September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS–1784–P. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Submitted electronically via regulations.gov

Dear Administrator Brooks-LaSure:

The American Academy of Sleep Medicine (AASM) appreciates the opportunity to comment on the proposed rule for the 2024 Physician Fee Schedule (PFS) and Quality Payment Program, as the proposed revisions will directly impact the care provided by AASM members to patients with sleep disorders and will also significantly affect physician reimbursements for these services. The AASM is dedicated to advancing sleep care and enhancing sleep health to improve lives, and the comments included in this response reflect the needs of more than 9,000 individual AASM members and 2,500 AASM-accredited sleep facilities, providing sleep medicine services to the Medicare population.

2024 PFS Rate-setting and Conversion Factor and Medicare Physician Payment

The AASM strongly opposes the proposed 3.36% decrease in the Medicare Conversion Factor, for Calendar Year 2024. While the AASM realizes that this Conversion Factor accounts for many factors, including the statutorily required budget neutrality adjustment of -1.25% due to the potential adoption of the new office visit add-on code, this reduction in the Conversion Factor will have grave consequences for providers and their ability to continue providing high quality care to patients with sleep disorders. A July 2023 survey completed by 197 randomly selected members of the AASM estimated that roughly 33% of responding sleep medicine practices/facilities were concerned about remaining financially solvent through the end of the year. More than 150 AASM-accredited sleep facilities have closed since 2020, and we anticipate additional facility closures by the end of the fourth quarter of 2023, as reimbursements continue to decline, limiting access to

care for the patient populations in the affected areas. While Congress enacted the Consolidated Appropriations Act of 2023, to relieve some of the strain of the potential 4.56% cut to Medicare physician payment rates, payment rates were still reduced by 2% across the board, despite Congressional action. The proposed additional payment reductions will make it increasingly difficult to make sleep facilities sustainable, as providers continue navigating the already significant reductions in payment implemented over the last three years, while simultaneously navigating soaring prices due to record inflation, ongoing staffing shortages, the continued impact of a significant device recall used to treat patients with sleep apnea, and physician burnout, due in part to regulatory issues and administrative burden.

The AASM encourages CMS to reconsider such a significant conversion factor reduction, as reductions in payment will continue to create long-term financial instability and unpredictability in the Medicare physician payment system and may ultimately lead to reductions in Medicare-participating physicians and physician practices. Issues with access to care and delays in care will ultimately lead to negative outcomes in the Medicare patient population. The AASM strongly supports HR 2474, the Strengthening Medicare for Patients and Providers Act and urges CMS to significantly reduce the budget neutrality adjustment, while working with Congressional leaders to address physician payment, to ensure that physicians can continue to be fairly compensated for providing high quality patient care.

Determination of PE RVUs

Medicare Economic Index
In the 2023 PFS final rule, CMS finalized rebasing and revising the Medicare Economic Index (MEI) to better reflect current market conditions, as a significant amount of time has elapsed since the last update of the MEI in 2014. However, CMS decided to delay implementation and instead solicited comments regarding other potential implementation strategies. The AASM, along with over 170 other healthcare organizations, encouraged the Agency to delay implementation until the American Medical Association (AMA) completes the Physician Practice Information (PPI) survey, which will collect data from financial experts at physician practices about cost data at the specialty level, ensuring that the updated MEI weights are based on reliable and accurate data, for rate setting. The AASM fully supports the Agency's decision not to propose incorporating the 2017-based MEI in PFS rate-setting for 2024. Additionally, while we acknowledge that the Agency is planning to review data from the Services Annual Survey later this year, we again emphasize the importance of reviewing data from the PPI survey, once shared. The AASM will continue to work with the AMA to encourage sleep medicine providers to participate in the survey.

Request for Information: Strategies for Updates to Practice Expense Data Collection and Methodology
The AASM appreciates the CMS request for information to gather ideas and recommendations for updating practice expense data collection and methodology. However, the AASM encourages CMS to use the specialty data currently being collected in the AMA PPI survey for this purpose, as the data will be stratified to highlight trends, be it differences or similarities.

Potentially Misvalued Services Under the PFS

CPT codes 94762 *(Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure))* and 95800 *(Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time)* were nominated as potentially misvalued codes by an interested party and CMS is requesting comment as to whether the codes may be misvalued, due to the practice expense. The primary reason these codes were nominated is to replace existing equipment with the disposable WatchPAT One device (SD263) and add the computer, desktop, with monitor (ED021).

The interested party recommends replacing the pulse oximeter 920 M Plus (EQ353) with the WatchPAT One device (SD263). The AASM does not support this recommendation as updating the device would suggest that the typical patient receiving this service would be assessed with the disposable WatchPAT device when this is not the case in clinical practice. Not only does the interested party recommend replacing the pulse oximetry device with the disposable WatchPat device, which would exclude the pulse oximetry device used for the typical patient, but it is unclear why it is necessary to add the computer, desktop, with monitor (ED021) to the practice expense for the code. After a review of the practice expense inputs in question, the AASM does not believe that 94762 is misvalued and recommends that CMS rejects the recommendations by the interested party.

The party also suggests that 95800 was misvalued and suggests replacing the reusable WatchPAT 200 Unit (EQ335) with the disposable WatchPAT One device (SD263), as they suggested for 94762. While the AASM cannot speak to the number of providers that have switched over to disposable devices, we realize that providers are increasingly considering incorporating disposable devices into their practices, given the recent COVID-19 public health emergency. However, we do not support the interested party's recommendation to remove the Oximetry and Airflow device (EQ336), as this device would still be necessary to use with other devices to measure airflow. Again, we have no data to support the necessity or use of the computer, desktop, with monitor (ED021). The AASM agrees with the interested party that this code may be misvalued. Additionally, we recommend a review of invoices, to determine a more accurate value for SD263.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act

Summary and Request for Feedback on Proposals to Update the Process of Review for Adding, Removing, or Changing the Status of Services on the Medicare Telehealth List
CMS is proposing to revise the process for analysis of services under consideration for addition, removal, or change in status on the Medicare Telehealth Services List. While steps 1-3 seem clear, the AASM would like additional clarification on steps 4 and 5. Step 4 indicates that CMS will consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in previous final rulemaking. It would be clearer to propose that CMS consider whether a proposed service includes a specific list of required service elements, rather than comparing to another code or service. This will make the requirement clearer to those suggesting codes for inclusion on the telehealth services list whether codes meet the criteria. With regard to Step 5, we would like clarification as to what type of data would have to be presented as evidence of clinical benefit.

The AASM supports the proposed assignment of permanent or provisional status to a service. While CMS has made efforts to clarify the requirements for and distinctions between the current three categories, transitioning to the two categories will likely eliminate much confusion for Medicare providers. We also support the plan for CMS to revisit provisional status through the regular annual submissions and rulemaking processes.

In-person Requirements for Mental Health Telehealth
The Consolidated Appropriations Act of 2023 delays the requirement for an in-person visit with the physician or practitioner within 6 months prior to the initial mental health telehealth service, and again at subsequent intervals as the Secretary determines appropriate. Therefore, the telehealth in-person requirements for mental health disorders will be delayed until January 1, 2025. While the AASM supports the CMS proposal to revise the regulatory text, to delay the in-person requirements for mental health visits furnished by rural health clinics and federally qualified health centers until January 1, 2025, consistent with the Act, we also urge the Agency to work with Congress to evaluate data collected during the flexibility in order to consider whether to make the flexibility permanent. Permanently allowing telehealth services for

mental health disorders may not only increase the likelihood that patients will access these services but will also increase access to care for many patients.

Place of Service for Medicare Telehealth Services
The AASM appreciates the Agency's efforts to ensure that providers are being compensated for the provision of behavioral health services via telehealth. We agree that providers are functionally maintaining all practice expenses when providing these services. Specifically, we agree that providers need to maintain an office presence, despite providing services via telehealth for a significant portion of patients. Given the distinction between the two Place of Service (POS) codes, and considering that services billed with POS code 02 (telehealth provided other than in patient's home) will likely be furnished in originating sites that were typical prior to the public health emergency (PHE), the AASM supports the CMS proposal to reimburse claims billed with POS code 10 (telehealth provided in patient's home) at the non-facility rate, while claims billed with POS code 02 continue to be reimbursed at the facility rate.

Direct Supervision via Use of Two-way Audio/Video Communications Technology
Under Medicare Part B, certain types of services, including diagnostic tests, services incident to physicians' or practitioners' professional services, and other services, are required to be furnished under specific minimum levels of supervision by a physician or practitioner. Outside the circumstances of the PHE, direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service. CMS noted that there is concern about an abrupt transition to pre-PHE direct supervision requirements, as many providers and practices have modified their workflows to allow for supervision via audio and video communications technology, in lieu of in-person supervision. We agree that modification of workflows to allow for in-person supervision will take some time and support the Agency's proposal to continue to define direct supervision as the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024. However, the AASM continues to urge CMS to lean on the data, which has shown no indication of compromised patient safety and, ultimately, allowing direct supervision via use of two-way audio/video communications technology on a permanent basis will reduce barriers and delays in the provision of high-quality patient care, as well as potentially mitigate physician burnout.

Supervision of Residents in Teaching Settings
CMS noted in a 2021 final rule that after the end of the PHE for COVID-19, teaching physicians may meet the requirements of being present for the key or critical portions of services furnished by residents through audio/video real-time communications technology (virtual presence). However, this only applied for services furnished in residency training sites that were located outside of an Office of Management and Budget (OMB)-defined metropolitan statistical area (MSA), in order to expand training opportunities in rural settings. The AASM maintains that providing virtual supervision is helpful in extending training opportunities and may ultimately increase access to care, especially in sleep medicine and other specialties. Unless CMS has received data indicating that virtual supervision has led to patients no longer receiving the same safe, high-quality care as patients receiving care when in-person supervision is employed, we see no reason to revert to the in-person requirement. We agree with the CMS proposal to allow the teaching physician to have a virtual presence in all teaching settings through December 31, 2024. We also urge CMS to review the data collected during this time, to consider making virtual, real-time supervision permanent.

Reporting Home Address for Telemedicine Visits
The AASM strongly urges CMS to allow providers to provide telehealth visits without having to publicly display the physicians' home address on Medicare websites that include a physician lookup feature, due to privacy and safety concerns. We encourage CMS to make this flexibility permanent, rather than adhering to the December 31, 2023 expiration date. We also encourage CMS to announce any extension to the current expiration date well in advance of December 31, 2023.

Telephone Evaluation and Management Services
CMS previously finalized separate payment for CPT codes 99441 – 99443 and 98966 – 98968, for E/M assessment and management services provided via telephone (audio only). The AASM strongly supports continued payment for 98966 – 98968, in alignment with provisions in the Consolidated Appropriations Act of 2023, through the end of 2024, to allow non-physicians to continue billing for these services.

Valuation of Specific Codes

Phrenic Nerve Stimulation System (CPT codes 3X008, 3X009, 3X010, 3X011, 3X012, 3X013, 3X014, 3X015, 9X045, 9X046, 9X047, and 9X048)
The AASM partnered with the American College of Cardiology and the Heart Rhythm Society to submit a code change application to the CPT Editorial Panel, which included the request to convert 13 phrenic nerve stimulation system Category III codes (0424T – 0436T) to 12 new Category I codes. Upon approval of the application by the CPT Editorial Panel, the three organizations then surveyed the codes and submitted recommendations to the RUC, for review. We, therefore, strongly support the CMS proposal to accept the RUC recommendations for all 12 of these codes, as well as the proposed PE refinements for code 3X014, including the (CA039) post-operative visits (total time) and the equipment time for the exam table (EF023) equipment. It is very encouraging to see that CMS proposed to accept over 90% of the RUC recommendations in the proposed rule, as the societies work hard to participate in the RUC process and prepare values for submission, based on practice expense and physician work.

Evaluation and Management (E/M) Visits

In 2021, CMS finalized the addition of the new 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*, however, implementation of the code was delayed until 2024. CMS assumed an estimated utilization of 38% for the add-on code when initially implemented in 2024, followed by 54% once fully adopted. This utilization assumption alone leads to an over 2% budget neutrality adjustment. Despite adopting the CPT Editorial Panel's 2021 revised guidelines for the E/M Office or Other Outpatient codes, CMS did not abandon G2211. However, it remains unclear to AASM how this code fits in with the rest of the E/M coding guidelines and/or when it would be appropriate to report this in lieu of a high-level E/M code. The two most likely medical specialty societies whose members will ultimately report this code, American Academy of Family Physicians and American College of Physicians, agree with the AMA and other healthcare organizations to revise the utilization estimates, as they do not anticipate quick implementation of the code, given the unclear reporting guidance/instructions. The AASM, therefore, recommends that implementation of this code be delayed further until CMS can provide clear, concise instructions on when it is appropriate to use this code. Additionally, given the confusing nature of the code and associated guidance, we suggest the AMA revisit the estimated utilization upon initial implementation.

The AASM appreciates the Agency's consideration of feedback regarding the evaluation of E/M services, going forward. The AASM strongly believes that the methods used by the RUC and CMS are appropriate to accurately value E/M and other HCPCS codes, as we work with the RUC and many other societies to implement the survey process and revisit practice expense values on a regular basis, to provide recommended values to CMS. We also believe that the CPT Editorial Panel works diligently, through the establishment of Workgroups and through collaboration with society participants to accurately define and rigorously review all codes and services. We suggest that the CMS consider restoring the Refinement Panel process to employ a formal appeals process for stakeholders commenting on CMS proposed relative values.

Split or Shared Visits
In the 2022 PFS final rule, CMS finalized a policy for E/M visits furnished in a facility setting, to allow payment to a physician for a split (or shared) visit (including prolonged visits), where a physician and nonphysician practitioner (NPP) provide the service together (not necessarily concurrently) and the billing physician personally performs a substantive portion of the visit. CMS now proposes to delay the requirement that only the physician or practitioner who spends more than half of the total time with the patient during a split or shared visit can bill for the visit. The AASM strongly urges CMS to move forward by adopting the CPT guidelines for determining when a physician may report the E/M service, with the same implementation date of January 1, 2025, as adoption of this guidance would allow physicians or qualified health professionals (QHPs) to report split or shared visits based on time or medical decision making. Additionally, we have been privy to the CPT/RUC Workgroup's efforts to develop the guidelines with input from the participating healthcare organizations and believe this to be the best course of action.

Advancing Access to Behavioral Health

Adjustments to Payment for Timed Behavioral Health Services
CMS proposes to address the immediate need for improvement in valuation for timed psychotherapy services by reestablishing a rule that was initially finalized in the 2020 final rule to address valuation distortions for primary and longitudinal care through implementation of an add-on code for office/outpatient E/M services that involve inherent complexity. CMS would, therefore, apply an adjustment to the work RVUs for the psychotherapy codes payable under the PFS, based on the difference in total work RVUs for the office/outpatient E/M visit codes. This would result in an approximate upward adjustment of 19.1 percent for work RVUs for these services, comparable to the relative difference in office/outpatient visits that are also systemically undervalued absent such an adjustment. CMS is proposing to implement this adjustment over a 4-year transition. CMS believes that implementation of an adjustment to work RVUs for psychotherapy services, concurrent with implementation of HCPCS code G2211, will help address distortions that may occur within our valuation process that may otherwise result in understated estimates of the relative resources involved in furnishing psychotherapy services. While we agree with the upward adjustment, we still believe that CMS should delay implementation of G2211, as previously stated.

Request for Information on Digital Therapies, such as, but not limited to, Digital Cognitive Behavioral Therapy
Digital therapeutics are evidence-based, standalone or combination software products intended for management, maintenance, prevention or treatment of a disease, disorder or condition acting directly as a medical intervention or guiding the delivery of a medical intervention. These products have been shown to be reasonable and necessary forms of treatment for selected Medicare beneficiaries and may be furnished to patients in different forms and using different distribution approaches. Digital cognitive behavioral therapy (dCBT) devices are a subset of digital therapeutics which deliver CBT, an evidence-based psychological treatment that has been demonstrated to be effective for a range of mental health conditions including depression, insomnia, anxiety disorders, alcohol and substance use and eating disorders. AASM clinical practice guidelines recommend CBT as first line treatment for insomnia, in particular[i].

Digital cognitive behavioral therapy (dCBT), in particular, is also well-supported by clinical practice guideline recommendations. Cognitive behavioral therapy, on which dCBT is based, is supported by over 50 years of clinical evidence and recommendations as 1st-line treatment in many clinical guidelines for mental health treatment. Over the last two decades, dCBT has been shown to be an effective way of delivering CBT. In fact, dCBT for insomnia has been found to be non-inferior to face-to-face CBT for insomnia in a meta-analysis of 33 clinical studies[1] and has been included as a 1st-line treatment recommendation in several clinical guidelines[ii,iii,iv].

Current models for administering digital therapeutics, including dCBT, are models with close involvement of sleep providers and psychologists to ensure patients receive the necessary support and training. In most instances, the provider purchases access to dCBT and obtains access to the physician board and patient education and resource materials. The provider then educates the patient on use of the dashboard during a visit and will monitor and manage patient progress either remotely or through follow-up visits. For example, once a patient is screened and diagnosed with insomnia, they are granted access to a dCBT dashboard and educated on how to navigate the automated program, as dCBT is delivered at predetermined intervals/sessions. The program provides information, support, and recommendations in a personally tailored manner and includes behavioral, cognitive, and educational components. Prescheduled assessments are performed at different intervals throughout the treatment.

Additional important considerations:

- Access to cognitive behavioral therapy (CBT) and other evidence-based non-pharmacological interventions on which many digital therapeutics are based is often limited. There is a shortage of experienced psychologists and the time and cost investments required are often prohibitive for patients.
- The mechanism of action of many digital therapeutics, including dCBT and other psychotherapeutic interventions, typically do not present significant physical safety risks to patients.
- Regarding privacy and confidentiality, digital therapeutic manufacturers publish privacy policies and comply with both Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws to ensure the privacy of beneficiaries is not violated and any personal data are protected from breach with appropriate cybersecurity protections and protocols.
- Regarding the maintenance of data for recordkeeping and care coordination, data that is collected by the technology is typically shared with the referring psychologist and can be stored in the psychologist's electronic health record and made available to the patient in their electronic medical record.
- Digital therapeutics can fit under existing Medicare benefit categories, including incident-to services (e.g., digital therapeutics furnished by healthcare practitioners as part of their treatment of patients for continued access/use at home) or as durable medical equipment (e.g., digital therapeutics housed in virtual reality hardware systems that meet Medicare's durability requirements for use at home).

Applicability of Existing Remote Therapeutic Monitoring (RTM) codes to dCBT
There has been confusion about whether dCBT can be coded with CPT® code 98978; *Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days* (effective 1/1/23). The AASM believes that this code describes the supply of a device for monitoring CBT. There were no invoices received by CMS or the RUC for code 98978, which is consistent with the fact that digital CBT devices are being used primarily for delivering the underlying therapy, rather than for monitoring of ongoing practitioner-delivered CBT. The AASM would, therefore, support the modification of this code or the development of new codes to cover the supply of the therapeutic digital CBT device itself.

In cases where digital therapeutics are furnished incident-to a clinical psychologist's service, we do believe existing RTM codes (98975, 98980, and 98981) could be used to support billing for patient set-up & education and treatment management services for digital CBT and other digital therapeutics. These codes are well-suited to account for the professional services deployed for many digital therapeutics and RTM monitoring devices alike. However, as articulated above, new device supply codes need to be created, or existing codes need to be modified, to account for digital therapeutic devices that are designed to deliver

the underlying therapy rather than focus specifically on monitoring, data collection and transmission.

Reasonable & Necessary Criteria
Like coverage for many other mental health services, determination of whether a digital therapeutic for behavioral health is reasonable and necessary can be left to local Medicare Administrative Contractor (MAC) discretion. However, a requirement of meeting any applicable requirements for FDA premarket review (e.g., 510(k) clearance [unless category is exempt from review], de novo authorization, premarket approval) should be considered. For most digital therapeutics, FDA premarket review will require clinical data in the form of randomized controlled trial evidence demonstrating the safety and effectiveness of the device (de novo pathway) or demonstrating substantial equivalence in terms of safety and effectiveness to a predicate product (510(k) pathway).[2] Additionally, CMS or MACs can consider clinical guidelines to determine if the mechanism of action of the digital therapeutic is considered by specialty societies to be reasonable and necessary.

Updates to the Quality Payment Program

MIPS Payment Adjustments
CMS is proposing to increase the performance threshold to from 75 points to 82 points in 2024. While the AASM understands the desire to make requirements and thresholds more rigorous to drive improvements in patient care, we strongly urge CMS to reduce the performance threshold to a lesser degree. Establishing a threshold that penalizes more than one-half of MIPS eligible clinicians, who are currently facing near-record levels of inflation, in the midst of an over 3% payment reduction seems excessive. This proposal will only add to the current stressful and unsustainable long-term reimbursement structure for Medicare providers. The AASM, therefore suggests holding the performance threshold at 75 points until CMS and Congress can work together to address physician payment reform, as noted in HR 2474.

Promoting Continuous Improvement in MIPS
For the MIPS program, CMS developed policies and methodologies to assess clinicians' performance, and to support performance improvement across four performance categories (quality, cost, improvement activities, and promoting interoperability). As an alternative to the current methodology for assessing improvement in the quality category, the AASM suggests that CMS consider assessing performance improvement, year over year, taking into consideration a clinician's baseline and their most recent scores, to demonstrate improvement in their performance over time. This would reduce the impact of clinicians that only choose measures for which they have high scores and may encourage them to improve on some of the measures they do not score well on, initially.

Previously Finalized Quality Measures with Substantive Changes Proposed for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Years
D. 29 Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy

The AASM launched a quality measure maintenance initiative to update the Adult Obstructive Sleep Apnea quality measure set. Obstructive sleep apnea (OSA) remains a highly prevalent disorder that can lead to multiple adverse outcomes when undiagnosed and/or when left untreated. There continue to be gaps and variations in the provision of care for the adult patient population with OSA, which emphasizes the importance of the measure maintenance initiative for The Quality Measures for the Care of Adult Patients with Obstructive Sleep Apnea (originally developed in 2015). The AASM convened a Quality Measures Task Force in 2018 to review the current medical literature, other existing quality measures focused on the same patient population, and any performance data or data in the medical literature that show gaps or variations in care, to inform potential revisions to the quality measure set.

Therapy adherence is extremely important for patients with OSA to experience improvement in signs and symptoms of OSA. Despite the clear efficacy of PAP therapy, adherence continues to be highly variable in patients with OSA. The Task Force decided to modify the quality measure, consistent with the most current evidence and clinical practice. The updated version of the measure, published in 2022, is now included in the MIPS program, as a clinical quality measure.

Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP
CMS is proposing to include eight MIPS quality measures and four QCDR measures within the quality performance category of this MVP, which promote the management and care associated with otolaryngology. As the measure steward of measure Q277 (Sleep Apnea: Severity Assessment at Initial Diagnosis), the AASM strongly supports the inclusion of this measure in the Treatment of Ear, Nose, and Throat Disorders MVP. We also support the inclusion of all other proposed quality measures and improvement activities in this MVP, as they are relevant for members of the AASM that are also boarded in otolaryngology.

Promoting Interoperability Performance Category Performance Period
CMS is proposing that for the CY 2026 MIPS payment year, the performance period for the Promoting Interoperability performance category is a minimum of any continuous 180-day period within CY 2024, up to and including the full CY 2024 (January 1, 2024, through December 31, 2024). While CMS believes that this proposal would minimally increase the information collection burden on data submitters, the AASM would like to highlight that this would only add to the current administrative burden on providers, leading to burnout and reducing the likelihood that patients will receive high quality care.

Thank you for your consideration of these comments. The AASM appreciates the Agency's efforts to revise the Medicare Physician Fee Schedule in order to prioritize high quality clinical care for patients, while working to reduce administrative burden. We encourage the Agency to adopt the recommended changes summarized in this letter. Please feel free to contact Diedra Gray, AASM Director of Health Policy, at dgray@aasm.org or 630-737-9700, for additional information or clarifications.

Sincerely,

James A. Rowley, MD
AASM President

cc: Steve Van Hout, AASM Executive Director
Sherene Thomas, AASM Assistant Executive Director
Diedra Gray, AASM Director of Health Policy

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[i] Edinger JD, Arnedt JT, Bertisch SM, et al. Behavioral and psychological treatments for chronic insomnia disorder in adults: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2021;17(2):255–262.

[ii] Qaseem, A., Kansagara, D., Forciea, M. A., Cooke, M., Denberg, T. D., & Clinical Guidelines Committee of the American College of Physicians*. (2016). Management of chronic insomnia disorder in adults: a clinical practice guideline from the American College of Physicians. Annals of internal medicine, 165(2), 125-133.

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