

June 13, 2024

The Honorable Charles Ron Wyden  
Chairman  
Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Mike Crapo  
Ranking Member  
Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the Endocrine Society, the world's largest professional organization of endocrinologists, thank you for the opportunity to provide comments on your white paper on physician payment reform. 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, infertility, obesity, osteoporosis, endocrine tumors cancers (e.g., thyroid, adrenal, pancreatic, ovarian, pituitary) and thyroid disease. Our membership includes over 11,000 clinicians who are on the front lines in treating diabetes and obesity, which are two of the most common chronic illnesses in the United States. Many of our members treat Medicare beneficiaries with these costly, chronic conditions, and making reforms to physician payment will help ensure those beneficiaries continue to have access to high-quality care. We also think it is important to acknowledge that obesity is a chronic disease, which affects many Medicare beneficiaries, and ask that you consider making this acknowledgement in the paper.

As you may know, there is a shortage of adult endocrinologists across the country. In 2025, this is expected to increase to a shortage of approximately 2,700 endocrinologists and will continue to rise.<sup>1</sup> The Society believes that mis-valuation of evaluation and management (E/M) services, which are the primary services billed by endocrinologists in the Medicare Physician Fee Schedule (MPFS), is one factor contributing to this shortage. Given the discrepancies in physician reimbursement for our members, we welcome the opportunity to work with you to address this critical issue and we are pleased to share the following comments on your paper.

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<sup>1</sup> 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.



## **Addressing Payment Update Adequacy and Sustainability**

### ***As an alternative to current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?***

Unfortunately, physicians have endured over 30 years of stagnant Medicare reimbursement rates which have not accounted for inflation or the evolution of office-based medical care. As the Committee knows, between 2001 and 2024 Medicare physician payment has declined by 30 percent when adjusted for inflation. The Endocrine Society urges Congress to put the MPFS on par with other Medicare fee schedules by providing an inflationary update to the conversion factor (CF) annually. The endocrinology pipeline is facing unprecedented challenges and providing stability to physician payment could help address some of them. Since 2010, there has been no growth in the number of medical graduates entering endocrinology in the United States and approximately 78.5% of counties in the United States have no practicing endocrinologist.<sup>2</sup> Many patients, particularly those in rural and underserved areas, must travel long distances and endure significant wait times to see an endocrinologist. All these issues are even more troubling for our members when combined with the annual cycle of looming Medicare cuts.

Providing stability to physician reimbursement could help address the challenges currently facing endocrinologists. In the white paper, the Committee recognizes that the current policy threatens the viability of independent practices and does not reflect practice cost inflation. The Endocrine Society recommends that the Committee provide an annual inflation-based adjustment to the CF equal to the Medicare Economic Index (MEI). As recognized in the white paper, CMS has described MEI as the best measure available of the relative weights of the three components of MPFS payments – work, practice expense, and malpractice. We urge you to work with your colleagues to pass legislation that provides long-term stability for physicians and their patients. We believe providing this stability is the first step to addressing the reimbursement challenges facing practicing endocrinologists.

### ***Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation?***

The Society is not aware of any advanced alternative payment models (A-APM) specifically being used by endocrinologists. A-APMs focused on chronic diseases such as diabetes are often incorporated into primary care bundles, which are not available specifically for endocrinologists. The Society urges Congress not to implement a differential CF at this time. We believe this policy should not be considered until there are viable A-APMs for

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<sup>2</sup> Goodson JD, Shahbazi S, Song Z. Physician Payment Disparities and Access to Services—a Look Across Specialties. *J Gen Intern Med.* 2019 Nov;34(11):2649-2651. doi: 10.1007/s11606-019-05133-0. Epub 2019 Aug 5. PMID: 31385213; PMCID: PMC6848648.



endocrinologists and other specialists to participate in. When there are meaningful A-APMs for specialists, we think there could be an opportunity to revisit this and consider a new CF framework.

### **Budget Neutrality and the Conversion Factor**

***What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting?***

The Society supports the Committee's efforts to ensure that the utilization of the MPFS services is accurately reported. This will ensure that the CF is appropriately adjusted based on the actual utilization. A good starting point would be to require the agency to compare the estimated utilization to actual utilization and adjust the CF based on the difference (either over- or underutilization). This could address discrepancies in estimated utilization and may significantly impact the budget neutrality adjustment. The Committee should also update the \$20 million budget neutrality threshold and index it to inflation. This threshold has not been updated since the 1990s and is long overdue to be updated. Congress should also provide for an increase every five years equal to the cumulative increase in MEI to ensure that physician payments keep pace with inflation and the cost of delivering care. Finally, the Committee should consider placing a cap on the negative budget neutrality adjustment that can be applied to the CF annually. This will support the necessary review of codes that potentially cause large budget neutrality adjustments, like the outpatient E/M codes. When these codes were updated in 2021, the much-needed increase was eroded partially by the budget neutrality adjustment. Our members bill primarily using outpatient E/M codes and we would support this cap to limit particularly large decreases in reimbursement.

### **Incentivizing Participation in Alternative Payment Models**

***How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?***

A-APMs are not available specifically for endocrinologists and these alternative payment models are often incorporated into primary care bundles which makes it too much of a risk for many of our members to participate. Currently, there are no incentives to participate in A-APMs and it is not attractive to enroll in models with downside risk, particularly if outcomes are based on some factors outside of the physician's control. Also, in the current environment our members continue to see both the CF and Medicare reimbursement decreasing annually. The downward pressure on Medicare physician payment does not make it attractive for



physicians, particularly those who treat complicated patients with chronic conditions, like diabetes and obesity, to expose themselves to additional risk. According to the 2023 Medscape Physician Compensation Report, endocrinologists are the fifth lowest compensated specialty, reimbursed less than half of the highest compensated specialty of plastic surgery.<sup>3</sup> Conversion factor cuts and negative payment adjustments influence the reimbursement of endocrinologists and their practices significantly.

At this point, the lack of relevant APMs is a primary barrier to specialty participation in the A-APM track. Congress could legislate that CMS develop and pilot a certain number of specialty models annually, working in partnership with the relevant specialty societies. One barrier that will be difficult to overcome is the number of Medicare beneficiaries with the condition required to support a model. Without a large enough patient population, it is impossible to develop and pilot specialty models. Congress and CMS should consider another method of APM participation in this instance.

### **Reducing Physician Reporting Burden Related to MIPS**

***What other policies, if any, would appropriately encourage improvement in quality of care delivered by clinicians under FFS Medicare?***

As structured, not all physicians have clinically meaningful participation options in the Merit-Based Incentive Payment System (MIPS). Even for specialties that have a robust set of measures, there may not be measures that are meaningful to all segments of their membership. In endocrinology, there may be relevant measures related to diabetes but many of our members specialize in other conditions for which there are no measures. Recognizing the financial and administrative investment that is required to develop and maintain measures, Congress and CMS should look for additional methods to measure quality performance and improvement through the information that is reported through electronic medical records and registries. The Society believes that quality reporting should not be an additional administrative burden on physicians and their staffs.

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<sup>3</sup> [https://www.medscape.com/slideshow/2023-compensation-overview-6016341?icd=login\\_success\\_email\\_match\\_norm#3](https://www.medscape.com/slideshow/2023-compensation-overview-6016341?icd=login_success_email_match_norm#3)



## **Supporting Chronic Care in the Primary Care Setting**

***In a hybrid PBPM payment model under FFS, which services should be paid through FFS versus PBPM? Are there services beyond primary care that would benefit from this type of payment model as well?***

As you may know, endocrinologists, like other internal medicine subspecialists, may serve as the medical home for patients with certain chronic conditions. Often, endocrinologists will direct the care of patients with diabetes and obesity. However, like primary care providers, endocrinologists face many of the same financial challenges including high medical debt and low reimbursement rates. This has created significant workforce challenges which have been highlighted in this letter. The Society encourages the committee to consider hybrid payment models that would apply beyond primary care to support specialists like endocrinologists who care for patients with chronic conditions.

## **Supporting Chronic Care Benefits in FFS**

***Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?***

There are a wide range of social and environmental factors that contribute to and result in poor health outcomes for people living with chronic conditions. For example, issues such as food security, housing, and transportation all influence health. Lack of access to healthy and nutritious food can result in higher rates of obesity and diabetes. For conditions like diabetes and obesity, nutrition support and medically tailored meals can play a key role in helping individuals manage these conditions. Transportation access also plays a significant role in health. For example, individuals with chronic conditions who rely on public transportation to reach their medical provider face major challenges when traveling to see their physician. Support for non-emergency medical transportation (NEMT) is critical to support patients with chronic conditions or those that require ongoing, longitudinal care. Not all patients have access to public transportation or their own vehicle, and a robust NEMT benefit would help ensure that patients can keep their appointments with their physicians needed to manage their conditions.

***What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?***

Continuing the telehealth flexibilities is an important policy to support chronic care in Medicare Fee-for-Service (FFS). Telehealth plays a crucial role in ensuring that adequate healthcare is provided to rural and underserved areas. Patients who lack access to transportation and those in hard-to-reach areas have also benefited from expanded access to



virtual care. Expanding access to telehealth services will ensure that underserved populations receive the care they need. For example, one [GAO report](#) found that that the proportion of Medicare beneficiaries utilizing telehealth was similar across racial and ethnic groups. The Society encourages the committee to extend the telehealth flexibilities including access to audio-only services. By keeping both the audio-visual and audio-only options, beneficiaries can access care in the instance that they cannot get to a doctor's office. Also, the reimbursement rate for telephone visits is substantially less compared to audio-visual visits despite it being the same amount of time spent with the patient, and we encourage you to consider payment parity for audio-only visits.

### **Additional Considerations: Ensuring Accuracy of Values within the PFS**

***What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS's RVU and rate-setting processes?***

***What third-party entities could produce the most credible and reliable analysis of CMS' RVU determination and rate-setting processes, and what key areas should such analysis examine?***

Endocrinologists are non-procedural specialists, and as was mentioned in the opening of the letter, we believe that mis-valuation of E/M services billed by our members is one factor contributing to a shortage of endocrinologists across the United States. According to Medicare 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.<sup>4</sup> Additionally, approximately 86% of E/M services billed by endocrinologists are provided in the office setting. The Society participates in the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC), and we believe it serves an important purpose in the valuation of specific services. However, we think the process does not work as well for E/M and non-procedural care as it does for procedures. Despite the best efforts of the AMA CPT and RUC and CMS, the challenges with E/M codes persist and are a driver of the shortage of endocrinologists, other cognitive specialists, and primary care physicians.

We support the establishment of a technical advisory committee (TAC) to define and value E/M and other non-procedural services more regularly. Following an analysis of data, research, methodologies, and knowledge gaps, a TAC would be well-suited to develop a set of recommendations to address inadequacies of E/M service code definitions and valuations and

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<sup>4</sup> 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-notice/cms-1784-p> Accessed Aug 24, 2023.



ensure payment is adequate for these services. Senators Sheldon Whitehouse (D-RI) and Bill Cassidy (R-LA) have introduced the *Pay PCPs Act*, which establishes a TAC to provide the Secretary with technical input regarding the accurate determination of relative value units. We support this legislation's intent to establish a committee of experts to provide this input on E/M and non-procedural services. However, we think the composition of a TAC should be modified from what is proposed in the Whitehouse-Cassidy legislation. It should include individuals with expertise in healthcare policy, such as physicians, patients, health economists, coders, health informaticists, and other stakeholders with expertise in payment policy; with this expertise, the committee will be well-positioned to address the challenges faced across cognitive specialties.

The TAC's charge should be to implement an evidence-based, data-driven approach to assess the E/M and non-procedural service code definitions and ensure that their valuations are accurate, reliable, and reflect the value of the specialty expertise and longitudinal care our members deliver to Medicare beneficiaries. Following an analysis of data, research, methodologies, and knowledge gaps, a technical advisory committee would be well-suited to develop a set of recommended changes to address inadequacies in the E/M service code definitions and valuations.

Thank you again for the opportunity to provide feedback on this critical issue. We stand ready to work with you to address the flaws in Medicare payment and implement reforms that bring stability to the physician reimbursement system. If you have any questions or we can be of any further assistance, please contact Rob Goldsmith, Director of Advocacy and Policy at [rgoldsmith@endocrine.org](mailto:rgoldsmith@endocrine.org).

Sincerely,

Robert Lash, MD  
Chief Medical Officer