Society appreciates the opportunity to submit comments on the 2012 Physician Fee Schedule. As always, the Society is grateful to CMS staff for the hard work that went into drafting the proposed rule. Please do not hesitate to contact Meredith Dyer, Health Policy Manager, at mdyer@endo-society.org, if we may provide any additional information or assistance as CMS moves forward in developing this rule.

Sincerely,



Janet E. Hall, M.D.
President
The Endocrine Society