American Association of Neuromuscular & Electrodiagnostic Medicine
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September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1770-P; Medicare Program; CY 2023 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 29, 2022)

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 2023. 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 6,000 neurologists, physical medicine & rehabilitation (PM&R) physicians, technologists, and other collaborators interested in neuromuscular (NM) 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 2023 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 more than 4% decrease in the Medicare conversion factor, from $34.6062 to $33.0775, 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 impact of the public health emergency (PHE) and (2) CMS should work with the medical community to encourage Congress to provide a positive update to the Medicare conversion factor in 2023 and in all future years to counteract the negative impacts of inflation on physicians, medical practices, and patient access to care. Additionally, AANEM is supportive of all efforts to mitigate the detrimental financial impacts of the 4% PAYGO sequester necessitated by passage of legislation unrelated to Medicare.

Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76XX0)

In October 2021, the CPT Editorial Panel approved the addition of CPT code 76XX0 for reporting real-time, complete neuromuscular ultrasound (NM US) of nerves and accompanying structures throughout their anatomic course, per extremity, and the revision of CPT code 76882 to add focal evaluation. CPT codes 76881 and 76882 were identified as part of the NM US code family with CPT code 76XX0 and surveyed for the January 2022 RUC meeting. The RUC proposed values for all three codes were based on the 25th percentile of a very robust survey. CMS' proposed values goes against the RUC recommendations and would result in drastic cuts to the NM US family.

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
76881	**Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation**	**0.54**	**0.90**
76882	**Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation**	**0.59**	**0.69**
76XX0	**Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity**	**0.99**	**1.21**

76881—In this proposed rule, CMS disagreed with the RUC's work RVU recommendation of 0.90 for CPT code 76881 which represents the survey 25th percentile. Instead, CMS proposes a work RVU of 0.54 using the reverse building block methodology. AANEM does not agree with any suggested approach that uses reverse building block methodology to systematically reduce work RVU's for services. Reverse building block methodology, or any other purely formulaic approach, should not be used as the primary methodology to value services. The RUC recommendation was based on the 25th percentile of a robust survey of physicians who utilize the service and this method has a long established history of being the standard for developing work RVUs.

CMS asserts that the proposed work RVU accounts for the 0.224 work RVU decrease as a result of removal of pre and post service time and the increase of 5 minutes of intra-service time while maintaining the current IWPUT of 0.027 with the argument that change in intensity had not been demonstrated. The RUC, however, did discuss the change in intra-service time and intensity related partially to the change from radiology to rheumatologists performing the scanning of the current patient population. US technology has evolved immensely since the code was valued in 2010, including proliferation of high-frequency US probes dedicated to musculoskeletal imaging with the ability to produce images with higher fidelity and more detail. The complete US code is increasingly used to evaluate for a greater range of complex musculoskeletal injuries and has replaced MRIs as the first line of investigation for many pathologies. Further, US is now being used to troubleshoot difficult cases that are inconclusive on either clinical evaluation or other imaging modalities which supports a change in overall physician time and work intensity.

CMS noted that this code is reported with an office Evaluation and Management (E/M) visit 58.9% of the time and a non-facility office visit 66.3% of the time. The code is imaging-specific so the physician work described in the code would not overlap with the E/M. Typically, the physician performing the imaging will not be the same physician providing the E/M service. The US service is a separate and identifiable visit from the E/M visit thus the rendering physician still requires time to review prior imaging for comparison, review patient clinical information, provide patient education, and obtain consent for the procedure. The technical skill required to review, interpret, and provide conclusive findings for US images are beyond the technical skill related to management decisions that occur during the E/M visit. Therefore, the history and pertinent clinical information must be reviewed, in addition to any prior applicable imaging studies in order to optimize the examination. Similarly, because it is an imaging code, post-service time is required because the physician performing the US must still perform the following: discuss, and explain findings of the examination to the patient as needed, separate from the E/M encounter, review and sign an imaging specific final report for the medical record, and communicate findings to the referring clinician as needed. An accurate comparison is important in assessing disease severity and changes to therapeutic interventions made since any prior US. Finally, the report must be dictated (or typed) and made available in the patient's chart.

It should be noted that there are over 20 codes in the RUC database with an XXX global period and 20 minutes intra-service time and 5 minutes pre and post-service time and all of these codes have work RVUs that are 2-3x higher than the CMS-proposed 0.54. The values are in line with the median survey value for CPT code 76881, yet the RUC recommended value is the survey 25th percentile. Moreover, the methodology employed by CMS has resulted in a proposed work RVU for CPT code 76881 that is less than the proposed work RVU for CPT code 76882. This is inappropriate considering that 76881 describes the physician work as a complete evaluation of a specific joint in an extremity, while 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in an extremity other than a joint (e.g., soft-tissue mass, fluid collection, or nerve[s]). CPT code 76881 requires US examination of all of the following joint elements: joint space (e.g., effusion) and peri-articular soft-tissue abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. CPT code 76882, on the other hand, does not assess all of the elements included in 76881. Thus, it is illogical for 76881 (a complete study) to have a lower work value than a limited one. CMS' proposal to assign 0.54 work RVUs to 76881 and 0.59 work RVUs to

76882 creates a rank order anomaly.

In summary, AANEM disagrees with CMS utilizing reverse building block methodology for valuing services and strongly recommends a work RVU of 0.90 as supported by the survey. The CMS recommended work value falls far below the survey 25th percentile and below the current value. US is radiation-free, higher-resolution than MRI, and provides critical anatomic information that greatly increases diagnostic accuracy, and it should be valued appropriately to improve healthcare across the United States. **AANEM urges CMS to accept a work RVU of 0.90 for CPT code 76881.**

For the direct practice expense (PE) inputs, CMS is proposing to remove 2 minutes of clinical labor time for CA006 (*Confirm availability of prior images/studies*), 1 minute of clinical labor time for CA007 (*Review patient clinical extant information and questionnaire*), and 2 minutes for CA011 (*Provide education/obtain consent*) for CPT code 76881 because "the RUC recommendation describe clinical labor activities that overlap with the E/M visit." AANEM disagrees with the removal of time for all three clinical labor activities as it is work which is required to be performed in addition to the E/M code. Each element of clinical labor is performed specifically for the NM US exam and does not overlap with the E/M. **AANEM disagrees with CMS removing a total of 5 minutes for clinical labor time and strongly urges CMS to maintain the RUC recommended direct PE times.**

76882—CMS disagrees with RUC's work RVU recommendation of 0.69 for CPT code 76882 which represents the survey 25th percentile. However, CMS agrees with the RUC that 15 minutes of intra-service time is warranted. CMS proposes a work RVU of 0.59 using the reverse building block methodology "to account for the 4-minute increase in intra-service time and the maintenance of the current IWPUT of 0.024." CMS notes there was no information indicating a change in intensity. AANEM notes that similarly with the complete US code, for the limited joint code, US technology has evolved immensely since the code was valued in 2010, including proliferation of high-frequency US probes dedicated to musculoskeletal imaging, with the ability to produce images with higher fidelity and more detail. For the typical patient, the limited joint US code is used to evaluate patients with acute injury and triage for urgent surgical intervention or conservative physical therapy. The improved level of detail by current US technology allows for physicians to perform this work with US rather than advanced imaging to optimize patient outcomes, but results in an overall increased intensity based on the number and quality of images to obtain and review for medical decision making.

AANEM does not agree with any suggested approach that uses reverse building block methodology to systematically reduce work RVUs for services. AANEM believes that any mathematical or computational methodology used to value physician work is illogical when robust survey results are available. The established valuation by the RUC is based on specialty society survey data and its use of magnitude estimation is the only methodology that makes sense in assigning physician work values. CMS states that by proposing work RVUs that maintain the current IWPUTs, it is maintaining relativity within the NM US family. AANEM strongly disagrees and believes that a rank order anomaly is created by CMS methodology which has resulted in a work RVU for CPT code 76881 that is less than the proposed work RVU for CPT

code 76882, as stated above. This flawed intensity argument relies on anchoring to incorrect IWPUT values established based on previous assumptions and ignores the rigorous values obtained from physician survey data and approved by accepted RUC methodology.

CMS disregards the input of 100 physicians by proposing to base the work RVU of code 76882 using reverse building block methodology. AANEM disagrees with the use of reverse building block methodology and concurs that CPT code 76882 should be valued based on the survey 25th percentile. **AANEM urges CMS to accept a work RVU of 0.69 for CPT code 76882.**

76XX0—CMS disagrees with the RUC recommended work RVU of 1.21 and states that "The RUC arrived at a recommended work RVU of 1.21 by comparing pre-, intra-, and post-service times to those of CPT code 76881, which CMS is proposing to modify due to overlapping work in the pre- and post-service time with E/M visits." AANEM can attest that the RUC reviewed the survey results from 66 physicians and determined that the survey 25th percentile work RVU of 1.21 appropriately accounts for the work involved in this service. CMS employed reverse building block methodology to propose a work RVU of 0.99 for CPT code 76XX0. This computation is based on the proposed work RVU of 0.54 for CPT code 76881 with proposed times of 20 minutes intra-service time and 0 minutes pre and post-service time and the time of 25 minutes intra-service time and 7 minutes pre and post-service time for CPT code 76XX0. AANEM reiterates its belief that any mathematical or computational methodology used to value physician work is inappropriate. The RUC's established valuation process is based on specialty society survey data and its use of magnitude estimation is the only methodology that makes sense in assigning physician work values to individual services as the physician fee schedule (PFS) is relative system and maintaining appropriate relativity between services is vital in valuing physician work.

RUC compared CPT code 76XX0 with comparator code 70553 M*agnetic resonance (e.g., proton imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences*) (work RVU=2.29, 25 minutes intra-service time and 37 minutes total time) and notes that the intra-service and post-service times are the same as 76XX0 yet there is more complex physician work involved with 70553, an MRI of the brain, thus it is appropriately valued higher than 76XX0. The physician is typically evaluating a significantly greater number of images for this CPT code which requires localization across both pre- and post-contrast sequences to evaluate for a greater range of pathology, potentially involved adjacent structures, and wider range of differential diagnostic considerations. CPT code 76XX0 is used for complex cases typically involving a diagnostic dilemma. This may include differentiating between different types of peripheral neuropathy, such as multifocal motor neuropathy with conduction block, chronic inflammatory demyelinating polyneuropathy (CIDP), acute inflammatory demyelinating polyneuropathy (AIDP), length dependent peripheral neuropathy, hereditary neuropathy with tendency to pressure palsies, etc. This procedure involves measuring the cross-sectional area of a nerve at multiple different sites throughout the length of an entire limb, calculating ratios, checking vascularity, evaluating echo intensity of affected muscles, determining patterns of peripheral nerve involvement, and saving cine loops. It includes scanning at least two joints and the limb in between, above and below those joints, so it is more than three times as much physician work as a limited limb US. The number of images involved in an US study is infinite, as the diagnostician is assessing the anatomy in real time, which involves the continuous mental processing of images in an infinite number of planes. The physician conducts the neuromuscular US, so the diagnostic

interpretation is not a matter of evaluating a set number of images obtained by a technician. Additionally, NM US has higher resolution than MRI and is the diagnostic modality of choice for evaluating small nerves and intra-nerve anatomy.

AANEM disagrees with the use of reverse building block methodology and concurs that CPT code 76XX0 should be based on the survey 25th percentile. **AANEM urges CMS to accept a work RVU of 1.21 for CPT code 76XX0.**

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. In this proposed rule, the total direct PEs would increase by roughly 30%, due largely to the sudden increase in payment for clinical labor, requiring a substantial budget neutrality adjustment (resulting in actual payment of roughly 44 cents on every dollar recognized in the PEs). The increase in payment for clinical labor will shift funds away from supplies and equipment. As a result, physician services that utilize high cost supplies and equipment will be disproportionally impacted. For example, the average reduction in the PE RVUs allotted to the main EDX codes (95860-95870, 95872, 95885-95887, and 95907-95913) is 3.22%. With the addition of the reduced conversion factor, this results in an average reduction in reimbursement of 7.50%. These reductions are further compounded as similar cuts occurred in 2022 for the same codes. 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 2023 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 and collected 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 Agency clarifies that they will not implement these new weights in 2023 as they must first seek additional comments due to significant redistribution. The CMS proposal 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.

The AMA has acknowledged that the data currently utilized for the MEI is outdated and has outlined a strategy to collect 2022 data in 2023. They understand the need for consistent and timely updates to the practice cost data and intend to develop a mechanism to update these data more frequently. **AANEM urges CMS to collaborate with the AMA on their new data collection effort to ensure consistency and reliability in physician payment. Updates to MEI weights should be postponed until new AMA survey data are available.**

Telehealth

As a result of the COVID-19 PHE, CMS temporarily expanded the Medicare telehealth list. 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' expansion of telehealth services and supports the decision to extend coverage for 151 days following the termination of the PHE.

AANEM further urges CMS to make permanent the coverage of many of the current telehealth services beyond the COVID-19 PHE. Many of AANEM's NM 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. Virtual visits are invaluable for many patients with neuromuscular conditions.

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 and has received many requests to temporarily add Telephone E/M visit CPT codes 99441, 99442, and 99443 to the Medicare Telehealth Services List on a Category 3 basis. **AANEM strongly supports permanent coverage and adequate reimbursement for 99441-99443 after the end of the PHE and the 151-day post-PHE extension period.** There is a substantial portion of the patient community served by AANEM members 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 and basic 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 continue to support CMS' creation of a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis that would include services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but

for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. However, we do not believe that ending coverage of these services 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 visit until January 1, 2024. CMS noted the concerns raised by the AMA and other medical specialty societies that implementing that 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.**

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 2023 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. Furthermore, with the devastating cuts that took place in reimbursement to the nerve conduction study (NCS) codes in 2013, the continued financial impact of the PHE, and the significant proposed reduction to the practice expense for these codes in 2023, the proposed reduction in conversion factor will have a significant and devastating impact on our members and the patients they care for and we urge CMS to do everything within their power to ameliorate these drastic cuts to physician practices that care for patients with NM diseases.

Quality Payment Program

We continue to have concerns regarding the QPP portion of the proposed rule. Many of our physicians subspecialize in NM medicine, electrodiagnostic (EDX) medicine, 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 of 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 our members.

Subgroup Reporting

AANEM supports the flexibility for practices to engage in optional subgroup reporting of measures

but urge CMS to not finalize its proposal to require multispecialty groups to form single specialty subgroups to participate in MVPs beginning in 2026. Because MVPs should focus on clinical conditions, episodes of care, and public health priorities, CMS should encourage subgroup compositions of multiple specialties, across multiple locations, and in various sizes to achieve the MVP's goals of improving care and reducing avoidable costs. AANEM also urges CMS to recognize the additional practice burden involved with 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.

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 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 supports the inclusion of two additional neurology MVPs (Optimal Care for Patients with Episodic Neurological Conditions and Supportive Care for Neurodegenerative Conditions) for use in CY2023 that could be beneficial to a portion of AANEM membership. However, it should be noted that in order to have more physician participation, developing 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 MVP participation. **We urge CMS to not set a hard sunset date until the program has proven successful and feasible.**

MIPS Payment Adjustments

AANEM does not support CMS' proposal to maintain the performance threshold at 75 points. The PHE has made it challenging for many practices, especially small practices, to prioritize MIPS performance and reporting. 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 one-third of MIPS eligible clinicians would receive a penalty based on the 2023 proposals and urges the agency to lower the 2023 MIPS performance threshold to avoid penalizing one in three physicians and other medical professionals and unfairly impacting small practices.

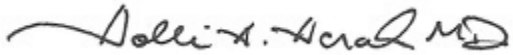
Alternative Payment Models (APMs)

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,



Holli Horak, MD, AANEM President