American Association of Neuromuscular & Electrodiagnostic Medicine
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September 11, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1784-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1784-P; Medicare Program; CY 2024 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (August 7, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the members of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), we appreciate the opportunity to provide comments in response to the Notice of Proposed Rulemaking for Revisions to Payment Policies under the Physician Fee Schedule (PFS) and updates to the Quality Payment Program (QPP) for 2024. We appreciate the outreach by the Centers for Medicare & Medicaid Services (CMS) to the physician community during this comment period and we hope that this open dialogue will continue in the future.

The AANEM is comprised of over 6,900 neurologists, physical medicine & rehabilitation (PM&R) physicians, technologists, and other collaborators interested in neuromuscular (NM) and musculoskeletal diseases. Our physician members diagnose and treat patients with disorders of muscles and nerves, such as carpal tunnel syndrome, cervical and lumbar radiculopathies, Guillain-Barre syndrome, ALS ("Lou Gehrig's disease"), diabetic and other forms of peripheral neuropathy, myasthenia gravis and muscular dystrophy. Many of these are considered rare disorders, e.g., myasthenia gravis.

General Comments

AANEM continues to be impressed that many of the changes in the 2024 proposed rule show CMS' willingness to listen to and work with the physician community. However, we do have serious concerns over the implementation of certain aspects of the proposed changes to both the PFS and the QPP.

We have grave concerns about the substantial reduction in payments to our physicians, as well as all clinicians generally, proposed in this rule, especially as all medical providers continue to try and grapple with significant inflation in practice costs. In turn, this creates long-term financial

instability and threatens patient access to care provided by Medicare-participating physicians. Our specific concerns and recommendations are discussed in more detail below.

Physician Fee Schedule

Conversion Factor

A 3.36% decrease in the Medicare conversion factor, from $33.8872 to $32.7476, will result in a substantial blow to physician practices already dealing with increased practice costs and inflation. While we understand this cut is necessitated by statutorily imposed budget neutrality requirements, we believe (1) that the budget neutrality requirement should be waived in light of the continuing inflation and rising practice expense (PE) costs and (2) CMS should work with the medical community to encourage Congress to provide a positive update to the Medicare conversion factor in 2024 and in all future years to counteract the negative impacts of inflation on physicians, medical practices, and patient access to care.

PE and Clinical Labor Pricing Update

According to the AMA, PEs comprise 44.8% of the physician payment and the pool from which these funds are drawn is fixed. The increase in payment for clinical labor is shifting funds away from supplies and equipment due to budget neutrality. As a result, physician services that utilize high cost supplies and equipment, such as electrodiagnostic (EDX) equipment and ultrasound machines, will be disproportionally impacted. While the increase in clinical labor is appropriate, it is not appropriate that physicians and other qualified health care professionals, notably from a few small specialties, including AANEM physicians, are negatively impacted by the change.

While AANEM agrees with CMS' decision to update the clinical labor pricing using the United States Bureau of Labor Statistics (BLS), we implore CMS to understand the underlying unfairness that the real increase in clinical labor costs for physician practices is not recognized through an update to the conversion factor. **AANEM calls on CMS to urge Congress to provide a positive update to the Medicare conversion factor in 2024 and all future years.**

Medicare Economic Index (MEI)

The MEI, first implemented in 1975, has long served as a measure of practice cost inflation and a mechanism to determine the proportion of payments attributed to physician earnings and practice costs. In 1993, the MEI components were updated using AMA data and then apportioned to 54.2% Physician Work, 41% PE and 4.8% Professional Liability Insurance (PLI). Currently, the allocation is 50.9% Physician Work, 44.8% PE and 4.3% PLI derived from MEI weights based on data obtained from the AMA's Physician Practice Information (PPI) survey which was last conducted in 2007/2008 using 2006 data. CMS proposes to update the MEI weights using 2017 data from the United States Census Bureau's Service Annual Survey (SAS). However, the CMS clarifies that they will continue to not implement these new weights in 2024, referencing the AMA's national study to collect representative data on physician practice expenses, the AMA PPI Survey. The AMA and Mathematica formally launched the PPI Survey on July 31, 2023. Data would be shared with CMS in early 2025 for the 2026 Medicare Physician Payment Schedule rulemaking process. AANEM supports CMS' recognition of the PPI Survey effort and postponing implementation of the updated MEI weights until data from the PPI Survey is available**.**

The CMS MEI proposal using 2017 data from SAS would dramatically shift payment allocation away from physician earnings (work) to PE: 47.3% Physician Work, 51.3% PE and 1.4% PLI using non-AMA data. This redistribution of physician payment from physician work to the business side of healthcare is particularly unfortunate as physicians face uncertainty about the Medicare conversion factor and continue to suffer from burnout. More should be done to emphasize the importance of physicians rather than to direct resources away from their individual contributions. Additionally, there are several flaws in utilizing the SAS data to update the MEI including the inability to exclude non-patient care sources (e.g., grants, investment income) from the total revenue counted for "Offices of Physicians" and exclusion of physicians who are employed in other health care settings, such as hospitals. **AANEM urges CMS to correct the error in their updated MEI weights and to postpone implementation of the updated MEI weights until after the AMA completes its national study to collect representative data on physician practice expenses.**

Telehealth

As a result of the COVID-19 PHE, CMS temporarily expanded the Medicare telehealth list of covered services. Telehealth has provided a way for Medicare patients to safely access routine healthcare services by reducing the risk of exposure to COVID-19 for both patients and medical staff. AANEM supports CMS' continued efforts to expand telehealth services beyond the expiration of the temporary PHE provisions that end in CY 2024.

AANEM further urges CMS to make permanent the coverage of many of the current telehealth services beyond the expiration of the temporary COVID-19 PHE provisions in 2024. Many of AANEM's physicians treat patients with debilitating nerve and muscle diseases that result in substantial functional impairments which make travel to in-person care difficult. Some of our member physicians have also found it helpful to "see" their patients in their usual living environment to help inform the development of treatment and safety plans. These virtual visits have also allowed clinicians to more easily interact with the patients' family members and other caregivers, which, again, helps facilitate treatment and care plans. Additionally, during virtual visits, patients are able to get their medication bottles and report their exact doses and timing, which is invaluable and cannot occur if the patient does not bring their medications to their in-person visits.

CMS has established separate coding and payment for audio-only E/M services for the duration of the PHE and 151 days following the termination of the PHE which expires CY 2024. **AANEM strongly supports permanent coverage and adequate reimbursement for audio-only telehealth after the end of the 151-day post-PHE extension period ending in CY 2024.** There is a substantial portion of the patient community served by AANEM member physicians that do not have access to computers or who cannot operate computers or mobile devices that have video and audio capability. AANEM believes that there are many scenarios where it is clinically appropriate for an audio-only encounter to occur, such as medication refills in a stable patient or for basic follow-up evaluations. By not providing adequate reimbursement for audio-only visits, CMS would be placing older, non-tech savvy patients and underserved communities at a disadvantage.

We support CMS' consolidation of Categories 1, 2, and 3 Telehealth Services List to a Category 1 or 2 where category 1 would be "permanent" and category 2 would be "provisional". AANEM believes this will help to ease some confusion regarding telehealth designation. However, we do not believe that ending coverage of the services designated as provisional due to the COVID-19 pandemic 151 days after the PHE ends provides sufficient time to fully understand the impact of these telehealth services in the post-pandemic healthcare setting and **urge CMS to consider extending coverage for at least an additional year to allow for further study.**

Evaluation and Management (E/M) and Split (or Shared) Services

AANEM appreciates that CMS is proposing to delay the requirement that only the physician or qualified health professional (QHP) who spends more than half of the total time with the patient during a split or shared visit can bill for the E/M visit until at least December 31, 2024. CMS noted the concerns raised by the AMA and other medical specialty societies, including AANEM, that implementing this policy would drastically disrupt team-based care and interfere with the way care is delivered in the facility setting. **AANEM strongly urges CMS to allow physicians and QHPs to select the billing practitioner for split or shared visits based on time or medical decision-making.**

CMS finalized the new evaluation and management (E/M) add-on code, G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)* in 2021 but then implementation was delayed for three years by Congress. CMS now proposes to implement it in 2024. AANEM appreciates that in order to mitigate anticipated cuts due to the budget neutrality impact of adding G2211, CMS has lowered the estimated utilization assumption of the add-on code from 90 percent in its 2021 rule to 38 percent when initially implemented in 2024 and 54 percent once the code has been fully adopted. AANEM is concerned with continued ambiguity about when to use this code and how to document it as well the additional across-the-board cut to the conversion factor due to budget neutrality requirements. CMS' proposal to not allow G2211 to be billed with modifier 25 further limits physicians who would be able to utilize this code as it would not be able to be utilized on visits where a procedure also takes place. **Given the continued ambiguity of how the code should be used, who can use the code, the overlap with current CPT E/M codes, and the across-the-board reduction in the conversion factor for all physician and QHPs, AANEM urges CMS to not implement G2211.**

AANEM continues to have concerns regarding the significant reduction in reimbursement to physicians who do not routinely report E/M services. The reduction in the conversion factor to accommodate budget neutrality in 2021 was extremely difficult for physicians to absorb into practices that are operating at maximum efficiency and the further reduction proposed for 2024 with the implementation of G2211 to maintain budget neutrality will be even more devastating to practices. **We urge CMS to work with the medical community to encourage Congress to implement positive updates to the Medicare conversion factor to offset the necessary increases in costs associated with providing care.**

Appropriate Use Criteria for Advanced Diagnostic Imaging

AANEM supports CMS' proposal to indefinitely suspend the Appropriate Use Criteria (AUC) program. AANEM believes that permanently suspending this program is necessary as further implementation could have significant detrimental impact on timely patient access to care. AANEM applauds CMS for recognizing the potential risks of this program as well as its limited benefits given the redundancy that the AUC program shares with aspects of the QPP.

Quality Payment Program (QPP)

We continue to have concerns regarding the QPP portion of the proposed rule. Many of our physicians subspecialize in neuromuscular (NM) medicine, electrodiagnostic (EDX) medicine, and/or neurophysiology. These physicians see a very select subset of patients and, in some cases (such as for EDX testing), only see the patient once for an EDX evaluation with the follow-up care being provided by the referring physician. As a result, our members have found it nearly impossible to find meaningful quality measures under Medicare's past value-based/quality programs that relate to the care they provide their patients. Due to the lack of follow-up performed by our physicians and the general trend away from process measures to outcome-based measures, there seems to be no good pathway for our members to meet the QPP standards. Additionally, many of our members have had trouble finding any alternative payment models (APMs) that work with their specialized practices. Finally, while we support CMS' effort to simplify the MIPS program by shifting to MIPS Value Pathways (MVPs), we have serious concerns about the ability of CMS to create MVPs that will be applicable to the majority of our members.

Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)

AANEM supports and appreciates CMS' effort to try and simplify the participation process for clinicians participating in MIPS via the creation of MVPs. However, from what has been reported by other groups more intimately involved in the development of MVPs, CMS has largely missed the mark in achieving any reduction in the existing complexity and burdens of MIPS with MVPs. None of the proposals in this rule appear to simplify the MIPS participation, reporting, or scoring processes or ease any of the burdens clinicians already face with MIPS. Rather, the MVPs appear to create new challenges as clinicians are funneled down very specific specialty or condition-specific pathways.

Nonetheless, many of our members complain that the existing MIPS program is too complex and there are too many different measures and activities to choose from. AANEM therefore supports any effort on the part of CMS to simplify MIPS but strongly urge CMS to partner with **every** specialty society in the development of MVPs. One of the major issues our members face is the fact that there are very few (if any, in some cases) quality measures that apply to their subspecialized practices. Our physician membership is comprised almost exclusively of physical medicine and rehabilitation (PM&R) physicians and neurologists but few, if any, of the quality measures in each of those two specialty sets apply to NM or EDX-focused practices and we fear that forcing these physicians into silos based on their specialty will only further limit their options on reporting for quality measures. Furthermore, if CMS elects to attempt to create MVPs based on conditions that the physician treats, we have concerns that our physicians treat patients with a multitude of conditions which may make it difficult to categorize the patient under condition-specific MVPs. Moreover, many of the conditions which our physicians treat are quite rare so even if there was an applicable MVPs available, it would be difficult for our members to meet the

minimum case requirement of 20 to be eligible for the full points. For example, a practice may only see one patient with ALS in a year. In addition, our physicians that focus primarily on EDX testing treat few, if any, patients and thus it would be inappropriate to use many of the condition-focused measures. For example, many of our physicians perform diagnostic testing on diabetic patients to check for neuropathy but they have no involvement in the actual management of the patient's diabetes and it would be inappropriate to measure them based on any of the diabetes measures.

AANEM does support the inclusion of the additional Rehabilitative Support for Musculoskeletal Care MVP for use in CY2024 as it could be beneficial to a small portion of AANEM's membership. However, it should be noted that in order to have more physician participation, developing more MVPs relevant to the outpatient setting must be prioritized.

AANEM supports CMS' proposed gradual transition from MIPS to MVPs, starting with voluntary participation in MVPs, but notes the need to simplify the requirements beyond what has been done with MVPs to-date. Furthermore, we believe CMS needs to demonstrate the viability of MVPs in a meaningful way before even discussing a mandated transition and CMS should actively identify incentives to encourage voluntary MVP participation in the meantime. **We urge CMS to not set a hard sunset date until the program has proven successful and feasible.**

Subgroup Reporting

AANEM supports the flexibility for practices to engage in optional group or subgroup reporting of measures but urges CMS to not codify the rule that only single specialty groups may participate as a group for MVP reporting, and that multispecialty groups that want to report an MVP will be required to form subgroups for that purpose beginning in 2026. Because MVPs should focus on clinical conditions, episodes of care, and public health priorities, CMS should encourage group compositions of multiple specialties, across multiple locations, and in various sizes to achieve the MVP's goals of improving care and reducing avoidable costs. In addition, AANEM also urges CMS to recognize the additional practice burden involved with group/subgroup reporting via incentives such as scoring incentives or lessened reporting burden elsewhere. AANEM supports this flexibility as long as it remains optional and would encourage CMS to extend this concept to the reporting of all MIPS measures, not just the MVP bundle.

MIPS Payment Adjustments

AANEM does not support CMS' proposal to increase the performance threshold to 82 points and is concerned that CMS would propose an increase that results in a significant increase in physicians being penalized by MIPS as the program has been largely paused since 2019 due to the significant disruptions caused by the COVID-19 pandemic. Small practices have historically struggled significantly to meet the performance threshold compared to larger group practices that have more resources in place for data collection and reporting. AANEM is alarmed that CMS estimated that 46 percent of MIPS eligible clinicians would receive a penalty based on the 2024 proposals and urges CMS to lower the 2024 MIPS performance threshold to avoid penalizing nearly one HALF of physicians and other medical professionals while also unfairly impacting small practices.

Alternative Payment Models (APMs)

There continues to be very few APMs and even fewer Advanced APMs that NM/EDX physicians are able to utilize. We have done extensive research into the viability of developing an APM that may be applicable to our members, but it quickly became apparent that such an endeavor is extremely resource-intensive, especially for a smaller organization such as AANEM, and, thus, it is not a feasible undertaking at this time. Therefore, we continue to respectfully request that CMS provide additional resources targeting specialists and subspecialists with no current APM options to aid in the development of new APMs.

Conclusion

We thank you for your consideration of our recommendations. We hope that this letter will serve as part of a continuing and collaborative discussion with CMS as the regulations are finalized and implemented. We would welcome meeting with CMS to answer questions related to any of our suggestions.

Sincerely,

Robert Irwin, MD, AANEM President