September 12, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS–1832–P. Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Submitted electronically via regulations.gov

Dear Administrator Oz:

The American Academy of Sleep Medicine (AASM) appreciates the opportunity to submit comments on the proposed rule for the 2026 Physician Fee Schedule (PFS) and Quality Payment Program. The proposed revisions will have a direct impact on the care provided by AASM members to patients with sleep disorders. The comments included in this response directly reflect the needs of more than 9,000 individual AASM members and 2,400 AASM-accredited sleep programs, dedicated to advancing sleep care and enhancing sleep health to improve the lives of patients with sleep disorders, including the Medicare population.

Sleep disorders—including obstructive sleep apnea, insomnia, narcolepsy, and circadian rhythm disorders—affect millions of Medicare beneficiaries, exacerbate cardiometabolic and behavioral health conditions, and contribute to higher health care costs if left untreated. As such, Medicare policies that appropriately support the delivery of sleep care are essential to ensuring access, reducing downstream costs, and improving quality of life for Medicare beneficiaries.

2026 PFS Rate-setting and Conversion Factor

We appreciate CMS's efforts to incorporate statutory updates into the 2026

conversion factors. However, the AASM remains deeply concerned that the proposed updates fail to account for the rising costs of keeping physician practices operational. The consistent decrease in physician reimbursement continues to negatively impact physician practices and make the practice of medicine unsustainable for many, including but not limited to sleep medicine providers. Sleep medicine practices continue to face significant financial pressures, including costs of diagnostic technology (e.g., polysomnography, home sleep apnea testing devices, etc.), staff shortages, and increasing administrative burden. In 2024 alone, 49 accredited sleep facilities closed, and in 2025, 36 sleep facilities closed, to date. These sleep facility closures have led to the AASM Board of Directors highlighting Practice Success as one of the AASM strategic goals, ensuring access to high-quality care for patients with sleep disorders. Without permanent payment updates, access to sleep specialists will continue to decrease, particularly in rural and underserved communities.

For the last several years, Congress has enacted the Consolidated Appropriations Act to relieve some of the strain of the annual Medicare physician payment rate cuts, and most recently, Congress approved the One Big Beautiful Bill Act, which included a temporary, one-year, 2.5% update for the 2026 Medicare Physician Fee Schedule. While the AASM supports this update, after five consecutive years of payment reductions, this does not offer a permanent fix to the ever-increasing cost of providing high-quality care amidst consistently increasing inflation rates. The AASM continues to urge CMS to work with legislators to implement a permanent fix to this problem by establishing an annual inflation-based update to the Physician Fee Schedule. This update would allow physician practices to remain viable and continue to provide high-quality care to patients in 2026 and beyond. In the meantime, the AASM also strongly encourages CMS to work with Congress to adopt MedPAC's recommendation for Medicare Economic Index (MEI)-linked updates to ensure sustainable Medicare payment, thereby preventing more facility closures, which ultimately lead to reduced access and delays in care to the Medicare patient population.

Determination of PE RVUs

Proposed Efficiency Adjustment

The AASM appreciates and supports CMS's intent to maintain accurate and sustainable valuation of services; however, the AASM strongly opposes the application of a -2.5% efficiency adjustment to Work RVUs and intraservice physician time for non-time-based services. This across-the-board reduction is arbitrary, lacks empirical justification, and unfairly assumes that physicians—including sleep specialists—have uniformly become more efficient in delivering care. Sleep medicine services such as polysomnography interpretation, cognitive behavioral therapy for insomnia, and longitudinal CPAP management remain labor- and time-intensive and have not experienced reductions in resource use over time. Additionally, sleep disorders manifest differently across patients, and their diagnosis and treatment must be personalized. A standardized or uniform approach risks overlooking important variations in symptom severity, comorbid conditions, and shared decision-making. A patient-centered model of care, tailored to the individual, is essential to achieving optimal health outcomes. Reducing Work RVUs for essential diagnostic and therapeutic services could potentially reduce Medicare beneficiary access to timely diagnosis and treatment of sleep disorders. The AASM respectfully

requests that CMS withdraw the proposed -2.5% adjustment to Work RVUs for CY 2026, as finalizing this proposal would largely impact high-value non-time-based services essential to patient safety, and excluding or diminishing the input of practicing physicians in resource valuation risks patient access to care.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology – Physician Practice Information (PPI) Survey

The AASM strongly supports the transition from the outdated Socioeconomic Monitoring System (SMS) dataset to the Physician Practice Information (PPI) survey data for determining practice expense (PE) inputs. The SMS dataset, last updated decades ago, no longer reflects the cost realities of modern physician practices. Reliance on this antiquated data source has contributed to systematic underestimation of practice expenses, particularly for specialties like sleep medicine that are technology- and labor-intensive. The PPI survey, developed through a collaborative effort with the American Medical Association (AMA) and specialty societies, including sleep medicine, provides a more robust and representative picture of practice expenses across the physician community. We therefore urge CMS to adopt the PPI survey as a replacement for SMS data, consistent with longstanding AMA advocacy to modernize PE inputs and improve accuracy of payment.

We recognize that CMS has raised concerns about the validity and reliability of the PPI data, including potential limitations in sample size, response rates, and representativeness. While these concerns warrant consideration, we caution against using them as a basis to eliminate or diminish the role of PPI data in payment policy. Importantly, the PPI survey was designed to address methodological limitations inherent in the SMS dataset, and its use reflects the most current, physician-sourced practice expense information available.

To address CMS's concerns, we recommend that the Agency:

1. Validate data at the specialty level: Ensure that PPI inputs align with observed practice expenses for diagnostic-heavy specialties like sleep medicine, where costs for equipment, data management, and specialized personnel may not be fully captured in aggregate analyses.

2. Enhance transparency: Clearly report how PPI survey data are being incorporated into the PE methodology and publish specialty-level impact analyses to allow stakeholders to identify and correct anomalies.

3. Iterate and improve: Recognize that the PPI survey provides a significantly more accurate foundation than the SMS dataset, while also committing to continuous refinement of survey design, sampling, and weighting in collaboration with the AMA and specialty societies.

From our perspective, the risks of continuing to rely on outdated SMS data far outweigh the methodological concerns with the PPI survey. The PPI dataset reflects a substantial advancement in capturing the current costs of physician practice and provides the most valid foundation available for

Medicare's practice expense methodology. By adopting the PPI data with appropriate safeguards, CMS can modernize its payment system, improve accuracy, and protect access to care in specialties such as sleep medicine that rely on resource-intensive diagnostic and therapeutic modalities.

Updates to Practice Expense Methodology – Site of Service Payment Differential

The AASM opposes CMS's proposal to reduce indirect PE RVUs for facility-based services. Sleep physicians often provide inpatient consultations and interpret facility-based sleep studies, while still maintaining office-based infrastructure, administrative staff, and clinical personnel. This policy presumes duplicative payment without accounting for the ongoing overhead of physician practices and will further incentivize vertical consolidation and limit flexibility in care delivery thereby limiting access to care. The proposal also risks penalizing sleep specialists for maintaining diverse care settings and could accelerate consolidation, reducing patient access. Therefore, the AASM urges CMS to reconsider this proposal or, at a minimum, provide exceptions for specialties such as sleep medicine that continue to maintain significant practice expense across care settings.

Potentially Misvalued Services Under the MFS

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

The AASM supports CMS's goal of ensuring accuracy and integrity in the valuation of physician services. However, we are concerned that CMS's proposed expansion of the potentially misvalued code identification (PMI) process exceeds statutory authority and risks undermining the established, transparent mechanisms for code review. Currently, CMS is authorized to identify potentially misvalued codes based on clearly defined statutory triggers. The RUC process has long provided a pathway for identifying and revaluing codes using empirical data and clinical expertise. By proposing to broaden PMI criteria beyond those outlined in the statute, CMS would introduce uncertainty, reduce transparency, and would risk targeting services without sufficient evidence of misvaluation.

We, therefore, urge CMS to:

1. Withdraw the proposal and continue utilizing the existing RUC process, which already ensures regular and evidence-based review of codes through a physician-led mechanism, or 2) substantially revise the proposed expansion of PMI triggers, ensuring that the process remains consistent with statutory authority.
2. Avoid arbitrary or duplicative review of services, particularly in specialties where services are resource-intensive and have already been thoroughly evaluated by the RUC.
3. Engage specialty societies prior to initiating any PMI review to ensure that potential triggers are interpreted appropriately and reflect clinical realities.

Expanding the PMI process without clear statutory authority, transparent criteria, or physician input risks destabilizing the payment system and reducing beneficiary access to critical services. We therefore strongly urge CMS to withdraw this proposal and instead work collaboratively with the

physician community to ensure that code valuation reviews remain evidence-based, transparent, and statutorily consistent.

Public Nominations: Electronic analysis of implanted neurostimulator pulse generator/transmitter (CPT codes 95970, 95976, and 95977)

Hypoglossal nerve stimulation is an implantable therapy for obstructive sleep apnea (OSA) and has become an important treatment option for patients who are unable to tolerate, or are inadequately managed using, positive airway pressure (PAP) therapy and are candidates for this surgical option. Medicare beneficiaries may fall into this category, and ensuring appropriate valuation of follow-up services is essential to maintaining access to this therapy. Undervaluing the electronic analysis codes diminishes reimbursement for an effective treatment and may reduce patient access to care. This service involves more than a simple device interrogation; it requires a comprehensive assessment of stimulation parameters, airway response, patient tolerance, and treatment efficacy. This process is resource-intensive and critical to ensuring both the safety and effectiveness of therapy for OSA, a chronic condition that significantly impacts cardiovascular, metabolic, and neurocognitive health if left untreated.

Upon review of the 2023 Medicare claims data, we note that electronic analysis of implanted neurostimulator pulse generator/transmitter codes are most often reported by neurologists, while otolaryngologists (ENT physicians) perform hypoglossal nerve stimulation implantation procedures for patients with OSA. While sleep medicine physicians frequently manage patient selection, diagnostic evaluation, and longitudinal care, the initial technical electronic analysis of the device is not generally performed by the sleep medicine physician.

The AASM recommends that CMS request and review the detailed survey data, referenced by the nominator of these codes, to determine whether the codes appropriately reflect the intensity, expertise, and time required to manage therapy with implanted neurostimulators. Given the multi-disciplinary nature of OSA management, we also urge CMS to engage multiple specialty societies, including otolaryngology and sleep medicine, in any future deliberations to ensure that code valuation decisions are grounded in clinical practice realities.

Valuation of Specific Codes

Methodology for the Direct PE Inputs to Develop PE RVUs – Practice Expense Refinement Table

The AASM appreciates CMS's continued efforts to refine the practice expense (PE) methodology to ensure fair and accurate valuation of physician services. However, we are concerned that the proposed changes to the development of direct PE inputs risk introducing instability and undervaluing resource-intensive diagnostic services, including those central to sleep medicine.

Sleep medicine is uniquely reliant on expensive equipment and highly trained staff. Costs unique to independent sleep labs (e.g., specialized equipment, technician staffing) may not be well-reflected in hospital-based datasets, potentially undervaluing outpatient sleep practices. Polysomnography (PSG),

home sleep apnea tests (HSATs), and multiple sleep latency testing (MSLT) require dedicated monitoring equipment, disposable supplies, and the continuous presence of skilled technologists. These resource costs are substantial and must be appropriately captured in the direct PE inputs to maintain access to care for Medicare beneficiaries.

We share the RUC's concern that CMS's proposed methodology departs from longstanding precedent without sufficient transparency or specialty-level validation. Specifically, adjustments to the scaling and allocation of direct PE inputs, particularly when combined with the incorporation of Physician Practice Information (PPI) survey data for indirect PE, could result in duplicative or unintended reductions. For sleep medicine, this would disproportionately impact services that are already resource- and labor-intensive.

Accordingly, we recommend that CMS:

- Retain methodological stability: Avoid abrupt departures from the established PE methodology without clear evidence that changes will improve accuracy.
- Conduct specialty-level impact analyses: Model and publish the projected effects of direct PE methodology changes on individual specialties, including sleep medicine, prior to implementation.
- Phase in changes gradually: If revisions are finalized, implement them over a multi-year period to prevent destabilizing year-over-year shifts in payment rates.
- Engage specialty societies: Collaborate with the RUC and physician specialty organizations to ensure that methodological refinements reflect the real-world resource costs of providing care.

Modernizing PE data inputs is an important goal, but changes to the underlying direct PE methodology should be approached systematically. We urge CMS to adopt an evidence-based, transparent process that ensures accurate valuation of services, to protect patient access to medically necessary care and ensure appropriate reimbursement for each service.

Telehealth

The AASM applauds CMS for its continued commitment to expanding access to care, reducing unnecessary barriers, and ensuring sustainable reimbursement for telehealth services in the CY2026 Medicare Physician Fee Schedule proposed rule. Sleep medicine is a specialty that has seen significant improvements in access, outcomes, and patient satisfaction through the use of telehealth, particularly for services such as cognitive behavioral therapy for insomnia (CBT-I), follow-up visits for OSA, and longitudinal management of other chronic sleep disorders.

We strongly support CMS's efforts to modernize telehealth policy in ways that align with patient-centered care and the evolving delivery of sleep medicine services.

Removal of Frequency Limitations

We strongly support CMS's proposal to permanently eliminate frequency limitations on telehealth services. Sleep medicine care often requires ongoing follow-up visits and adjustments to therapy (e.g., positive airway pressure management). Arbitrary limits on visit frequency undermine the flexibility needed to provide high-quality, individualized care.

Virtual Direct Supervision

The AASM strongly supports CMS's proposal to adopt a definition of direct supervision that includes audio/video real-time communication, after years of ongoing advocacy, in this regard. This flexibility enhances the ability of sleep specialists to provide oversight to advanced practice providers and technologists, particularly in regions with workforce shortages, without compromising patient safety. We encourage CMS to extend this flexibility to all geographic settings, including metropolitan areas, to ensure equitable access to care and appropriate supervision across practice environments.

Provider Enrollment and Address Flexibility

Consistent with previously submitted comments, the AASM continues to urge CMS to make the flexibility allowing providers to use their affiliated practice address, rather than a home address, on Medicare enrollment and billing forms permanent. This policy is critical to protecting provider privacy, reducing administrative burden, and supporting the retention of sleep specialists who deliver telehealth services.

Remote Monitoring and Digital Health Tools

Sleep medicine is uniquely positioned to benefit from expanded access to remote monitoring technologies. Devices that track sleep parameters, adherence to positive airway pressure therapy, and circadian rhythm disturbances are critical to ongoing sleep disorder management. We support CMS's adoption of updated remote physiologic and therapeutic monitoring codes and urge CMS to ensure that reimbursement for these services accurately reflects the clinical time, complexity, and value involved, consistent with the American Telemedicine Association Action's comments.

Digital Mental Health Therapeutics

AASM supports CMS's efforts to expand coverage for digital therapeutics, including those aimed at treating insomnia and other sleep disorders. We encourage CMS to recognize the role of FDA-authorized digital therapeutics in delivering evidence-based behavioral interventions for sleep disorders and to ensure appropriate valuation to facilitate adoption.

Facilitating Diagnostic Testing Through Telehealth

The AASM also urges CMS to support policies that facilitate access to diagnostic testing ordered and managed through telehealth encounters. For sleep medicine, this is particularly relevant for home sleep apnea tests (HSATs), which are frequently initiated following a telehealth consultation. HSATs are essential for diagnosing obstructive sleep apnea in Medicare beneficiaries, especially in rural and underserved areas where access to in-lab polysomnography may be limited.

- Telehealth integration allows for appropriate patient selection, test ordering, patient education on device use, and follow-up interpretation without requiring unnecessary in-person visits.
- Policies that ensure HSAT and related diagnostic services remain reimbursable when initiated via telehealth will directly improve access, reduce delays in diagnosis, and lower downstream costs from untreated OSA.

Evaluation and Management (E/M) Visits

Evaluation and Management (E/M) Visit Complexity Add-on

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)

The AASM supports CMS's proposal to allow G2211 to be billed with home and residence-based E/M visits, as this reflects the complex, longitudinal nature of sleep medicine. These policy decisions are essential to protecting the value of core patient care services in sleep medicine and recognizing the complexity of prolonged management for patients with sleep disorders. However, we strongly urge CMS to correct its prior budget neutrality miscalculation that contributed to harmful conversion factor cuts in 2024. Sleep patients often have multimorbidity (e.g., OSA, cardiovascular disease, obesity, insomnia) that necessitates complex longitudinal management, making G2211 highly relevant to our field. We believe such correction is necessary to ensure that the code fulfills its intended purpose without disadvantaging sleep medicine and other specialties.

Determination of Professional Liability Relative Units (PLI RVUs)

The AASM acknowledges and appreciates CMS's proposal to increase malpractice RVUs by +3.0% in CFY 2026. While this adjustment reflects recognition of ever-changing liability costs, we are concerned that it will provide only a modest and incomplete offset to the substantial reimbursement reductions caused by the proposed -2.5% work-efficiency adjustment to non-time-based services. When viewed in combination, these cuts will reduce the financial viability of providing critical diagnostic services in facility and non-facility settings. The AASM respectfully requests that CMS reassess the balance between work and malpractice RVU adjustments to ensure that the combined effect of CY 2026 doesn't create distinct negative impacts on specialties with high diagnostic service volumes.

The AASM is also concerned by CMS's proposal to crosswalk sleep medicine PLI values to the general medicine category, as this does not accurately reflect the risk profile associated with the specialty. Sleep medicine is a distinct subspecialty with clinical and risk characteristics more closely aligned with neurology than with general medicine. Sleep physicians routinely interpret and manage complex neurophysiologic testing such as polysomnography (PSG), multiple sleep latency testing (MSLT), and maintenance of wakefulness testing (MWT). These services involve interpretation of continuous physiologic data, monitoring of cardiorespiratory function, and management of patients with comorbid

neurologic, cardiopulmonary, and psychiatric conditions. The liability profile of these activities differs significantly from that of general medicine and requires a more nuanced crosswalk.

The AASM, therefore, recommends that sleep medicine be crosswalked to neurology for PLI purposes, as this approach more accurately captures the liability risk associated with the specialty and ensures appropriate relative valuation. We are in agreement with the RUC that crosswalking sleep medicine to general medicine will underestimate the professional liability exposure of sleep medicine physicians, resulting in undervaluation of services. The AASM also believes that crosswalking to general medicine would further compound the financial instability facing physician practices. We also encourage CMS to commit to specialty consultation in future PLI determinations to ensure that crosswalks accurately reflect the risk environment in which physicians practice.

Geographic Practice Cost Indices (GPCIs) & Small Practice Impact

Sleep medicine is particularly vulnerable to geographic disparities, with many small and rural practices already at risk of closure. The AASM urges CMS to extend the work GPCI floor to avoid steep cuts in rural areas, which would otherwise worsen access to sleep specialists.

Administrative Burden RFI

The AASM appreciates CMS's request for information on strategies to reduce administrative burden for physicians and health care organizations. We strongly support efforts to streamline documentation, reporting, and compliance requirements, as administrative complexity is a significant driver of physician burnout and a barrier to patient access.

For sleep medicine providers, the following areas represent opportunities where CMS could meaningfully reduce administrative burden while preserving program integrity:

1. Prior Authorization Requirements
    - Sleep physicians routinely encounter burdensome prior authorization requirements for diagnostic testing (e.g., polysomnography, home sleep apnea testing) and for durable medical equipment (e.g., positive airway pressure therapy). These requirements delay care, increase costs, and create administrative workload that disproportionately affects small and independent practices. We urge CMS to expand its use of real-time electronic prior authorization, enforce compliance with prior authorization response timeframes, and monitor inappropriate denial rates.
2. Documentation Requirements for Sleep Testing
    - Current documentation rules for polysomnography and home sleep apnea testing are often duplicative and non–evidence-based. For example, requirements for repeat documentation of medical necessity, despite prior testing or clear clinical indications, add unnecessary workload without improving patient outcomes. Streamlining documentation policies would reduce burden while maintaining appropriate oversight.

3. Quality Reporting in MIPS and MVPs

    - While AASM supports quality measurement, the current MIPS program creates excessive and complicated reporting requirements that do not adequately reflect the value of sleep medicine care. Sleep physicians often must report on measures that are not directly related to their practice. We urge CMS to prioritize development and approval of specialty-specific quality measures and to simplify reporting requirements for small and specialty practices.

4. Telehealth Flexibility

    - During the COVID-19 public health emergency, temporary flexibilities—such as telehealth for follow-up visits and streamlined patient consent processes—significantly reduced administrative burden while improving access. We recommend that CMS permanently adopt these flexibilities to reduce administrative overhead associated with scheduling, documentation, and compliance monitoring.

5. Audit and Compliance Processes

    - CMS and Medicare Administrative Contractor (MAC) audits for sleep services, particularly diagnostic testing, often vary widely in interpretation and create significant administrative costs for practices. We encourage CMS to issue clearer, standardized guidance for MACs on documentation and coverage requirements for sleep services to reduce audit-driven burden.

We urge CMS to prioritize reforms that eliminate duplicative documentation, streamline prior authorization, expand specialty-specific quality measures, and provide clarity in compliance requirements. Reducing these administrative burdens will allow sleep medicine physicians to devote more time to patient care, improve access to treatment, and reduce costs for both practices and the Medicare program.

Updates to the Quality Payment Program

MIPS Payment Adjustments

The AASM appreciates CMS's proposal to maintain the MIPS performance threshold at 75 points for the next three years. This approach provides much-needed stability and predictability for clinicians, particularly those who have faced challenges in meeting the performance threshold in previous years. By keeping the threshold consistent, CMS enables clinicians to focus on sustained quality improvement and gradual performance gains, rather than having to adapt to shifting benchmarks each year. This consistency also supports more strategic planning, encourages investment in long-term improvements, and fosters a more equitable environment for clinicians working to enhance care delivery and patient outcomes.

MIPS Value Pathways (MVPs)

The AASM appreciates CMS's proposal to introduce six new MIPS Value Pathways (MVPs) for the Calendar Year 2026 performance period. While the newly proposed pathways do not specifically pertain to Sleep Medicine, we recognize and value CMS's continued efforts to expand MVP options that serve a broad range of medical specialties. This inclusive approach is essential to ensuring that all clinicians, regardless of specialty, have access to meaningful participation pathways that reflect their unique clinical practice.

As CMS moves toward phasing out traditional MIPS in favor of MVPs, we emphasize the importance of continuing to develop pathways that are inclusive of all specialties, including those that may currently be underrepresented. Because sleep medicine is a cross-cutting field, we encourage CMS to develop or adapt MVPs to reflect relevant sleep medicine measures within chronic disease, cardiometabolic, and behavioral health frameworks. Ensuring that every clinician has a viable, relevant MVP option will be critical to supporting equitable participation and advancing the goals of value-based care.

Additionally, we acknowledge CMS's proposal to allow Qualified Clinical Data Registries (QCDRs) a one-year transition period after a new MVP is finalized before being required to fully support that pathway. This phased implementation approach is both practical and necessary, as it provides QCDRs with sufficient time to make the technical, operational, and educational adjustments needed to effectively support new MVPs. Allowing this lead time will help ensure successful adoption, reduce administrative burden, and enhance the accuracy and utility of the data collected.

Small Practice Flexibility

We support CMS's proposed flexibility for small multispecialty practices in MVP reporting, which will reduce administrative burden and protect small sleep practices embedded within larger groups.

Cost Performance Category

The AASM supports CMS's proposal to implement a two-year, informational-only feedback period for newly introduced MIPS cost measures. Since clinicians do not actively submit data for the Cost category, this approach allows them to better understand how their performance is evaluated through administrative claims. The feedback period provides valuable insight into cost attribution and performance, enabling clinicians, especially those in smaller or specialized fields like sleep medicine, to identify relevant measures and focus on improvement efforts before being held accountable through scoring. Implementing this informational-only feedback period will promote fairness, transparency, and more effective participation in the MIPS program.

Ambulatory Specialty Model

The AASM appreciates The Agency's efforts to promote an inclusive approach to value-based care through the proposed implementation of a new mandatory payment model in 2027, which would apply to clinicians in select areas and treat patients with heart failure or low back pain. This model, which is structured similarly to MIPS Value Pathways (MVPs), utilizes a set of required performance measures specifically tailored to the clinical conditions being treated, rather than applying broadly across entire

specialties. While the AASM appreciates the proposal to create more clinically relevant and condition-specific participation pathways, which encourage clinical coordination and promote preventive care, we are concerned that introducing a new mandatory model while the MVP framework is still undergoing development and refinement may create confusion among clinicians regarding reporting expectations and program alignment. Practices will also need ample time to increase capabilities in data reporting, care team integration, and EHR interoperability. To support a smoother transition and promote greater understanding and engagement, we recommend that CMS focus on the full implementation and stabilization of the MVP program before moving forward with additional mandatory models.

Advanced Alternative Payment Models

We appreciate CMS's efforts to broaden Advanced APM opportunities but are concerned about the lack of specialty-relevant models for sleep medicine. Sleep specialists play a critical role in managing OSA, insomnia, and circadian rhythm sleep-wake disorders, which can significantly impact the cost and outcomes of cardiometabolic and behavioral health conditions. We urge CMS to develop APM pathways that incorporate sleep care, either through specialty models or by explicitly recognizing sleep management within broader chronic disease models.

Core Elements in an MVP RFI

The AASM recognizes CMS's effort to enhance the focus of MVPs by exploring the use of key quality measures within each pathway referred to as Core Elements. While we understand the intent, we recommend a careful, data-driven approach before implementing such a requirement, especially if it becomes mandatory. It is important to first understand each MVP's structure, relevant specialties, existing reporting patterns, and performance baselines. CMS should also consider potential challenges clinicians may face in reporting all Core Elements, such as limitations related to scope of practice or patient population, to ensure equitable and practical implementation.

Well-being and Nutrition Measures RFI

The AASM acknowledges CMS's efforts to incorporate well-being, nutrition, and holistic health measures into the Quality Payment Program (QPP). We recognize the importance of nutrition and BMI counseling in overall health and have incorporated these components into the AASM quality measure portfolio. As part of our recent quality measure maintenance initiative, we have updated measure sets for key sleep-related conditions, including obstructive sleep apnea (OSA), insomnia, narcolepsy, and restless legs syndrome and will keep this initiative in mind as we plan future quality measure development and maintenance initiatives.

Data Quality RFI

The AASM appreciates CMS's focus on strengthening data quality in health information exchange, particularly as electronic data becomes increasingly central to care delivery, quality reporting, and research. Over the past year, we made the difficult decision to sunset our clinical data registry due to persistent challenges related to data accuracy and integrity. High-quality, reliable data is essential to

ensuring effective clinical decision-making and advancing patient care. To promote better collaboration between clinicians and health IT vendors, we recommend engaging clinicians early in system design, fostering transparent and ongoing communication, and promoting the adoption of standardized data formats and interoperability frameworks across vendor platforms.

Chronic Disease Prevention & Social Drivers of Health

We support CMS's request for information on chronic disease management and recommend explicit recognition of sleep disorders as a chronic disease driver. OSA, insomnia, and circadian rhythm sleep-wake disorders worsen cardiometabolic outcomes, increase accident risk, and exacerbate behavioral health conditions. The AASM urges CMS to include sleep health in any future policies to expand prevention, digital therapeutics, and motivational interviewing.

Proposed Rule Correction – (12) Sleep Study (CPT code 95800)

While 95800 has not been flagged as potentially misvalued for 2026, the AASM is amenable to CMS modifying the typical device for CPT code 95800 from the WatchPAT 200 device with the more frequently utilized version of the device, the WatchPAT ONE, which is disposable. Our comment letter to the 2025 Physician Fee Schedule proposed rule noted that the majority of AASM-accredited sleep facilities were still using reusable home sleep apnea test (HSAT) devices, however, that data encompassed all HSAT devices (i.e., 95800, 95801, and 95806) and not just those billed as 95800. The AASM believes that the more recent data shared by the interested party, including the updated survey data, supports the change of the typical device for 95800 to the WatchPAT ONE.

Thank you for your consideration of these comments. The AASM appreciates the Agency's continuous efforts to revise the Medicare Physician Fee Schedule in a way that prioritizes high quality clinical care for patients and fair reimbursement for providers, 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 Quality & Health Policy, at dgray@aasm.org or 630-737-9700, for additional information or clarifications.

Sincerely,

Anita V. Shelgikar, MD, MHPE
President, AASM

cc: Steve Van Hout, MBA, CAE
Sherene Thomas, PhD
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