September 14, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: File Code CMS–1848–P. Medicare and Medicaid Programs; CY 2027 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 2027 Physician Fee Schedule (PFS) and Quality Payment Program. The proposed revisions will directly affect the care AASM members provide 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.

2027 PFS Rate-setting and Conversion Factor

CMS proposes a CY 2027 conversion factor of $33.17 for qualifying APM participants and $32.84 for non-qualifying participants, representing reductions of 1.19% and 1.68%, respectively, compared with CY 2026. These decreases occur despite statutory updates because the temporary 2.5% physician payment increase enacted for CY 2026 expires at the end of the year. The AASM is deeply concerned by the continued instability of Medicare physician payment and the impact of the CY 2027 Physician Fee Schedule proposed conversion factors on physician practices and sleep medicine providers. CMS projects a reduction in both the qualifying APM and non-qualifying APM conversion factors for CY 2027 despite sustained inflationary pressures, workforce shortages, increasing administrative requirements, and rising practice costs.

Conversion Factor Category	CY 2026 CF	Proposed CY 2027 CF	Dollar Change	Percent Change
Qualifying APM Participant (QP)	**$33.57**	**$33.17**	**-$0.40**	**-1.19%**
Non-Qualifying APM Participant	**$33.40**	**$32.84**	**-$0.56**	**-1.68%**

The AASM recognizes that CMS is operating within a statutory framework established by Congress. However, the proposed conversion factors further highlight how unsustainable the current physician payment system has become. The current system repeatedly places physicians in the position of absorbing inflationary pressures while also facing reductions tied to budget neutrality requirements, statutory payment updates, and other payment adjustments. Physician practices are one of the few sectors of the healthcare system that lack an automatic inflationary update tied to the actual cost of providing care. At the same time, physician practices continue to experience substantial increases in labor costs, employee benefits, information technology expenses, medical supplies, compliance activities, cybersecurity obligations, accreditation requirements, and facility overhead. These expenses continue to rise regardless of whether Medicare payment keeps pace.

While individual policy changes may appear modest in isolation, the cumulative effect of the Agency's proposed adjustments creates additional financial pressure on physician practices that have already experienced years of payment instability. AASM is concerned that continued reductions tied to efficiency assumptions may not reflect the real-world costs of furnishing care, particularly as practices face rising expenses that cannot be mitigated solely through operational efficiencies.

Sleep medicine practices and sleep facilities face unique operational and financial challenges, making sustained payment reductions especially concerning. Sleep medicine providers often maintain specialized infrastructure for diagnosing and managing sleep disorders, including accredited sleep centers, unattended sleep testing programs, telehealth capabilities, remote patient management services, and complex diagnostic technologies. These services often require dedicated technical personnel, specialized equipment, accreditation activities, quality assurance programs, and ongoing investment in technology and clinical workflows. Additionally, many sleep medicine practices are small or independent physician practices that lack the alternative revenue streams available to larger health systems. These practices must absorb ongoing increases in staffing costs, facility expenses, information technology investments, and regulatory compliance requirements while continuing to provide access to diagnostic testing and long-term management services for patients with chronic sleep disorders. Year after year of payment reductions have forced many sleep practices to make the difficult decision to close their centers or consolidate services. The continuous decline of reimbursement also exacerbates physician workforce shortage, as it becomes harder to attract talent into the healthcare field, and especially so for a field like sleep medicine that is a subspecialty, requiring an additional fellowship year.

The AASM is also increasingly concerned that continued payment instability may affect access to sleep medicine services, particularly in rural, underserved, and community-based settings. Sleep disorders are highly prevalent chronic conditions that require ongoing evaluation, treatment monitoring, patient education, and longitudinal management. Maintaining access to timely diagnosis and treatment is critical given the association between untreated sleep disorders and numerous chronic conditions, including cardiovascular disease, hypertension, diabetes, stroke, depression, and cognitive impairment.

The AASM strongly urges CMS not to finalize the proposed reduction to the Medicare conversion factor and to continue partnering with Congress on meaningful physician payment reform. Sleep medicine practices, like many physician practices, continue to face escalating staffing, technology, and operational costs that are not reflected in annual payment updates. Additional reductions in Medicare reimbursement may impair practices' ability to maintain access to diagnostic and therapeutic sleep services, particularly in rural and underserved communities, ultimately affecting patient access to timely, high-quality care.

Telehealth flexibilities and modifiers

Telehealth critical care consultations

G0508: Telehealth consultation, critical care; first 30 to 74 minutes.
G0509: Telehealth consultation, critical care; each additional 30 minutes (List separately in addition to code for primary service).

The AASM supports CMS's proposal to revise the code descriptors for HCPCS codes G0508 and G0509 and to establish the accompanying modifiers intended to clarify the reporting of telehealth critical care consultation services. CMS appropriately notes that questions have arisen regarding the meaning of the terms "initial" and "subsequent" in the current descriptors following the permanent removal of the limitation restricting billing of critical care telehealth consultation services to one service per day. We agree that additional clarification is warranted to ensure accurate and consistent reporting of these services. The proposed descriptors define the services more clearly by time and service structure, rather than using terminology that could be misinterpreted as limiting the number of billable services furnished during an episode of care. The proposed changes clarify when each code should be reported and reduce ambiguity associated with the prior references to "initial" and "subsequent" consultations and the typical physician time language.

AASM also supports CMS's proposal to establish modifiers that distinguish whether the practitioner furnishing the telehealth critical care consultation has previously furnished an evaluation and management service to the patient. These modifiers will provide important contextual information for claims processing and program integrity purposes while preserving beneficiary access to telehealth critical care expertise. The proposed modifier structure offers a clear and operationally feasible mechanism for identifying the relationship between the consulting practitioner and the patient without creating unnecessary administrative burden.

Overall, AASM believes these proposals will improve coding accuracy, reduce provider confusion, promote consistent billing practices, and better reflect how telehealth critical care consultation services are furnished in clinical practice. We encourage CMS to finalize the revised code descriptors and associated modifiers as proposed.

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

AASM supports allowing the teaching physician to bill for telehealth services when either the teaching physician or the resident is physically present with the beneficiary, provided the service is included on the Medicare Telehealth Services List. This proposal appropriately recognizes the realities of modern clinical practice and medical education while maintaining meaningful in-person involvement in patient

care. Allowing either the teaching physician or the resident to be physically present with the patient can enhance access to specialty care, particularly for beneficiaries in rural, underserved, and medically complex settings where access to sleep medicine specialists and other subspecialists may be limited. By reducing unnecessary logistical barriers, the proposal supports efficient use of telehealth technologies while ensuring that beneficiaries continue to receive care in a supervised educational environment. We encourage CMS to finalize this proposal as written and continue evaluating opportunities to modernize teaching physician requirements in a manner that reflects evolving models of telehealth-enabled care delivery.

Valuation of Specific Codes Including Potentially Misvalued Services Under the PFS

Unattended Sleep Testing (CPT codes 95X18 – 95X23)

Code	Long Descriptor
95X18	Unattended sleep study, set-up, data acquisition and technical analysis; low complexity of 3-4 channels that generate at least 3-5 parameter categories
95X19	Unattended sleep study, set-up, data acquisition and technical analysis; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories
95X20	Unattended sleep study, set-up, data acquisition and technical analysis; high complexity of 11 or more channels that generate at least 9 parameter categories
95X21	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; low complexity of 3-4 channels that generate at least 3-5 parameter categories
95X22	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; moderate complexity of 5-10 channels that generate at least 6-8 parameter categories
95X23	Unattended sleep study, interpretation and report by a physician or other qualified health care professional; high complexity of 11 or more channels that generate at least 9 parameter categories

CPT Codes 95X18, 95X19, and 95X20

The AASM agrees with the RUC's conclusions regarding CA021 and CA042 and believes the recommended incremental increases appropriately reflect typical clinical practice.

With respect to CA021, patients typically present to the sleep center to receive equipment, review instructions, watch a demonstration of how to apply the equipment, and perform a test run of the device before the study. The demonstration and training have historically reduced failure rates and required more time as equipment complexity increases. Higher-complexity studies also require additional patient instruction, the application of respiratory effort belts and sensors, equipment fit customization, and verification that patients can correctly self-apply the equipment at home. These activities support the RUC recommendation of 15 minutes for CPT codes 95X18 and 95X19 and 25 minutes for CPT code 95X20. These patient-facing activities are integral to obtaining a technically adequate study on the first attempt. If the clinical staff time required for individualized education, sensor placement instruction, fit adjustment, and test application is undervalued, practices may have fewer resources to prevent technically inadequate studies and repeat testing.

Similarly, the CA042 recommendations appropriately reflect the work performed after the device is returned. The download, scoring review, quality assurance activities, preparation of physician summaries, and cleaning and repackaging of reusable equipment increase as study complexity increases. The RUC agreed with the specialty societies that the recommended inputs are appropriate and reflective of typical clinical practice. For CPT codes 95X18, 95X19, and 95X20, the recommended clinical staff times of 40, 50, and 70 minutes, respectively, reflect the combined work of downloading study data, conducting first- and second-pass manual review by a respiratory technician, preparing a summary for the interpreting physician, and cleaning and repackaging reusable equipment. The Subcommittee agreed that automated summaries are not sufficient for accurate interpretation and that manual scoring of all channels and events remains necessary and is supported by the medical literature. Automated output must be reviewed against the full physiologic record to identify artifacts, verify signal quality, confirm respiratory events, and reconcile discrepancies across channels before the study is presented for physician interpretation. Automated summaries may help but do not replace the trained technologist's manual review and quality-assurance responsibilities. Members also confirmed that download time appropriately increases across the code family because each code involves different software applications, increasing channel complexity, and more than eight hours of recorded data. Likewise, cleaning and repackaging time increases with each code due to the additional respiratory belts and device components requiring disinfection and preparation for reuse. This activity is separate and distinct from CA024, Clean room/equipment by clinical staff, and there is no overlapping respiratory technologist work during the service period. Based on these considerations, the AASM strongly recommends 40 minutes of CA042 for CPT code 95X18, 50 minutes for CPT code 95X19, and 70 minutes for CPT code 95X20, in agreement with the RUC recommendations. Accordingly, the AASM urges CMS to finalize the RUC-recommended CA021 and CA042 inputs without refinement.

Equipment Time

The AASM supports the RUC recommendation of 960 minutes of equipment time for CPT codes 95X18 through 95X20. As discussed during the RUC review, the 16-hour period reflects typical clinical workflows, established RUC database conventions, and the fact that the equipment is dedicated to a specific patient and unavailable for use by another patient during that time. The relevant consideration is not limited to the device's active recording time, but rather the entire period during which the equipment is committed to the patient's care.

For example, a patient may visit the sleep center in the late afternoon to receive the device, complete equipment training, and perform a test application before returning home. The study is then conducted overnight, and the patient may not return the equipment until the following morning or later that day. Throughout this entire period, the equipment remains assigned to that individual patient and cannot be redeployed for another study, regardless of the number of hours spent actively recording physiologic data.

Accordingly, the 960-minute equipment time accurately reflects typical operational use of unattended sleep testing devices and the period during which the equipment is unavailable for alternative clinical use. The AASM therefore agrees that 960 minutes is representative of standard practice and should be retained.

Supply and Equipment Pricing

The AASM appreciates CMS' request for additional invoices for the new supply and equipment items associated with CPT codes 95X18 through 95X20. Despite outreach efforts by the societies involved in the RUC valuation of the codes, obtaining invoices from sleep practices for devices that were both representative of what is typically used and included all the appropriate detailed information necessary for RUC review proved to be challenging within the available timeframe. We agree that a single invoice does not adequately represent prevailing market costs and encourage CMS to carefully evaluate all supplemental pricing information from manufacturers, suppliers, sleep centers, and other stakeholders.

Rather than reducing pricing assumptions based upon limited available data, we strongly urge CMS to consider all additional invoices submitted during rulemaking to ensure that pricing accurately reflects current acquisition costs. For example, the invoice currently included is for a reusable test and does not capture the rising number of disposable tests being utilized by clinicians, as evidenced by data submitted by an interested party to the 2026 physician fee schedule proposed rule. Updated market information may support higher direct PE valuations for the equipment and supplies associated with these services and help ensure continued beneficiary access to high-quality unattended sleep testing. Consistent with CMS' solicitation, the AASM encourages consideration of additional invoices for supply item SA143 and equipment items EQ417, EQ418, and EQ419 when determining final PE pricing.

CPT Codes 95X21, 95X22, and 95X23

The AASM appreciates CMS' acceptance of the RUC-recommended work RVUs for CPT codes 95X21 and 95X22. However, we urge CMS to finalize the RUC-recommended work RVU of 1.60 for CPT code 95X23 to maintain relativity within the code family and appropriately recognize the physician work associated with the most complex unattended sleep study interpretation service.

CMS is proposing a work RVU of 1.42 based on a crosswalk to CPT code 92014 (Ophthalmological services). The AASM has reviewed this crosswalk and does not believe it accurately reflects the physician work required to interpret an unattended sleep study involving 11 or more channels that generate at least nine parameter categories. The work of interpreting a high-complexity unattended sleep study requires integrated review of multiple synchronized physiologic signals, assessment of signal artifact and data adequacy, identification and characterization of respiratory events, correlation of findings across parameter categories, and synthesis of those findings into a diagnostic report. An ophthalmologic examination does not involve the same form of prolonged multichannel physiologic data review or signal integration. The CMS crosswalk appears to have been selected primarily because it yields a lower intensity value, even though the surveyed service has time values very similar to those of the RUC-recommended crosswalk code. The AASM feels strongly that the RUC-recommended crosswalk to MPC code 99203 more appropriately reflects the physician work, clinical decision-making, and cognitive effort associated with furnishing this service.

We are particularly concerned about CMS' assertion that a work RVU of 1.60 would create an intensity level that is not typical for CPT codes 95X21 and 95X22. CPT code 95X23 represents the most comprehensive and complex service within this family and requires interpretation of substantially more physiologic information than the lower-complexity services. In addition, the surveyed code may include approximately twice as many channels and parameter categories as the lowest-complexity code in the family. The resulting increase in physician work, clinical judgment, and interpretation effort justifies a higher work RVU.

Further, the RUC recommendation of 1.60 is already conservative. CMS acknowledges that the RUC-recommended work RVU is below the survey 25th percentile of 1.75. Reducing the valuation below an already conservative benchmark risks undervaluing the physician work required to provide this service. Therefore, the AASM believes that assigning a value below the survey-based recommendation fails to adequately reflect the total physician work, intensity, and clinical judgment involved in the service.

The AASM also feels that the comparison services cited during the RUC review process, including CPT codes 74176, 93351, and 78452, demonstrate that a work RVU of 1.60 is reasonable and appropriate given the similar intra-service and total physician times associated with those services. These comparator services support the conclusion that the RUC-recommended valuation appropriately recognizes the complexity and physician work associated with CPT code 95X23. The AASM urges CMS to finalize the RUC-recommended work RVU of 1.60 for CPT code 95X23.

Analytic Crosswalk Error

The CY 2026–CY 2027 Analytic Crosswalk, published along with the proposed rule supplemental documents, incorrectly maps the new unattended sleep testing codes. Specifically, codes 95X18 and 95X21 should crosswalk from CPT 95800, while codes 95X19 and 95X22 should crosswalk from CPT 95806. The AASM respectfully requests that CMS update the utilization data analytic crosswalk in the proposed rule to ensure that the code mapping accurately reflects the recommendations developed through the RUC process. As currently proposed, the analytic crosswalk incorrectly assigns a disproportionate share of Independent Diagnostic Testing Facility (IDTF) utilization to the moderate-complexity codes rather than the low-complexity codes. This misalignment has meaningful reimbursement implications because CMS relies on the utilization crosswalk to determine the specialty mix used for indirect practice expense (PE) allocation when calculating PE RVUs. Inaccurate assignment of IDTF volume, which is associated with a substantially lower indirect practice cost index (IPCI) than physician-based specialties, artificially depresses the proposed PE RVUs for the moderate-complexity codes while inflating the PE RVUs for the low-complexity codes. To ensure that payment rates accurately reflect the RUC recommendations and the underlying practice expense resources required to furnish these services, AASM urges CMS to correct the analytic crosswalk in the final rule.

G Codes (G0398, G0399, G0400)

CMS implemented HCPCS Level II codes G0398, G0399, and G0400 in 2008; these codes have been outdated since the Category I sleep testing codes were initially established in 2011. AASM believes that the new unattended sleep testing CPT codes, 95X18–95X23, are adequate for reporting unattended sleep testing procedures. The AASM, therefore, supports the RUC recommendation to delete G codes G0398, G0399, and G0400.

Remote Monitoring (CPT Codes 98975 – 99470)

Requirements and valuation

AASM is concerned that the proposed valuation changes for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services may not adequately reflect the resources required to furnish clinically meaningful, technology-enabled care. AASM therefore urges CMS not to finalize the proposed valuation changes until the Agency has collected and analyzed reliable information

regarding the actual costs of the devices, clinical labor, technology, connectivity, patient support, and program infrastructure necessary to furnish these services.

Remote monitoring can support longitudinal care for patients with chronic conditions by allowing clinicians to evaluate relevant health information between scheduled encounters, assess treatment response, identify potential barriers to adherence, and determine when additional clinical intervention may be necessary. These capabilities are particularly relevant to sleep medicine, where effective treatment frequently depends on ongoing assessment and sustained patient engagement rather than a single episode of care. Depending on the patient and treatment plan, sleep medicine professionals may use remotely collected information to evaluate treatment use, adherence, symptoms, therapeutic response, and the need for adjustments or additional evaluation.

Remote monitoring involves substantially more than furnishing a device. Resources for these programs may include connected devices, data transmission, software, electronic health record integration, technical support, patient education, clinical data review, patient engagement, escalation protocols, documentation, compliance activities, and program administration. These functions are essential to transforming remotely collected information into clinically actionable care. A valuation methodology that focuses primarily on the cost of a basic, commercially available device risks overlooking the technology and clinical infrastructure required to securely transmit, review, interpret, and act upon patient information. This concern is especially important in sleep medicine, as remote monitoring programs may require patient onboarding and education, troubleshooting device or connectivity issues, reviewing longitudinal data, communicating with patients and caregivers, coordinating among care team members, and documenting clinical decisions. Treatment adherence data or other device-generated information do not, by themselves, improve care. Clinical value arises when qualified health care professionals and appropriately supervised clinical staff review the information, place it in the context of the patient's treatment plan, communicate with the patient, and take appropriate action.

AASM is also concerned about the proposal to remove clinical staff time from the valuation of remote monitoring treatment management services. Clinical staff can play an important role in patient education, reviewing incoming information, identifying concerns consistent with practitioner-approved protocols, communicating with patients, documenting interactions, and escalating clinically significant findings to the billing practitioner. Excluding clinical staff time from the valuation would understate the resources required to furnish these services and could be particularly problematic if CMS simultaneously adopts policies requiring practices to assume greater responsibility for employing the clinical personnel who perform remote monitoring activities.

AASM supports appropriate safeguards to ensure that remote monitoring services are medically necessary, clinically integrated, and accurately billed. However, program-integrity concerns should be addressed through proportionate, evidence-based guardrails rather than valuations that may make legitimate services financially unsustainable. AASM joins the Alliance for Connected Care in recommending that CMS delay the proposed remote monitoring policies and work with stakeholders on a balanced approach that protects patients, preserves clinically integrated care, and strengthens program integrity, while cautioning that broad restrictions could disproportionately affect small practices, rural providers, and safety-net organizations.

AASM therefore recommends that rather than finalizing the proposed reductions in the valuation of RPM and RTM services for CY 2027, CMS collect and evaluate actual cost information regarding connected devices, software, data transmission, connectivity, electronic health record integration, technical support, patient onboarding and education, clinical labor, documentation, compliance, and

program administration. We also recommend that CMS avoid relying on the price of a basic device as a proxy for the cost of a clinically integrated remote monitoring program. Devices used in such programs may require connectivity, secure data transmission, software, technical support, replacement processes, and integration into clinical workflows. Remote monitoring should not be valued as a stand-alone commodity or merely as a device's acquisition cost. Its value and resource requirements arise from the combination of technology, clinical review, patient engagement, professional oversight, and integration into an individualized plan of care. For patients with sleep disorders, these services can support the ongoing assessment and engagement often necessary to manage chronic conditions and sustain treatment. AASM urges CMS to preserve an accurate and sustainable payment pathway by maintaining current valuations while it obtains the data needed to develop a comprehensive, evidence-based methodology.

Remote Monitoring Comment Solicitation

AASM appreciates the Agency's interest in reducing administrative burden and improving the coding and payment structure for RPM and RTM services. We also support efforts to make Medicare requirements clearer and easier for practitioners and beneficiaries to understand. However, the Academy is concerned that bundling the existing remote monitoring services into four new Medicare-specific HCPCS G-codes could increase administrative complexity, reduce transparency regarding the services furnished, and create payment and access challenges for practices that use remote monitoring as part of clinically integrated care.

Potential Administrative Burden of Medicare-Specific G-Codes

Although the proposed G-codes may be intended to simplify reporting, creating a Medicare-specific coding structure would require practices to maintain different coding and billing workflows for Medicare and other payers. For sleep medicine practices, in particular, maintaining parallel coding systems could require modifications to electronic health records, charge-capture processes, billing software, staff training, compliance reviews, and patient-facing financial information. These operational changes may be especially burdensome for small, independent practices, rural providers, and safety-net organizations that have limited administrative and information technology resources, making remote monitoring programs harder to sustain. Creating Medicare-specific codes could also make it harder for practices to apply uniform documentation and billing protocols across patient populations. Rather than reducing burden, the new structure may simply shift it from selecting among existing codes to determining which coding framework applies to each patient and ensuring the correct workflow is followed for the relevant payer.

AASM recommends that CMS conduct a detailed administrative impact analysis before establishing the proposed G-codes. This analysis should address the costs of updating billing systems, modifying electronic health record workflows, revising compliance policies, training clinical and administrative personnel, and maintaining separate Medicare and non-Medicare reporting processes.

Concerns Regarding Bundling Remote Monitoring Services

AASM is also concerned that bundling multiple remote monitoring components into comprehensive monthly codes may not reflect how these services are furnished in clinical practice. The existing code structure distinguishes between device setup and patient education, collection and transmission of data, and treatment management activities. These components may occur at different points during an episode of care and may not all be furnished or separately reportable during every calendar month.

These distinctions are important in sleep medicine. A patient may require substantial education and technical support when beginning a remotely monitored treatment but may need a different combination of data review, adherence support, communication, and clinical intervention in subsequent months. Conversely, a patient may continue transmitting data during a month in which the applicable treatment management threshold is not met. A bundled code should not require practices to attest that every included element was performed when the patient's clinical needs did not require every component. Bundling may therefore create two undesirable outcomes. A practice may be unable to bill for medically necessary work because one component of the bundle was not furnished, or may feel pressure to perform a component that is not clinically necessary simply to satisfy the requirements of the bundled code. Neither result would support patient-centered care or accurate Medicare payment.

AASM is also concerned that consolidation could reduce CMS's ability to determine which components of remote monitoring are being furnished and how frequently they are used. The current coding structure provides information about whether claims involve device supply and data transmission, setup and education, or clinical treatment management. Replacing those distinctions with broader monthly G-codes could make it more difficult to identify the source of utilization changes or distinguish clinically appropriate patterns from potentially anomalous billing. Preserving component-level reporting may serve program-integrity objectives more effectively than combining several activities into a single bundled code. If CMS's objective is to improve oversight, AASM recommends enhancing claims-level data rather than reducing coding granularity. CMS could, for example, develop mechanisms that identify the ordering practitioner, the general category of information being monitored, and the practitioner or entity responsible for treatment management.

AASM also urges CMS to consider how bundled codes would operate when different components of a remote monitoring program are furnished through clinically integrated arrangements. A physician practice may order the service, establish the care plan, review clinically significant information, and make treatment decisions, while an affiliated entity or qualified clinical partner supports device logistics, patient onboarding, technical assistance, or other permitted activities under practitioner supervision. For example, in a growing practice model in sleep medicine, a sleep physician may evaluate a patient, diagnose obstructive sleep apnea, prescribe PAP therapy, and oversee ongoing treatment management, while a separate entity facilitates device selection, dispensing, patient onboarding, and equipment replacement, in accordance with the physician-directed care plan.

A bundled code should not prevent payment merely because permissible components are furnished through an accountable, clinically integrated arrangement. Any final policy should clearly distinguish legitimate clinical partnerships from arrangements in which an entity independently solicits beneficiaries or initiates monitoring without meaningful involvement from the treating practitioner.

CMS should also consider whether replacing the existing codes would be premature given recent refinements to the remote monitoring code families. The existing CPT structure was expanded for CY 2026 to recognize shorter periods of transmitted data and lower treatment management time thresholds. CMS should allow sufficient time to evaluate the effects of these changes before replacing the structure with an alternative Medicare-specific code set. Changes in utilization after introducing more granular codes should not automatically be viewed as evidence that consolidation is necessary. Such changes may reflect improved coding specificity or the ability to serve patients whose clinically appropriate monitoring needs do not meet the older thresholds.

Rather than adopting the four proposed bundled G-codes, AASM recommends that CMS retain the existing RPM and RTM code families while pursuing targeted revisions that improve clarity, accountability, and consistency. Specifically, AASM recommends that CMS:

1. Retain component-level coding and flexible reporting. CMS should preserve separate coding for setup and education, device supply and data transmission, and treatment management services, while avoiding requirements that all service components be furnished during the same billing period regardless of clinical need.
2. Maintain distinctions between RPM and RTM and preserve coding consistency across payers. CMS should avoid combining services that monitor different types of health information or support different treatment functions without evidence that they require comparable resources and should avoid creating a Medicare-only coding structure unless existing codes cannot meet program objectives.
3. Clarify documentation and reporting requirements. CMS should provide concise guidance regarding medical necessity, patient consent, data transmission, treatment management activities, interactive communication, practitioner oversight, and any claims information necessary to improve transparency and accountability.
4. Support clinically integrated care models. CMS should permit qualified clinical partners operating under practitioner-directed care plans, supervision, and escalation protocols to support remote monitoring services.
5. Coordinate coding and payment policy decisions through a transparent, data-driven review process. CMS should evaluate any proposed coding revisions alongside the costs of devices, software, connectivity, clinical labor, patient support, and compliance activities, with input from specialty societies, practitioners, patient advocates, technology experts, and other stakeholders. Coding consolidation should not be used as an indirect mechanism for reducing payment without reliable resource data.
6. Provide adequate implementation time for any finalized changes. Any new coding structure should be accompanied by sufficient time for education, systems modifications, testing, and orderly transition of existing patients.

AASM does not support replacing the existing RPM and RTM code families with the four proposed HCPCS G-codes for CY 2027. The proposed consolidation risks increasing administrative burden, creating inconsistent coding across payers, obscuring information about the individual services furnished, and making payment contingent on components that may not all be clinically necessary during the same month. AASM encourages CMS to retain the existing code families while implementing targeted improvements to documentation, claims transparency, practitioner accountability, and program-integrity oversight. Before pursuing broader bundling, CMS should collect data on current utilization and resource costs, assess the effects of recent coding changes, and engage stakeholders that would be impacted in developing a coding structure that supports accurate reporting and beneficiary access to clinically appropriate remote monitoring.

E/M Visit Complexity Add-On – MOD1

AASM appreciates CMS's efforts to simplify coding and reporting requirements by converting HCPCS code G2211 into modifier MOD1. AASM agrees with CMS's longstanding recognition that certain office and outpatient evaluation and management (E/M) visits involve resources beyond those captured in the base E/M code because they serve as the focal point for ongoing care related to a patient's single serious condition or a complex set of interrelated conditions. Sleep medicine physicians routinely furnish this type of longitudinal care for beneficiaries with chronic sleep disorders, including obstructive sleep apnea, central sleep apnea, narcolepsy, hypersomnia, insomnia, parasomnias,

circadian rhythm sleep-wake disorders, and sleep-related movement disorders. The Academy also believes that converting G2211 to a modifier could reduce administrative burden and improve workflow efficiency by incorporating visit complexity recognition directly into the E/M reporting framework rather than requiring submission of a separate add-on code. However, CMS must make this transition while maintaining existing policy intent.

AASM is concerned that a modifier-based approach could inadvertently lead to narrower application, reduced utilization, or lower reimbursement if Medicare Administrative Contractors, auditing entities, or practitioners become uncertain about appropriate use. CMS should therefore provide clear guidance confirming that the transition to MOD1 is intended to preserve the same recognition of longitudinal, continuous, relationship-based care currently represented by G2211. The Academy recommends that CMS explicitly state that practitioners should continue to append MOD1 when furnishing visits that represent the ongoing management of a patient's serious or complex condition, consistent with existing G2211 policy. Clear educational guidance will help ensure consistent reporting and reduce unnecessary administrative burden for clinicians. AASM supports CMS's proposal to convert HCPCS code G2211 into modifier MOD1 if the Agency's intent is to simplify reporting while preserving the underlying policy objective of recognizing the additional resources associated with longitudinal patient care.

AASM strongly encourages CMS to ensure that the valuation associated with MOD1 accurately reflects the additional physician work, clinical staff resources, and practice expenses involved in longitudinal relationship-based care. G2211 recognizes the inherent complexity of ongoing management for patients whose care requires continuous assessment, coordination, treatment adjustment, and follow-up over time. These resource requirements will not change simply because CMS modifies the reporting mechanism. In sleep medicine, many patient encounters involve activities that extend beyond the face-to-face visit itself, including interpretation of treatment data, assessment of treatment adherence and effectiveness, review of diagnostic testing results, coordination with primary care physicians and other specialists, patient counseling, and management of chronic therapies. Beneficiaries frequently require repeated visits over many years to maintain treatment effectiveness, address comorbid conditions, and respond to changes in clinical status. Therefore, any reduction in valuation resulting solely from the conversion of G2211 into a modifier would be inconsistent with the clinical resources that the policy was originally intended to recognize. Therefore, AASM recommends that CMS maintain valuation for MOD1 that is equivalent to the value currently recognized through G2211 unless compelling evidence demonstrates that the underlying physician work and practice expense resources have changed.

Shared Medical Appointment (HCPCS code GSMAS)

AASM supports establishing a distinct HCPCS code for appropriately furnished shared medical appointments. Providing a defined coding and payment pathway would recognize that these encounters are structured medical services rather than general health education sessions. Shared medical appointments may offer a clinically appropriate way to combine individualized assessment and treatment planning with education and peer support for patients managing common chronic conditions. This model is particularly relevant to sleep medicine as many sleep disorders require longitudinal management, sustained patient engagement, education, and reinforcement of treatment recommendations. Depending on the condition and care plan, patients may benefit from education regarding treatment expectations, use of prescribed therapies, adherence barriers, sleep-related behaviors, symptom monitoring, and the importance of follow-up care. A group setting can support these shared educational needs while still allowing the billing practitioner to evaluate each beneficiary individually and address patient-specific clinical concerns.

AASM agrees that participation should be voluntary. A shared medical appointment should not replace an individual encounter when a private visit is clinically necessary, when the patient prefers individual care, or when discussion of sensitive medical information in a group setting would be inappropriate. Beneficiaries should receive clear information about the group format and should not experience reduced access to individual care because a practice offers shared appointments.

Proposed Code Descriptor

AASM generally supports the proposed descriptor because it identifies several essential characteristics of a shared medical appointment. Specifically, it states that the session is voluntary, involves patients with common medical conditions, is billed and led by a physician or qualified nonphysician practitioner, integrates group-based services with individualized clinical assessment and care, and is reported once for each patient participating in the session. However, AASM recommends that CMS clarify several elements before finalizing the descriptor and related billing guidance.

First, CMS should clarify the individualized clinical service that must be furnished to each beneficiary. The phrase "individualized patient clinical assessment and care" properly distinguishes the proposed service from group education alone, but practitioners would benefit from examples of the minimum individualized elements expected. These could include a patient-specific assessment, review of clinical status and treatment response, modification or confirmation of the care plan, counseling tailored to the beneficiary, or another medically necessary clinical activity documented in the patient's record. Second, the phrase "common medical condition(s)" should be interpreted with sufficient flexibility to include patients whose conditions are clinically related but not identical. For example, a sleep medicine group could reasonably include patients who share a common treatment modality or management need even if their individual diagnoses, comorbidities, or treatment barriers differ. CMS should avoid an interpretation that requires every participant to have precisely the same diagnosis when the group's clinical content and individualized services remain relevant to each beneficiary. Third, CMS should clarify what it means for the service to be "billed and led" by the physician or qualified nonphysician practitioner. AASM understands this phrase to mean that the billing practitioner retains responsibility for the service, furnishes the required practitioner work, and provides individualized clinical assessment and care. Other qualified healthcare professionals, clinical staff, or auxiliary personnel should be permitted to furnish appropriate portions of the education, counseling, patient support, and care coordination under applicable supervision requirements. Fourth, CMS should explain how the requirement for two to 10 patients applies when fewer than two patients ultimately participate because of a cancellation, technical problem, acute illness, or other circumstance outside the practitioner's control. A practice should not lose payment for an otherwise medically necessary service furnished to a beneficiary solely because another scheduled participant does not attend. In that circumstance, CMS should permit the practitioner to report the appropriate individual service when its requirements are satisfied. Finally, CMS should clarify whether the group size limit applies to the number of Medicare beneficiaries, the number of patients for whom GSMAS is billed, or the total number of patients participating in the session regardless of payer. A clear national policy would reduce variation in billing and audit interpretations.

Proposed Work RVU and Work Time

AASM supports CMS's effort to establish a work RVU and physician time assumptions specifically for GSMAS. The valuation should recognize that a shared medical appointment is not simply an individual E/M visit divided among several patients. The physician or qualified nonphysician

practitioner remains responsible for preparing for the session, leading or overseeing the clinical discussion, assessing each patient's status, addressing patient-specific concerns, making individualized clinical decisions, documenting the services furnished to each beneficiary, and coordinating follow-up when necessary. At the same time, the valuation should appropriately account for efficiencies associated with furnishing common educational and counseling content in a group setting. AASM believes the appropriate valuation should balance these efficiencies against the additional complexity of managing several patients during one session, maintaining an orderly and clinically relevant discussion, protecting confidentiality, and ensuring that each beneficiary receives an individualized service.

AASM supports finalization of the proposed work RVU and work-time assumptions to the extent that they fully account for both the shared group activities and the individualized work attributable to each beneficiary. CMS should confirm that the proposed time assumptions include all required preservice, intraservice, and postservice physician or practitioner activities. In particular, the valuation should recognize the time required for patient-specific clinical review, individualized assessment and decision-making, documentation, and follow-up planning. CMS should also clarify whether GSMAS is valued as a time-based service and whether a minimum session duration must be met. The proposed descriptor specifies the number of participating patients but does not state a time threshold. If CMS intends time to be a billing requirement, that requirement should appear in the descriptor or in clear national guidance. If time is not an explicit reporting requirement, CMS should explain how practitioners should distinguish a substantive shared medical appointment from a shorter group education or counseling activity.

Proposed Direct Practice Expense Inputs

AASM supports the inclusion of direct practice expense inputs that reflect the clinical labor, supplies, and equipment ordinarily required to furnish a shared medical appointment. The final direct PE inputs should account for the resources associated with scheduling and preparing multiple patients, confirming consent to participate in the group format, preparing the physical or virtual environment, supporting patient participation, assisting with education and counseling, documenting clinical information, and coordinating follow-up.

For sessions furnished through telehealth, practices may incur additional costs associated with platform administration, technical support, patient instructions, troubleshooting, privacy protections, and management of the virtual session. CMS should confirm that its valuation methodology appropriately accounts for the resources required to furnish GSMAS through an interactive telecommunications system and does not assume that a virtual group appointment requires no meaningful practice expense. AASM also recommends that CMS clarify how clinical staff time is allocated when staff support activities benefit the entire group but other activities are specific to an individual patient. The direct PE methodology should avoid both undercounting shared resources and duplicating the same resource across every beneficiary. Transparent identification of the proposed clinical labor tasks, minutes, supplies, and equipment would allow affected specialties to assess whether the recommended inputs accurately reflect typical practice.

Resulting Valuation

AASM supports a valuation that makes shared medical appointments feasible while appropriately reflecting the efficiencies of group-based care. The final payment should be sufficient to support the individualized clinical assessment, practitioner oversight, clinical staff involvement, documentation,

technology, and administrative infrastructure required for a compliant service. A valuation that recognizes only the shared educational component would understate the resources required by the proposed descriptor. Conversely, the code should not be valued as though a complete individual E/M service is furnished separately to every participant without any efficiencies from the group format. CMS should maintain an appropriate balance between these considerations and explain how the proposed work RVU, work time, and direct PE inputs produce that balance.

Proposed Changes to Payments Using Modifier 25

AASM urges CMS not to finalize its proposal to reduce payment by 50 percent when a separately identifiable office/outpatient evaluation and management (E/M) service reported with modifier -25 is furnished on the same date as a procedure with a 0-, 10-, or 90-day global period. AASM shares the concerns expressed in the American Medical Association's multi-stakeholder sign-on letter that the proposal rests on an unsubstantiated assumption of overlap and could significantly affect access to care in office-based physician practices. AASM agrees that Medicare payment should accurately reflect the resources required to furnish services. However, when a practitioner reports an E/M service with modifier -25, the practitioner is affirming that the E/M service was significant, separately identifiable, and above and beyond the usual preoperative or procedural work already included in the procedure code. By definition, these services represent distinct clinical work and should not automatically be presumed to contain duplicative resources requiring a broad payment reduction.

AASM is concerned that CMS characterizes the overlap it seeks to address as "likely" but has not identified specific services for which current payment values systematically overstate physician work or practice expense. CMS has not quantified the alleged overlap, identified the specific resources it believes are duplicative, or explained the evidentiary basis for selecting a 50 percent reduction. The Academy believes that a payment reduction of this magnitude should be supported by objective evidence demonstrating both the existence and extent of duplicative payment. Without such evidence, an across-the-board reduction risks reducing payment for services that accurately reflect the resources required to furnish care.

CMS and the AMA/Specialty Society RVS Update Committee (RUC) already maintain established mechanisms for identifying and removing duplicative physician work and practice expense when services are commonly furnished together. The RUC valuation process is specifically designed to evaluate overlap among related services and remove duplicative time and intensity when appropriate. CMS independently reviews these recommendations and retains authority to modify values where it believes overlap has not been adequately addressed. The valuation process already addresses overlap for services that are typically furnished on the same day as an E/M service. Therefore, an additional 50 percent payment reduction would risk applying a second reduction to resources that may already have been removed through established relativity and valuation processes. If CMS has concerns regarding residual overlap involving specific codes or families of services, AASM believes those concerns would be more appropriately addressed through the existing misvalued code process and code-specific review rather than through a uniform payment reduction applied broadly across specialties and services.

AASM is also concerned that the proposed 50 percent reduction is not appropriately targeted to any identified area of overlap. Existing multiple-procedure payment reduction policies generally focus on the particular payment component where efficiencies can reasonably be expected to occur. In contrast, the modifier -25 proposal would reduce the entire value of the lower-valued service, including physician work, practice expense, and malpractice components, regardless of whether overlap has been demonstrated within those elements. The Academy believes that this approach is inconsistent with

CMS's longstanding efforts to improve payment accuracy through targeted valuation adjustments. The proposal may reduce payment for physician work and practice expenses that remain necessary to furnish the service, and that may not overlap with the separately identifiable E/M service.

The proposed policy may have unintended consequences for physicians who manage chronic diseases and who frequently furnish diagnostic, therapeutic, and procedural services in office-based settings. Sleep medicine physicians often provide longitudinal management of complex sleep disorders while also furnishing related procedures and services as part of comprehensive patient care. In many circumstances, the separately identifiable E/M service addresses issues that extend beyond the procedural service itself, including review of diagnostic findings, treatment decision-making, management of comorbid conditions, counseling regarding treatment options, adherence challenges, and ongoing care coordination.

A reduction in payment for these separately identifiable services could also disproportionately affect independent physician practices that bear the full cost of clinical staff, equipment, supplies, and other practice expenses. The sign-on letter notes that office-based practices are particularly vulnerable because they cannot offset payment reductions through facility revenue streams and, in some circumstances, reduced payment could fall below the direct costs associated with furnishing care.

AASM is concerned that this proposal could ultimately discourage physicians from furnishing comprehensive same-day care, create unnecessary scheduling burdens that require multiple appointments, increase beneficiary inconvenience, and reduce access to timely care for Medicare patients.

AASM supports accurate valuation of Medicare services but does not support the proposed 50 percent payment reduction for separately identifiable E/M services reported with modifier -25. The Academy believes the proposal has not been supported by sufficient evidence, risks duplicating overlap adjustments already incorporated into existing valuation methodologies, and may negatively affect independent physician practices and beneficiary access to care. AASM therefore urges CMS to withdraw the proposal and continue addressing any demonstrated instances of overlap through targeted, evidence-based valuation review processes.

Revisions to Teaching Physician Policy Related to the Primary Care Exception

AASM supports CMS's efforts to provide additional flexibility within the Primary Care Exception framework. The Academy agrees that advancements in care delivery, supervision technologies, and educational models warrant periodic reassessment of longstanding regulatory requirements. Allowing residency programs greater flexibility, while maintaining appropriate teaching physician oversight, can help expand access to care, improve clinic efficiency, and create meaningful educational experiences for physician trainees. Many residency training programs operate in environments that increasingly emphasize interdisciplinary collaboration, chronic disease management, telehealth services, and longitudinal patient relationships. Policies that permit teaching physicians and residents to work together using contemporary supervision models may better reflect how care is delivered in modern practice while maintaining accountability for patient safety and quality of care.

AASM also notes that teaching physician policies can influence access to care in rural and underserved communities, where workforce shortages may be particularly pronounced. Expanded flexibility under the Primary Care Exception may help residency programs serve larger patient populations and expose trainees to a broader range of clinical experiences. Such exposure may encourage future practice in

underserved areas and ultimately improve access to both primary and specialty care services. For patients with sleep disorders, improved access to primary care may facilitate earlier identification of symptoms, timely referrals, and better coordination of treatment for sleep-related conditions and associated comorbidities.

Potentially Misvalued Services Under the PFS

Electronic analysis of implanted neurostimulator pulse generator/transmitter

The American Academy of Sleep Medicine (AASM) appreciates CMS's review of potentially misvalued services and its ongoing efforts to ensure that Medicare payment accurately reflects current clinical practice and the resources required to furnish services. AASM is particularly interested in the electronic analysis of implanted neurostimulator pulse generator/transmitter services because these codes may be used in the management of patients with sleep-related breathing disorders who receive implantable neurostimulation therapies, including phrenic nerve stimulation therapies for central sleep apnea.

We recognize that substantial changes in utilization patterns, evolving technologies, and shifts in the specialties furnishing services may appropriately prompt further review of existing valuations. However, the information provided in the proposed rule does not clearly demonstrate that CPT codes 95970, 95976, and 95977 are misvalued or that they should be valued similarly to CPT codes 93150, 93151, and 93153 solely because they involve interrogation and programming of implanted neurostimulation devices. The proposed rule indicates that the nominator believes valuation differences exist despite the services being clinically similar and cites utilization data suggesting changes in the specialties furnishing these services. The AASM understands that utilization growth or changes in specialty participation do not, by themselves, establish that two services require equivalent physician work, clinical staff involvement, equipment resources, or practice expense inputs. The appropriate valuation of physician services should be based on the resources required to furnish the service rather than on utilization trends alone.

CPT codes 93150, 93151, and 93153 were recently reviewed through the CPT and RUC processes and reflect current assessments of physician work and practice expense resources associated with implanted phrenic nerve stimulation therapy. If CMS believes that the implanted neurostimulator codes warrant further evaluation, the appropriate question is not whether the services involve implanted neurostimulation technology generally, but whether the physician activities, device interrogation functions, programming complexity, clinical staff requirements, equipment needs, and overall practice expense resources are sufficiently comparable to justify similar valuation. A crosswalk may be appropriate if objective evidence demonstrates substantial similarity in the resources required to furnish the services.

Should a future review demonstrate that the physician work, clinical labor, equipment requirements, and practice expense resources associated with CPT codes 95970, 95976, and 95977 are materially comparable to those associated with CPT codes 93150, 93151, and 93153, CMS could consider whether alignment of valuation is appropriate. However, this determination should be based on comprehensive survey data, resource cost analyses, and specialty input, in addition to utilization changes.

Request for Information: Redesigning Primary Care to Make America Healthy Again

Technology and AI-Augmentation in Primary Care via the Medicare AWV

The AASM supports CMS's efforts to leverage digital tools and AI-enabled technologies to improve preventive care, identify unmet health needs earlier, and strengthen care coordination for Medicare beneficiaries. As CMS evaluates opportunities to modernize the Annual Wellness Visit (AWV), we encourage the agency to consider how these technologies could be used to improve the identification of sleep health concerns through both the existing Health Risk Assessment (HRA) framework and any future AI-assisted screening or decision-support tools. CMS currently requires the AWV to include an HRA that assesses health status, psychosocial risks, behavioral risks, and functional status, creating a natural opportunity to identify sleep-related symptoms and risk factors that may otherwise go unrecognized.

Sleep health is a foundational component of overall health and is closely associated with numerous chronic conditions that disproportionately affect the Medicare population, including cardiovascular disease, hypertension, diabetes, obesity, cognitive impairment, depression, and fall risk. In addition to being associated with other comorbidities, untreated sleep disorders can impair daily functioning, reduce work performance, and diminish quality of life. Individuals experiencing excessive daytime sleepiness may also face an elevated risk of workplace and driving-related accidents. Despite the prevalence and clinical significance of sleep disorders, sleep-related questions are not consistently incorporated into preventive care assessments, and many beneficiaries remain undiagnosed. CMS should explore opportunities to encourage the inclusion of validated sleep-health screening questions within the HRA framework, particularly questions related to chronic insomnia symptoms, excessive daytime sleepiness, sleep duration, sleep quality, and risk factors for obstructive sleep apnea. Incorporating sleep-health assessments into routine preventive care could help identify beneficiaries who may benefit from further clinical evaluation before more serious health consequences develop. To ensure clinical relevance and patient-centeredness, CMS should engage appropriate clinical and patient stakeholders in identifying validated approaches suitable for broad adoption within the Medicare population.

The AASM believes that AI-enabled technologies may offer additional opportunities to support sleep-health screening within the AWV. For example, AI-assisted patient questionnaires, digital intake tools, and clinical decision-support systems could help identify patterns of symptoms or comorbid conditions associated with undiagnosed sleep disorders and flag patients who may warrant further assessment. Such tools could assist primary care clinicians by synthesizing information already collected through the HRA and other clinical documentation to generate personalized recommendations, educational resources, or referral suggestions. Importantly, AI technologies should function as decision-support tools that augment clinician judgment rather than replace clinical evaluation, diagnosis, or individualized treatment planning.

As CMS considers future technology-enabled enhancements to the AWV, the agency should also prioritize interoperability and workflow integration. Sleep-health screening tools should be incorporated into existing clinical workflows and electronic health record systems in ways that minimize administrative burden and avoid duplicative data collection. Any AI-enabled functionality should use standardized data elements and transparent methodologies that can be validated, monitored, and refined over time. CMS should also ensure that beneficiaries retain appropriate privacy protections and that AI applications are developed and deployed in accordance with principles of transparency, safety, equity, and clinical validity.

The AASM further encourages CMS to evaluate whether technology-enabled AWV enhancements can improve referral pathways and care coordination for Medicare beneficiaries identified as being at risk for sleep disorders. Many patients with sleep-related symptoms remain undiagnosed or experience delays in receiving appropriate evaluation and treatment. Digital screening tools, automated patient education resources, and clinical decision-support mechanisms may help connect patients to appropriate follow-up care, including further evaluation by qualified clinicians when indicated. These efforts could support earlier intervention, improve management of chronic conditions, and advance CMS's broader goals of preventive care and population health management.

Overall, the AASM supports CMS's exploration of technology and AI-augmentation within the Medicare Annual Wellness Visit and encourages the agency to recognize sleep health as an important component of preventive care. We strongly encourage CMS to consider opportunities to strengthen sleep-health screening within the existing Health Risk Assessment framework, evaluate the potential role of AI-enabled tools in identifying undiagnosed sleep disorders, and promote interoperable, patient-centered approaches that improve care coordination while minimizing burden on clinicians and beneficiaries. By incorporating sleep health into future AWV modernization efforts, CMS can help advance earlier identification of sleep disorders and improve the overall health and well-being of Medicare beneficiaries.

Current Procedural Terminology (CPT) Request for Information (RFI)

The American Academy of Sleep Medicine (AASM) appreciates CMS's interest in evaluating the effectiveness, transparency, and future evolution of the Current Procedural Terminology (CPT) coding system. Accurate clinical coding is foundational to patient care, quality measurement, claims processing, reimbursement, interoperability, health services research, and the adoption of emerging technologies. As a medical specialty society representing physicians, scientists, advanced practice providers, and accredited sleep centers dedicated to improving sleep health and patient outcomes, AASM relies heavily on CPT to accurately describe services furnished to patients with sleep disorders.

AASM strongly believes that physicians and other qualified health care professionals who furnish medical services are uniquely positioned to assist in accurately describing those services. Clinical expertise is essential when determining whether a service is clinically distinct, how a service should be defined, whether existing codes adequately describe clinical work, and how emerging technologies should be integrated into the coding system. The Academy, therefore, supports maintaining a clinically driven code development process that incorporates broad stakeholder participation, including specialty societies, practicing clinicians, health systems, payers, technology developers, federal agencies, and patient representatives. The CPT Editorial Panel structure provides an established mechanism for obtaining this input while preserving the clinical integrity of the code set. The AMA response correctly notes that any stakeholder may submit a code application and that the process includes public participation, advisory review, and Panel deliberation.

From a sleep medicine perspective, one of the greatest strengths of CPT is its ability to accommodate innovation while preserving coding consistency across the health care system. Sleep medicine increasingly incorporates technologies such as remote physiologic monitoring, implantable neurostimulation devices, digital therapeutics, wearable technologies, artificial intelligence-assisted data analysis, and home-based diagnostic testing. AASM believes it is essential that coding systems provide a clear and predictable pathway for describing these innovations as evidence develops. The Category III code pathway has been particularly valuable because it allows emerging technologies to be tracked and studied while evidence accumulates. AASM supports continued modernization of the

CPT process and appreciates recent efforts to accelerate Category III code releases, improve pathways for innovative technologies, and be more transparent with meeting materials and deliberations.

AASM agrees that coding and medical necessity are separate concepts that should remain distinct. The primary purpose of CPT is to accurately describe the service furnished. Decisions regarding coverage and medical necessity are properly made through payer-specific coverage policies, national coverage determinations, local coverage determinations, and clinical judgment applied to the circumstances of an individual patient. CPT should continue to function as clinical nomenclature rather than a coverage determination mechanism. Maintaining this separation is particularly important in sleep medicine, where coverage policies often vary significantly among payers despite the existence of uniform coding descriptions for the same services.

AASM believes there are substantial benefits associated with maintaining a single national coding standard for physician and other qualified health care professional services. Consistent coding terminology facilitates interoperability, supports longitudinal research, enables quality measurement, improves claims processing, and reduces administrative burden for clinical practices. Additionally, because sleep medicine is inherently multidisciplinary, involving pulmonology, neurology, psychiatry, otolaryngology, primary care, cardiology, pediatric medicine, and other specialties, a common national coding language is essential. Fragmentation of coding standards could increase administrative burden, reduce comparability of data, complicate interoperability efforts, and create confusion for clinicians, payers, vendors, and patients. While AASM supports continued modernization and transparency of existing processes, the Academy is not aware of an alternative coding framework that currently offers the same combination of clinical specificity, national adoption, interoperability, and broad stakeholder participation as CPT.

Although AASM supports the CPT framework, the Academy also supports ongoing efforts to strengthen transparency, stakeholder engagement, and responsiveness to innovation. Emerging technologies continue to challenge traditional coding frameworks, and sleep medicine has often served as an early adopter of digital health tools, remote monitoring platforms, wearable technologies, and AI-enabled diagnostics. AASM encourages continued collaboration among CMS, the AMA, specialty societies, technology developers, and other stakeholders to ensure that CPT remains capable of describing rapidly evolving models of care. The Academy supports efforts to improve accessibility of CPT materials and the efficiency of the overall process, increase stakeholder participation, streamline pathways for emerging services, and strengthen interoperability with other clinical terminologies and health information standards.

Proposed Changes to the Ambulatory Specialty Model (ASM)

Although sleep medicine clinicians are not currently included as ASM participants, the model establishes policies that may influence future specialty payment models and broader Quality Payment Program requirements. Sleep medicine is highly dependent on longitudinal chronic disease management, patient-reported outcomes, interoperability, prior authorization, collaboration with primary care, and care delivery in small and rural practices. Accordingly, the AASM urges CMS to ensure that ASM policies are clinically meaningful, operationally feasible, transparent, and developed with specialty society input before they are applied to additional conditions or specialties.

The AASM recommends that CMS finalize the proposals that reduce burden and protect clinicians from penalties for circumstances beyond their control, while modifying several proposals that may create disproportionate administrative burden or hold clinicians accountable for actions and data

outside their direct control. CMS should also commit that any future expansion of ASM to sleep disorders or sleep medicine clinicians will occur only through notice-and-comment rulemaking and after consultation with the AASM and practicing sleep medicine clinicians.

Quality Reporting and Scoring for Small Practices

The AASM appreciates CMS's continued recognition that small practices may lack the staffing, infrastructure, and EHR customization capabilities needed for individual-level quality reporting. However, the proposal to disregard all individual-level quality submissions whenever any group-level submission is received could create unintended consequences. A group-level submission could be transmitted without the knowledge of each clinician, could contain incomplete data, or could override a more accurate individual submission.

The AASM recommends that CMS establish a transparent election process before the submission period begins, under which a small practice selects either group-level or individual-level reporting for the applicable performance year. CMS should provide advance confirmation of the selected reporting level, permit correction of an erroneous election, and notify affected clinicians before disregarding an otherwise valid individual submission. If conflicting submissions are received, CMS should apply the submission that most accurately reflects the clinician's care and should provide an opportunity for review before final scoring.

Voluntary Patient-Reported Outcome Data Submission

The AASM supports the development of meaningful patient-reported outcome (PRO) measures and agrees that voluntary data collection can help CMS assess feasibility before adopting new performance measures. PROs are particularly relevant in sleep medicine, where symptoms, daily functioning, treatment burden, and quality of life are important indicators of care.

However, the proposed reporting requirements may be burdensome, especially for small and independent practices. Collecting baseline and follow-up assessments, submitting detailed data, and meeting CMS reporting requirements could require significant investments in technology, staff time, patient outreach, and vendor support.

The AASM therefore recommends that CMS retain the voluntary nature of this initiative and:

1. Publish all technical specifications, privacy protections, and reporting requirements before the performance year begins.
2. Limit data collection to information necessary for measure development and protect sensitive patient information.
3. Ensure the incentive does not create inequities among clinicians with differing technology capabilities or patient response rates.

CMS should not make participation mandatory until the resulting patient-reported outcome-based performance measures (PRO-PM) have been fully tested and demonstrated to be reliable, valid, feasible, and equitable through the established rulemaking process.

Promoting Interoperability and Electronic Prior Authorization

The AASM supports CMS's goal of improving prior authorization through interoperable electronic exchange. In sleep medicine, prior authorization is commonly required for diagnostic testing and

therapies, and electronic prior authorization could reduce administrative burden and delays in care when payer and EHR systems are adequately integrated.

For the 2027 performance year, the AASM supports CMS's proposal to make the Electronic Prior Authorization measure optional and unscored. However, CMS should provide bonus points for voluntary reporting to encourage early adoption.

The AASM is concerned that beginning in 2028, clinicians who are unable to attest to the electronic prior authorization measure could receive a zero score for the entire Promoting Interoperability performance category, a consequence that appears disproportionate given the many factors outside a clinician's direct control that influence successful participation. While the AASM supports the broader goal of streamlining prior authorization through electronic transactions and improving interoperability across the health care system, successful implementation depends on the readiness and functionality of multiple external entities, including payer application programming interfaces (APIs), EHR vendor capabilities, third-party technology partners, and the availability of applicable electronic prior authorization transactions. Clinicians should not be subject to significant payment penalties when barriers to compliance arise from technology limitations, delayed vendor implementation, inconsistent payer participation, or circumstances beyond their control. The AASM therefore encourages CMS to closely monitor industry readiness and extend transition periods if payer and EHR capabilities remain uneven across the marketplace. CMS should also establish broad and meaningful exclusions for situations in which clinicians lack access to necessary payer APIs, EHR functionality, vendor support, or sufficient prior authorization volume to meaningfully participate in the measure. In addition, the AASM recommends that CMS consider proportional scoring approaches that recognize partial participation and progress toward adoption rather than assigning zero points to the entire Promoting Interoperability category based on a single unmet attestation requirement. To support successful implementation, CMS should release detailed technical specifications, testing resources, educational materials, and implementation guidance well in advance of the applicable performance year, providing clinicians, vendors, and payers adequate time to prepare. Finally, CMS should continue evaluating whether electronic prior authorization initiatives achieve their intended objectives of reducing administrative burden, improving efficiency, and shortening authorization processing times, rather than merely shifting administrative work from one platform or participant to another. Encouraging adoption through support, flexibility, and demonstrated value will be more effective than imposing punitive scoring consequences and will help ensure that clinicians are not unfairly penalized for technology limitations that remain beyond their control.

Future Expansion to Additional Conditions and Specialties

CMS has indicated that it may consider expanding the Ambulatory Specialty Model (ASM) to additional clinical conditions and specialties in the future. While the AASM appreciates CMS's interest in exploring broader specialty participation in value-based care models, we urge the Agency not to expand the ASM to sleep medicine without a separate notice-and-comment rulemaking process and direct engagement with the AASM and other sleep medicine stakeholders. Before applying the model to any new specialty, CMS should demonstrate that the targeted condition is routinely and longitudinally managed by participating clinicians; that quality and cost measures are clinically relevant, reliable, and focused on outcomes clinicians can meaningfully influence; and that attribution methodologies accurately identify the clinician responsible for directing and coordinating patient care. The Agency should also ensure that participants receive timely patient-level data and actionable performance feedback, that new model requirements do not duplicate existing reporting programs or create conflicting administrative obligations, and that payment adjustments are appropriately balanced

so they do not threaten access to specialty care, particularly in small, independent, rural, or underserved practice settings. In addition, specialty societies and practicing clinicians should be actively involved in model design, implementation, and ongoing evaluation to ensure that performance measures, attribution methodologies, and accountability structures accurately reflect real-world clinical practice.

Sleep disorders are complex chronic conditions that often require multidisciplinary evaluation and long-term management across multiple care settings. Accordingly, if CMS considers developing a future sleep-focused model, it should recognize the interconnected roles of sleep physicians, primary care clinicians, dentists, behavioral health professionals, sleep technologists, durable medical equipment suppliers, and other members of the care team. Any future model should support evidence-based diagnosis, individualized treatment selection, long-term adherence monitoring, and meaningful patient outcomes while appropriately accounting for the collaborative nature of sleep medicine care. The AASM encourages CMS to avoid model designs that create incentives for under-testing, undertreatment, inappropriate patient attribution, or avoidance of complex patients, and instead focus on measures and accountability structures that promote high-quality, coordinated, patient-centered care.

Quality Payment Program (QPP)

The AASM appreciates CMS's continued commitment to modernizing quality measurement, improving interoperability, and reducing reporting burden. We are encouraged by CMS's efforts to simplify participation pathways, promote more clinically meaningful measurement, and align quality reporting with broader value-based care initiatives. We offer the following comments regarding the proposed changes to the Merit-based Incentive Payment System (MIPS), MIPS Value Pathways (MVPs), Advanced Alternative Payment Models (Advanced APMs), and related Requests for Information (RFIs).

Transition from Traditional MIPS to MVPs

The AASM recognizes CMS's longstanding concerns regarding traditional MIPS, including its administrative complexity, extensive measure inventory, and limited alignment between selected measures and clinicians' actual practice patterns. We generally support CMS's vision of progressing toward a more streamlined quality reporting framework that emphasizes specialty-specific measurement, clinically relevant outcomes, and alignment across quality, cost, and interoperability domains. However, we urge CMS to ensure that the transition away from traditional MIPS occurs in a deliberate and measured manner. As CMS considers sunsetting traditional MIPS after the 2028 performance year, clinicians across all specialties must have access to mature, comprehensive, and clinically meaningful MVP options before mandatory participation.

For sleep medicine clinicians, successful transition will require:

- Availability of specialty-relevant quality measures.
- Sufficient reporting infrastructure and technical support.
- Appropriate benchmarking methodologies.
- Transparent and equitable scoring processes.
- Continued engagement of specialty societies during MVP development and refinement.

CMS should continue providing operational flexibility during the transition period and establish clear readiness criteria before eliminating traditional MIPS participation pathways.

Expansion of MIPS Value Pathways

The AASM supports CMS's continued expansion and refinement of MIPS Value Pathways (MVPs). The MVP framework has the potential to better align quality measurement with clinical practice by reducing reporting burden and focusing participation on measures that are most meaningful within a clinician's specialty. As CMS continues developing MVPs, the AASM encourages the agency to maintain strong engagement with specialty societies and clinical experts, ensure that specialty-specific measure inventories remain robust, current, and clinically meaningful, and avoid overreliance on measures that may not adequately reflect the care provided by smaller or highly specialized physician populations. We also encourage CMS to continue refining quality and cost measures to support fair and accurate comparisons among clinicians practicing in different settings and specialties. The growing importance of MVPs significantly increases the value of specialty society participation in quality measure development. The AASM, along with other medical specialty organizations, possesses substantial clinical expertise and is uniquely positioned to help ensure that MVP measure sets accurately reflect the care delivered by sleep medicine providers and appropriately capture the outcomes that matter most to patients.

Advanced Alternative Payment Models

The AASM supports CMS's efforts to strengthen participation in Advanced Alternative Payment Models (APMs) and promote greater alignment between physician payment and accountable care. We recognize CMS's broader strategy of encouraging movement toward population-based payment arrangements and accountable care structures. However, opportunities for participation in Advanced APMs remain limited for many sleep medicine physicians, particularly those practicing in independent settings or smaller specialty-focused practices. As CMS continues refining Advanced APM policies, the AASM encourages the agency to expand opportunities for specialty physician participation, ensure that quality measures used within Advanced APMs appropriately reflect the value and outcomes of specialty care, and promote greater alignment between Merit-based Incentive Payment System Value Pathways (MVPs), Qualified Clinical Data Registry (QCDR) measures, and Advanced APM quality requirements. We also encourage CMS to evaluate barriers that may limit participation among smaller physician practices and to consider policy modifications that support broader engagement across diverse practice settings. These efforts would help ensure that value-based payment opportunities remain accessible, meaningful, and achievable for a wide range of physician specialties, including sleep medicine.

Request for Information: Fast Healthcare Interoperability Resources (FHIR)-Based Digital Quality Measurement

The AASM supports CMS's long-term vision for digital quality measurement and agrees that standardized electronic data exchange has the potential to improve reporting efficiency, enhance interoperability across health care systems, and reduce administrative burden for clinicians. The transition to FHIR-based digital quality measurement represents an important opportunity to improve the consistency, accuracy, and usability of data used for quality reporting programs while supporting broader care coordination and patient-centered outcomes assessment. However, successful implementation will depend on the readiness of providers, electronic health record vendors, qualified clinical data registries (QCDRs), and other quality reporting infrastructure to support standardized data capture, extraction, and exchange.

As CMS advances this transition, the AASM encourages the agency to adopt a deliberate and phased implementation approach that recognizes the significant operational, technical, and financial investments required of physician practices and quality reporting entities. Many specialty practices, including sleep medicine practices and facilities, continue to face challenges related to interoperability, variation in EHR functionality, and limited access to technical resources needed to support advanced digital reporting requirements. CMS should work closely with specialty societies, measure developers, health IT vendors, and registries to ensure that FHIR implementation standards are sufficiently flexible to accommodate specialty-specific workflows and data elements. In addition, CMS should prioritize alignment of digital quality measurement requirements across federal programs to minimize duplicative reporting obligations and reduce unnecessary administrative complexity.

The AASM also encourages CMS to recognize the critical role of specialty society registries and QCDRs in the future digital quality ecosystem. These entities have made substantial investments in quality measure development, clinical data validation, benchmarking, and physician engagement, and they can serve as valuable partners in advancing digital quality measurement. CMS should ensure that specialty registries have adequate time, resources, and technical guidance to adapt existing reporting systems to support FHIR-based measures and digital quality reporting standards. Finally, CMS should continue evaluating the real-world impact of digital quality measurement implementation on physician burden, data quality, and patient care outcomes to ensure that the transition achieves its intended goals without creating unintended barriers for physician participation, particularly among smaller and independent specialty practices.

Many sleep medicine practices are small, independent organizations that operate with limited health information technology resources and administrative infrastructure. As CMS transitions toward FHIR-based digital quality measurement and reporting, these practices may face substantial implementation challenges that could affect their ability to participate successfully in federal quality reporting programs. In many cases, sleep medicine providers rely heavily on third-party EHR vendors whose interoperability capabilities, FHIR readiness, and support services vary considerably across the marketplace. As a result, the pace and success of adoption may depend less on physician readiness and more on the capabilities and investment priorities of individual technology vendors. Practices may also incur significant costs associated with software upgrades, interface development, data mapping, workflow redesign, and ongoing system maintenance needed to support FHIR-based data exchange. These financial challenges may be particularly burdensome for smaller physician practices that lack the economies of scale available to larger health systems. In addition, many specialty practices have limited access to health IT personnel and technical expertise, making it difficult to implement, test, troubleshoot, and maintain increasingly complex interoperability requirements. Even after initial implementation, FHIR-based integrations will require ongoing updates, validation, monitoring, and maintenance as standards evolve and quality measure specifications change over time. To ensure equitable participation and avoid disadvantaging smaller and independent physician practices, the AASM encourages CMS to consider targeted support mechanisms such as grant funding, technical assistance programs, implementation toolkits, vendor testing environments, and educational resources designed to facilitate adoption. CMS should also consider temporary scoring flexibilities, performance safeguards, and transition policies during the implementation period to account for technical challenges outside of a clinician's control. Providing adequate support and implementation flexibility will help promote broader participation in digital quality measurement initiatives while preserving access to quality reporting opportunities for specialty practices of all sizes.

The AASM also recommends that CMS maintain alternative reporting pathways throughout the transition to FHIR-based digital quality measurement until the new reporting framework has

demonstrated reliability, completeness, accuracy, and operational feasibility across a broad range of clinical settings. While the AASM supports the long-term goal of standardized digital quality reporting, existing reporting mechanisms should not be retired prematurely or before stakeholders have sufficient experience with FHIR-based approaches in real-world practice environments. CMS should ensure that required data elements can be captured as part of routine clinical workflows without imposing additional documentation burden on physicians or disrupting patient care. The agency should also verify that FHIR-based reporting methodologies can accurately reproduce performance rates currently generated through established reporting systems so that clinicians are not disadvantaged by differences in data extraction or measure calculation. In addition, providers, registries, and health information technology vendors should have adequate opportunities to test, validate, and reconcile submissions before FHIR-based reporting becomes the primary reporting mechanism. Particular attention should be given to ensuring that specialty-specific clinical concepts, workflows, and data elements, including those relevant to sleep medicine, are fully supported within emerging interoperability standards and digital measure specifications. A transition strategy grounded in demonstrated readiness, robust testing, stakeholder engagement, and successful performance validation will promote broader adoption of digital quality measurement while minimizing disruption to ongoing quality improvement efforts, preserving data integrity, and ensuring that patient care remains the primary focus throughout implementation.

As digital quality measurement evolves, specialty societies must remain active partners in measure development and maintenance. CMS should collaborate closely with specialty societies to ensure that FHIR-based specifications accurately reflect specialty workflows and do not inadvertently create barriers to participation.

Request for Information: MVP Scoring Methodology

The AASM supports CMS's goal of improving scoring fairness within the Merit-based Incentive Payment System (MIPS) and agrees that clinicians should primarily be evaluated relative to peers participating within the same MIPS Value Pathway (MVP), where performance comparisons are generally more clinically relevant and reflective of similar practice characteristics. If CMS elects to pursue normalization methodologies, the AASM recommends that normalization occur at the final MVP score level rather than within individual performance categories whenever feasible. Applying normalization at the overall MVP level may help preserve the integrity of individual quality, cost, and improvement activity measures while reducing the risk of introducing unintended distortions within specific performance categories. This approach may also provide greater transparency and make scoring methodologies easier for clinicians to understand and interpret.

The AASM strongly supports the implementation of an early pilot phase before any normalization methodology is adopted on a mandatory basis. Given the complexity of performance scoring and the potential impact on payment adjustments, CMS should test proposed normalization approaches in a voluntary or demonstration environment while traditional MIPS reporting options remain available. A pilot period would provide an important opportunity for CMS, specialty societies, registries, and participating clinicians to evaluate the real-world effects of proposed scoring changes before they influence payment outcomes. During this testing phase, CMS could assess the impact of normalization on payment adjustments across specialties and practice settings, evaluate clinician understanding of the revised scoring methodology, and identify any operational challenges that may arise during implementation. Such testing would also allow CMS to detect unintended consequences, including circumstances in which certain specialties, practice sizes, or clinical populations experience disproportionate advantages or disadvantages as a result of the normalization process. In addition, pilot

testing would provide valuable data to refine calculations, validate assumptions, and improve the accuracy and reliability of scoring methodologies before widespread adoption. A thoughtful, transparent pilot approach would increase stakeholder confidence, promote clinician understanding of the new framework, and help ensure that any normalization methodology ultimately adopted by CMS advances fairness and meaningful performance assessment without creating unintended barriers to participation for specialty physicians, including those practicing sleep medicine.

Before adopting normalization methodologies or implementing significant changes to quality scoring methodologies, the AASM encourages CMS to continue evaluating several foundational factors that may influence the fairness and reliability of performance comparisons across specialties and MVPs. In particular, CMS should carefully assess the impact on clinicians participating in MVPs that include sleep medicine quality measures, such as the **Pulmonology Care MVP** and the **Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP**, which incorporate AASM Measure Q277 (Sleep Apnea: Severity Assessment at Initial Diagnosis) and, in the Pulmonology Care MVP, Measure Q279 (Sleep Apnea: Assessment of Adherence to Obstructive Sleep Apnea Therapy). Clinicians reporting through these MVPs may have a more limited selection of specialty-relevant measures compared with clinicians participating in other MVPs, potentially affecting scoring opportunities and performance comparisons. CMS should ensure that any future normalization approach accounts for differences in measure availability, measure mix, patient populations, and reporting opportunities across MVPs so that clinicians are not disadvantaged simply because they practice in specialties with narrower measure inventories. The agency should also continue addressing challenges associated with topped-out measures, which may limit measure discrimination and make it difficult to distinguish high-quality performance among clinicians who consistently achieve strong outcomes. In addition, sufficient benchmark maturity is essential to ensure that measure scores are stable, reliable, and based on adequate performance data before they are incorporated into normalized scoring approaches. CMS should also carefully monitor whether proposed normalization methodologies create unintended advantages or disadvantages for certain specialties, practice types, or clinical settings, particularly when measure inventories, patient populations, and reporting opportunities vary substantially across disciplines. These considerations are especially important for specialties such as sleep medicine, where the number of available quality measures may be more limited than in broader primary care or multi-specialty practice environments. Addressing these foundational challenges before finalizing major scoring changes will help ensure that normalization methodologies accurately reflect clinician performance, preserve meaningful specialty participation in quality programs, and promote equitable comparisons across diverse areas of medical practice. As CMS continues to transition toward broader MVP participation, equitable benchmarking methodologies will be essential to ensure that clinicians reporting sleep-related quality measures are evaluated based on performance, rather than on structural differences in available measure sets.

Request for Information: Star Rating Assignment Methodology for Administrative Claims Quality Measures

The AASM supports CMS's efforts to modernize the star rating methodology for administrative claims-based quality measures and generally agrees that public reporting methodologies should be aligned with the underlying scoring approaches used for administrative claims-based measure assessment. Greater methodological consistency has the potential to improve transparency, reduce confusion among stakeholders, and ensure that publicly reported results more accurately reflect the performance measures used within CMS quality programs. At the same time, the AASM believes that any revisions to the star rating methodology should be carefully evaluated to ensure that they meaningfully improve

score differentiation and provide useful information to patients, purchasers, and other stakeholders without reducing the interpretability of reported results. Publicly reported star ratings must remain straightforward and understandable while accurately reflecting clinician performance and quality improvement efforts across a diverse range of specialties and practice settings.

Prior to implementing any revised methodology, CMS should conduct comprehensive specialty-specific impact analyses to better understand how proposed changes may affect performance outcomes across different clinical disciplines, particularly specialties with smaller patient populations or more limited measure inventories. The agency should also evaluate potential unintended consequences, including the possibility that methodological changes could create disparities in public reporting outcomes that are unrelated to actual differences in quality of care. In addition, CMS should ensure that any revised methodology remains transparent, reproducible, and easily interpretable for both clinicians and patients, preserving confidence in the accuracy and usefulness of publicly reported performance information. Meaningful stakeholder engagement will also be critical throughout the development and implementation process. The AASM encourages CMS to work closely with specialty societies, Qualified Clinical Data Registries (QCDRs), measure developers, and other affected stakeholders to assess the operational and clinical implications of proposed changes and to identify opportunities for refinement before implementation. Taking these steps will help ensure that revised star rating methodologies are equitable across specialties, accurately reflect clinical performance, support meaningful quality improvement activities, and continue to provide patients with reliable and actionable information regarding physician quality.

The AASM appreciates CMS's efforts to modernize physician quality reporting and advance a more streamlined, specialty-focused quality framework. We support initiatives that reduce administrative burden, encourage meaningful quality improvement, promote interoperability, and facilitate participation in value-based care arrangements. As CMS advances these reforms, we encourage continued collaboration with specialty societies, registries, clinicians, and technology partners to ensure that implementation is equitable, feasible, and clinically meaningful. A measured transition that preserves flexibility, supports small practices, and maintains specialty-relevant quality measurement will help maximize success while minimizing disruption to patient care.

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 clarification.

Sincerely,

Fariha Abbasi-Feinberg, MD
President, AASM

cc: Steve Van Hout, MBA, CAE
Sherene Thomas, PhD
Diedra Gray, MPH