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When Simpler Sleep Tests Are Reimbursed Less: The Access Implications of Medicare's Proposed HSAT Framework

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According to AASM analysis of CMS's proposed CY 2027 Physician Fee Schedule, reimbursement for unattended, low-complexity home sleep tests could decrease by approximately 32%.[1] If simpler HSATs become financially unsustainable to provide, patients may face fewer testing options, longer diagnostic wait times, and greater barriers to care. The price of an individual test is not the cost of the diagnostic pathway; payment policy should consider how reimbursement affects access, capacity and patients' ability to reach diagnosis and treatment.

Some patients may require overnight in-lab polysomnography, while others may be appropriately diagnosed using unattended home studies that capture multiple physiological signals. For appropriately selected patients, a simpler home sleep apnea test (HSAT) can provide the information needed to establish a diagnosis and inform next steps in care.

A well-designed diagnostic pathway preserves all three options. It lets clinicians match the test to the clinical need, suspected severity, while also considering practical factors that may affect successful test completions such as the patient's life circumstances.

The Centers for Medicare & Medicaid Services' (CMS) proposed CY 2027 physician fee schedule intends to replace the current unattended sleep study codes with a new six-code family that separates technical and professional components and stratifies tests by complexity.[1] Under the current interpretation, overall Medicare reimbursement for some low-complexity home sleep tests could fall by approximately 32%, while moderate-complexity studies could receive modest increases.[1] This proposed overhaul could create a reimbursement gradient that unintentionally disadvantages the simplest clinically appropriate tests – low-complexity HSATs used for uncomplicated adults presenting with an increased risk of moderate-to-severe OSA.

The concern, however, is not simply that one type of test may be reimbursed less than another.

It is that, in real-world settings, the price of the test is not the cost of the pathway. Whether a lower payment ultimately delivers better value depends not only on the resources required to furnish an individual test, but also on how the payment structure affects test availability, diagnostic capacity and patients' progression to diagnosis and eventual treatment.

CMS's approach is intended to improve reimbursement accuracy by distinguishing unattended sleep studies by complexity. The proposed structure may help align payment more closely with the resources required to furnish different types of tests. Indeed, CMS is also seeking stakeholder input on several of the practice-expense assumptions used to value the new technical codes, including clinical labor, equipment utilization and market pricing, indicating that the final valuation remains

open to evidence and comment. From an economic perspective, if lower-complexity tests genuinely require fewer resources to furnish, lower reimbursement may be appropriate. But lower test complexity does not necessarily translate into proportionately lower provider costs.

Previous economic research illustrates the distinction between payer savings and provider sustainability, and why the costs of furnishing a test cannot be inferred from the test's relative simplicity alone. In a multicenter trial, a home-based diagnosis and treatment pathway cost payers $264 less per patient than the laboratory pathway, while provider costs were similar and the estimated operating margin for the home pathway was negative.[2]

The policy challenge, therefore, is how to ensure that greater payment precision does not unintentionally make clinically appropriate, lower-complexity testing harder to provide.

How Lower Reimbursement Rates Could Narrow Patient Access

If the proposed payment proves insufficient to support the costs of furnishing low-complexity HSATs, some providers may find those services less sustainable to offer broadly. The technical component must still support device inventory, patient onboarding, delivery and return logistics, failed studies, software infrastructure and staff time for setup. Smaller practices, community-focused programs and distributed testing models, in particular, may have less flexibility to absorb the difference. Over time, this could influence which technologies providers stock, how widely they offer low-complexity HSAT to Medicare patients, or whether testing becomes concentrated in higher-volume settings.

Any resulting access effects are unlikely to be distributed evenly. When clinically appropriate, low-complexity HSAT can provide a lower-burden route to diagnosis, with practical advantages for patients facing transportation barriers, inflexible work schedules, caregiving demands or mobility limitations. If the simplest clinically appropriate test becomes less available, some patients may face a more burdensome route to diagnosis. Underpayment can therefore narrow access without any explicit restriction on coverage.

The Price of the Test Is Not the Cost of the Pathway

Payers and benefit architects must look beyond the price of an individual claim and consider the cost and performance of the complete sleep diagnostic pathway.

The scale of unmet diagnostic need in OSA is high. About 1 billion adults globally have OSA.[3] In the United States, estimates suggest that roughly 80% of people with OSA are undiagnosed.[4,5] More of this unmet need is beginning to reach diagnostic service as awareness increases and referral pathways expand.[6] Existing capacity constraints already translate into substantial delays. In a 2026 study across three U.S. Veterans Affairs sleep programs, patients following the traditional care pathway waited an average of 216 days from referral to diagnostic testing and 253 days to PAP initiation.[7]

Against this capacity backdrop, preserving multiple clinically appropriate routes to diagnosis is essential. Patients whose clinical presentation requires polysomnography should continue to receive it. But when HSATs are clinically appropriate, they help absorb some pressure by allowing selected patients to be evaluated without first entering a laboratory-based pathway.

Limiting availability of one appropriate pathway (lower complexity HSATs) may shift more patients into already constrained parts of the system. This could potentially increase wait times, delay diagnosis and increase the risk that some patients never complete testing.

The apparent savings on simple home-testing claims may therefore be displaced elsewhere in the pathway. Costs can reappear through additional consultations and specialist visits, increased laboratory testing, and the downstream consequences of delayed or missed diagnosis. As more patients seek evaluation, these displaced costs and capacity pressures will become increasingly consequential. At a time when the diagnostic system needs more scalable entry points, payment policy should not inadvertently weaken one of the pathways capable of expanding access.

A pathway-based view would evaluate how simple, low-burden testing affects wait times, testing completion rates, and treatment initiation for patients. Payer analyses should ask the following questions about low-complexity home sleep apnea tests:

- Do these offerings expand the number of patients who actually complete testing?
- Do they shorten time from referral to diagnosis and from diagnosis to treatment initiation?
- Do they reduce diagnostic drop-off among patients who face logistical or socioeconomic barriers to more complex testing?
- Does preserving access to simpler HSATs improve the return on Medicare's broader investment in chronic disease management?

Aligning reimbursement with the value of the complete diagnostic pathway rather than the price of a single test is a more coherent way to support scalable, equitable sleep care while still meeting fiscal and program-integrity goals.

Payment Policy Should Not Make Simplicity a Disadvantage

The proposed six-code structure offers an opportunity to recognize meaningful differences among unattended sleep studies. But greater coding precision should not come at the expense of access.

Payment rules shape the capacity of a care system. In a system where roughly four in five people with OSA remain undiagnosed, making the simplest clinically appropriate route to diagnosis harder to sustain risks moving access in the wrong direction. If simpler sleep tests are underpaid and rendered significantly impractical to provide, Medicare beneficiaries will not simply receive the same care for less. They may instead face a narrower, slower and more difficult route to diagnosis.

The policy conversation should, therefore, be how Medicare payment rules can support and preserve a diagnostic pathway that is clinically appropriate, scalable, and more accessible to the patients already most likely to be left behind.

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