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Building the Workforce for Sleep as Chronic Care

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CMS's proposed remote-monitoring requirements aim to strengthen accountability, but they also expose a wider workforce challenge. As sleep care moves beyond specialist centers, health systems will need integrated teams to support patients across diagnosis, treatment, follow-up and re-engagement.

Sleep care is gradually being pulled out of a specialist-centered model and into a broader framework that comprises chronic disease pathways, prevention, and integrated care. This shift has been driven by several forces. One is the growing recognition of the links between sleep disorders and cardiovascular, metabolic, and mental health conditions. Next is the increasing use of simpler, home-based diagnostics and telehealth; and finally, a wider push from stakeholders to make sleep disorder management more accessible through primary care and comorbid disease pathways.

This model change has important implications for care delivery. If sleep disorders are to be managed more like other chronic conditions, health systems need care models that can support patients longitudinally, across screening, diagnosis, treatment initiation, follow-up, behavioral support, re-engagement, and coordination with care for common comorbidities.

Efforts to expand access to diagnosis are already underway. But the larger task is ensuring that patients receive coordinated, longitudinal support once a sleep disorder is identified. Two fundamental questions underpin this: who will deliver this care, and who will be accountable for continuity across the patient journey?

A proposed CY 2027 Medicare Physician Fee Schedule brings this workforce and accountability questions into sharper focus.[1]

New accountability requirements for remote care

The Centers for Medicare & Medicaid Services (CMS) has proposed new requirements for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM).[2] Under current policy, RPM services are limited to established patients, but CMS is now proposing to extend that requirement to RTM. More, both RPM and RTM would now need to begin with a separately payable face-to-face visit, conducted either in person or via telehealth. The agency states that an existing clinical relationship and an initiating assessment are necessary to determine whether remote monitoring is appropriate and to ensure that the patient understands and consents to the service.

CMS has also raised concerns about remote-monitoring services performed by third-party companies whose staff have limited relationships with either the patient or the wider clinical team. Under the proposed new rule, the clinical staff time used to support RPM or RTM billing would generally need to be provided by clinical staff employed by the billing practitioner or practice. Those staff would not necessarily have to work physically within the practice, but they would need to operate under the practitioner's supervision and meet the other applicable requirements.

If finalized, these requirements could force practices that currently rely on third party contractors to bring more capacity in-house, redesign their workflows or reconsider whether they can continue offering reimbursable remote-monitoring services.

The proposed changes also extend beyond eligibility and staffing. CMS is proposing to revalue practice-expense assumptions for several RPM and RTM services, including lower valuations for certain device-related services. It is also seeking comment on whether the existing RPM and RTM code families should be consolidated into four HCPCS G-codes. Together, these changes could affect how monitoring services are billed and the economics of building and sustaining the teams needed to deliver them.

These proposals come after investigations into how remote monitoring is being delivered and billed. A 2024 HHS Office of Inspector General (OIG) review found, among other issues, that about 43% of Medicare enrollees who received RPM did not receive all its three components.[3] A subsequent OIG review also identified RPM billing patterns that warrant greater oversight to prevent fraud or waste.[4]

The CMS concerns are evidently legitimate. Remote monitoring should not become isolated transactions where patient data are collected without meaningful clinical oversight, communication or action. There should be transparency around who is responsible for reviewing patient data, when that review should occur, what will trigger an intervention and how this remote care connects with the rest of treatment and follow up.

However, strengthening accountability shouldn't mean reverting to a specialist/physician-centered delivery model. Health systems should instead focus on building teams that are accountable, scalable and clinically integrated. And for this distributed care to work, there needs to be clarity on who ultimately owns the patient journey. Depending on the setting, longitudinal sleep care could be led by specialty or primary care, supported by navigation teams or shared across disciplines. Different models may be appropriate in different systems, but accountability cannot become diffuse simply because care is multidisciplinary.

The capabilities exist, but are they organized for sleep care?

Many of the capabilities needed to support longitudinal sleep care are already present within health systems, but they are rarely integrated into a coherent sleep pathway. Stakeholders need to identify the professionals that could contribute meaningfully, and determine how their roles fit together within a model with clear clinical ownership.

- **Nurse navigators** may be well positioned to help patients move from an initial concern to testing, follow-up and treatment. They can follow incomplete referrals, identify practical barriers, coordinate across specialties and ensure that patients do not disappear between stages of care.
- **Respiratory therapists** already bring capabilities that could support diagnostic setup, patient education, treatment initiation and technical troubleshooting. Their experience with respiratory disease and device-based care can be particularly valuable where sleep disorders intersect with cardiovascular, pulmonary or metabolic conditions.
- **Behavioral sleep professionals** can address insomnia, treatment hesitancy, behavioral barriers and the sleep-related routines that influence whether patients remain engaged with care.
- **Primary care and cardiology care teams** can identify patients at risk for sleep disorders, initiate appropriate pathways and incorporate sleep follow-up into the management of related chronic conditions. They are also often better positioned than a distant specialist service to understand the patient's competing health priorities and day-to-day challenges.

But identifying relevant skills is not the same as establishing a practical workforce model. Many of these professionals face capacity pressures of their own, and their scope of practice, training and availability vary considerably across health systems. It also remains important to establish which team-based models improve outcomes, which simply redistribute workload, and where specialist assessment or involvement remains essential.

Multidisciplinary sleep care needs to be treated as a care-model question to evaluate, not a workforce fix that can be assumed to work simply because relevant professionals are present.

The next workforce question: Who owns longitudinal sleep care?

As sleep care becomes more distributed, the next major debate will be centered around who owns longitudinal care once a patient enters the system. Health systems will need to determine how to share responsibility across specialties, primary care and multidisciplinary teams without allowing continuity or accountability to become fragmented.

Several questions will shape how this model evolves:

- **Where and how should responsibilities be allocated?**
  Where do delays, disengagement and unmet support needs occur? And then which functions may be shared safely, which require specialist input or leadership?
- **What competencies and training are required?**
  Would existing professional training be sufficient, or would updated sleep-specific credentialing, CME or supervised experience be needed?
- **How should quality and accountability be measured?**
  What documentation standards, escalation thresholds and outcome measures would show that distributed care is improving continuity rather than creating new fragmentation?
- **Does the workforce actually have capacity?**
  Can existing teams absorb these responsibilities, or would health systems simply move bottlenecks from one part of the system to another?
- **Can current reimbursement sustain a longitudinal sleep-care workforce?**
  Multi-disciplinary, longitudinal sleep care needs financial structures that incentivise and support it. Do current reimbursement structures inadvertently encourage fragmented care? Which parts of the care pathway are reimbursed properly today, and which effectively sit outside payment models?

A care system transformation test

The CY 2027 proposed rule highlights a set of workforce questions that the sleep field will need to address. As Medicare places greater emphasis on accountable remote care, stakeholders can take the opportunity to properly define the models that can make longitudinal, multimodal, and more accessible sleep care work in the real-world.

The future of sleep care as chronic care does not only depend on bringing patients into the diagnostic pathway, but also on whether health systems can build the workforce required to deliver the care they need.

References

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