July 21, 2026

Submitted Electronically via *www.regulations.gov*

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2449-P
7500 Security Boulevard
Baltimore, MD 21244

Re: **Comments on CMS Notice of Proposed Rulemaking: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P, RIN 0938-AV69, 91 Fed. Reg. 30400, May 22, 2026)**

Dear Administrator Oz:

Introduction

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members are proud to be part of the continuum of care that assures beneficiaries and other patients receive cost-effective, safe, and reliable home care products and services. AAHomecare respectfully submits these comments in response to the above-captioned Notice of Proposed Rulemaking (NPRM).

Key Provisions of the NPRM Affecting DMEPOS Suppliers

Although the NPRM does not name durable medical equipment as a primary target of its reforms, several of its core provisions bear directly and adversely on DMEPOS suppliers and the beneficiaries who depend on them. AAHomecare highlights these provisions here so that CMS understands the full scope of the rule's practical reach into the DME space.

First, the proposed rule would cap State Directed Payments (SDPs) in Medicaid managed care at 100 percent of the total published Medicare payment rate for Expansion States and 110 percent for Non-Expansion States, extending this payment limit to all SDPs and all service types beginning

with rating periods on or after January 1, 2029. Because this expanded limit is not confined to the four service categories originally addressed by the Working Families Tax Cut legislation, it would, on its face, sweep in any future state directed payment arrangement for DME that a state elects to pursue through its managed care contracts. This is not a hypothetical risk. The NPRM's preamble offers an illustrative example with a state that "wished to improve access to care and prohibit potentially wasteful spending for durable medical equipment" by establishing minimum and maximum SDP fee schedules "at exactly the payment limit,"[1] thereby requiring managed care plans to pay the Medicare-based rate for DME services. This example demonstrates that CMS is actively contemplating direct application of the Medicare-benchmarked SDP framework to DME payments in managed care, notwithstanding the separate treatment DME receives elsewhere in the rule's fee-for-service provisions.

Second, the NPRM proposes a new targeted Medicaid FFS practitioner payment limit at 42 C.F.R. § 447.381, capping targeted payments to a subset of practitioners or providers at the same 100 percent or 110 percent of the applicable Medicare fee-for-service rate. Significantly, CMS proposes to exclude from this new limit any payments already subject to existing upper payment limits under 42 C.F.R. §§ 447.271, 447.272, 447.321, and 447.325, as well as payments subject to the existing statutory DME and clinical diagnostic laboratory expenditure limits at sections 1903(i)(7) and 1903(i)(27) of the Social Security Act, expressly "to avoid unnecessary duplication of requirements." CMS further invites comment on "whether any other existing limits or required payment methodologies" beyond those listed should be accounted for within, or excluded from, the scope of proposed § 447.381(b).

Third, the rule's underlying statutory authorities are themselves instructive. CMS grounds the SDP payment limits that were not mandated by the Working Families Tax Cut Act in sections 1902(a)(4) and 1903(m)(2)(A)(iii) of the Social Security Act, governing actuarial soundness of risk-based managed care contracts, and grounds the new FFS targeted payment limit in section 1902(a)(30)(A), which requires that Medicaid payments be consistent with efficiency, economy, and quality of care, and be sufficient to enlist enough providers to ensure that care is as available to Medicaid beneficiaries as it is to the general population. The rule is further motivated by the June 6, 2025 Presidential Memorandum on "Eliminating Waste, Fraud, and Abuse in Medicaid" and by section 71116 of the Working Families Tax Cut legislation (Public Law 119-21).

Taken together, these provisions confirm that while DMEPOS is not a named or primary target of the NPRM, the rule's Medicare-benchmarking logic, its illustrative extension to DME fee schedules within the SDP framework, and its invitation for comment on the scope of the new FFS payment limit all create material uncertainty and risk for DMEPOS payment policy that CMS must resolve before finalizing this rule.

Comments

While AAHomecare shares CMS's stated goals of promoting fiscal integrity and reducing waste in the Medicaid program, we are deeply concerned that the NPRM, as drafted, will have significant unintended adverse consequences for DMEPOS suppliers, the beneficiaries they serve, and the

[1] 91 Fed. Reg. 30,400, 30,427 (May 22, 2026).

broader Medicaid program's ability to deliver cost-effective, home-based care. The proposed payment limitations (including the new State Directed Payment (SDP) percentage-of-Medicare caps and the new fee-for-service (FFS) targeted practitioner payment limit at proposed 42 C.F.R. § 447.381) will create cascading fiscal pressures on state Medicaid programs that historically result in disproportionate rate reductions for services that are not the direct targets of reform, including DMEPOS.

AAHomecare urges CMS to withdraw the proposed rule or, at a minimum, substantially revise it to include explicit protections ensuring that DMEPOS reimbursement remains adequate, supplier networks remain stable, and beneficiaries continue to have timely access to medically necessary home medical equipment and supplies. Our detailed comments on the specific provisions and concerns follow below.

I. CMS Should Preserve State Flexibility to Support Medically Necessary Home Medical Equipment

The Medicaid program has long operated on the foundational principle that states retain substantial flexibility to design their programs in a manner responsive to local conditions, provider markets, and beneficiary needs. Section 1902(a)(30)(A) of the Social Security Act requires that state Medicaid payments be "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[2] This statutory standard and implementing regulations at 42 C.F.R. 204 implicitly recognize that states must have the flexibility to calibrate payment rates to local market conditions, including the distinct cost structures and supply-chain dynamics of DMEPOS.

The NPRM's imposition of a rigid Medicare-based percentage cap on state payment rates threatens this flexibility and conflicts with these longstanding Medicaid requirements. Many states have used their discretion under current law to establish Medicaid DMEPOS rates that reflect the unique characteristics of their Medicaid populations, including higher-acuity adults who require long-term equipment use, pediatric beneficiaries with specialized equipment needs, and individuals with developmental disabilities whose utilization patterns differ substantially from the Medicare population.

Recommendation: CMS should preserve, and expressly reaffirm in the final rule, states' authority to support medically necessary home medical equipment through rates that reflect Medicaid-specific access needs, particularly where documented access problems exist. CMS should further clarify that such rates may not be constrained by the SDP limits set forth in this rule.

II. CMS Should Protect Access to DMEPOS by Ensuring States Maintain Adequate Reimbursement Levels

Although DMEPOS is not directly included in the four service categories subject to the new SDP percentage-of-Medicare payment cap mandated by Public Law 119-21, section 71116 (i.e.,

[2] Section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. § 1396a(a)(30)(A).

inpatient hospital, outpatient hospital, nursing facility, and qualified practitioner services at an academic medical center),[3] and we do not believe DMEPOS payments should be affected by the other proposals in the NPRM, the proposed rule, if finalized, will nonetheless require states to fundamentally rebalance Medicaid spending as they bring supplemental payments into compliance with the new limits. When states face new constraints on supplemental payments to hospitals and physicians, they routinely reduce or freeze rates for services perceived as "non-priority." DMEPOS has consistently been among the first categories targeted for such reductions.

The consequences of inadequate DMEPOS reimbursement are well documented. When Medicaid rates for oxygen equipment, mobility devices, enteral nutrition, ostomy supplies, urological supplies, and wound care products fall below the cost of provision, suppliers cannot sustain participation in the program. Our members report that Medicaid rates in many states already do not cover the true cost of providing equipment, and providers frequently operate at a loss for every Medicaid beneficiary served. Additional fiscal pressure from the NPRM's proposed requirements will exacerbate this crisis.

Recommendation: CMS should explicitly state in the final rule that states must maintain adequate DMEPOS reimbursement and must not offset SDP limitations by reducing DME or medical supply rates. The final rule should require states to demonstrate, as part of their managed care rate certification and state plan amendment processes, that any payment restructuring undertaken to comply with the new SDP limits does not result in diminished access to DMEPOS.

III. CMS Should Recognize DMEPOS as a Cost-Saving Alternative to Institutional Care

DMEPOS is one of Medicaid's most effective tools for preventing hospitalizations, reducing emergency room utilization, and supporting beneficiaries' long-term independence in home and community-based settings. Clinical evidence consistently demonstrates that timely access to home oxygen therapy, mobility equipment, wound care supplies, and enteral nutrition prevents acute medical episodes that would otherwise require costly institutional care. Even modest reductions in access to these items can trigger significant increases in acute care spending—precisely the opposite of the efficiency and economy goals that CMS invokes as the statutory basis for this rulemaking.

Section 1902(a)(30)(A) of the Social Security Act requires that Medicaid payments be consistent with "efficiency, economy, and quality of care."[4] A rule that permits or implicitly encourages states to reduce DMEPOS rates as a byproduct of SDP compliance is fundamentally inconsistent with these statutory objectives. CMS cannot simultaneously pursue fiscal integrity and allow states to erode access to the very services that generate downstream savings by keeping beneficiaries healthy at home rather than in hospitals or nursing facilities.

Recommendation**:** CMS should acknowledge in the final rule that DMEPOS services are core to Medicaid's statutory efficiency, economy, and quality-of-care goals. The final rule should require

[3] Public Law 119-21, section 71116 (Working Families Tax Cut Act, enacted July 4, 2025).
[4] Section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. § 1396a(a)(30)(A).

states to evaluate and document the downstream medical cost impacts of any payment changes that affect DMEPOS reimbursement before implementing those changes.

IV. CMS Should Recognize Home Medical Equipment as Essential Healthcare Categorically Different from Other Provider Types

DMEPOS occupies a unique position within the Medicaid provider landscape that distinguishes it from hospital, physician, and nursing facility services in ways that are directly relevant to the NPRM's payment framework. Unlike most provider categories, DMEPOS suppliers must maintain physical inventory of equipment and supplies available for immediate deployment. A beneficiary discharged from a hospital who requires a wheelchair, hospital bed, or home oxygen concentrator cannot wait days or weeks for that equipment to arrive. Delays in access to medically necessary equipment can lead to unnecessary hospital readmissions, prolong hospital stays and disrupt continuity of care.

Moreover, DMEPOS suppliers provide ongoing clinical support, equipment maintenance, patient training, and emergency repair services that are integral to the safe use of home medical equipment. These obligations require suppliers to maintain service infrastructure (including delivery vehicles, respiratory therapists, assistive/rehabilitation technology professionals, and customer service staff) regardless of fluctuations in Medicaid reimbursement. The fixed-cost nature of DMEPOS provision means that even marginal rate reductions can render continued Medicaid participation economically unsustainable for suppliers, particularly those serving rural and underserved communities where patient volumes are lower, risking small businesses closing and loss of jobs for suppliers' employees.

Recommendation: CMS should recognize in the final rule that the unique service delivery model of DMEPOS (i.e., immediate availability, inventory maintenance, clinical support, and ongoing patient servicing) requires payment policies tailored to this category and cannot be adequately addressed through blanket payment limits designed for physician or hospital services.

V. CMS Should Require States and MCOs to Demonstrate Network Adequacy for DMEPOS

As states adjust payment structures to comply with the proposed rule, managed care organizations (MCOs) operating under new financial constraints will inevitably seek to reduce costs within their networks. AAHomecare is deeply concerned that MCOs will narrow DMEPOS networks or reduce contracted rates paid to DMEPOS suppliers, creating access deserts particularly in rural and underserved areas where the supplier base is already thin.

CMS currently maintains time-and-distance network adequacy standards for hospitals, physicians, skilled nursing facilities, and home health agencies, but no comparable standards exist specifically for DMEPOS suppliers. This gap is untenable. DMEPOS encompasses a wide range of product categories—respiratory equipment, complex rehabilitation technology, standard mobility equipment, enteral nutrition, ostomy and urological supplies, wound care, and others—each requiring specialized suppliers with distinct expertise. Network adequacy should

be assessed by DMEPOS product category and geographic area to ensure real patient choice and appropriate access.

Recommendation: CMS should require states to: (i) monitor DMEPOS network adequacy as part of managed care oversight, with standards separated by product category and geographic area; (ii) ensure that rate adjustments made in response to the final rule do not result in insufficient supplier participation; and (iii) report reductions in DMEPOS access as part of annual Medicaid managed care evaluations. AAHomecare stands ready to work with CMS to develop appropriate DMEPOS-specific network adequacy metrics.

VI. CMS Should Protect Beneficiary Access Across Geographic Areas and DMEPOS Product Categories

The NPRM's payment limitations risk supplier participation declines in Medicaid DMEPOS, particularly among specialized suppliers serving vulnerable populations. AAHomecare urges CMS to evaluate whether SDP limitations could reduce provider participation broadly, with specific attention to rural access, pediatric specialty access, complex rehabilitation technology (CRT) access, and home oxygen provider availability.

Beneficiaries requiring CRT, including power wheelchairs with specialized seating systems, speech-generating devices, and other individually configured equipment, are among the most vulnerable Medicaid populations and are served by a limited number of highly specialized suppliers. Similarly, pediatric DMEPOS involves equipment configurations and sizing requirements that many general DME suppliers cannot accommodate. If rate pressures force these specialized suppliers out of Medicaid networks, there may be no alternative providers available within reasonable travel distances.

Recommendation: CMS should require that access to DMEPOS be monitored by geographic area and product category, and should establish reporting requirements that would alert CMS and states to emerging access gaps before they become crises. Access monitoring should address, at a minimum, home oxygen, home mechanical ventilation, standard mobility equipment, Complex Rehab Technology, pediatric DMEPOS, enteral nutrition, and wound care supplies.

VII. CMS Should Clarify That Medicare-Based Payment Logic Should Not Be Imposed on Medicaid DMEPOS

The NPRM aligns certain Medicaid payment rates with Medicare rates, reflecting the June 6, 2025 Presidential Memorandum directing HHS to ensure Medicaid rates are not higher than Medicare "to the extent permitted by applicable law."[5] AAHomecare is deeply concerned that this Medicare-benchmarking approach, if extended or applied to DMEPOS in managed care, would produce rates fundamentally mismatched to the Medicaid population and service context.

Medicare's DMEPOS Competitive Bidding Program (CBP) and its resulting fee schedule were designed for the Medicare population—primarily elderly beneficiaries with relatively predictable, short-term equipment needs. The Medicaid population is materially different: it includes higher-

[5]Presidential Memorandum, "Eliminating Waste, Fraud, and Abuse in Medicaid" (June 6, 2025).

acuity adults requiring long-term equipment use (often decades), pediatric beneficiaries with growth-related equipment replacement needs, and individuals with developmental disabilities whose utilization patterns and product requirements have no Medicare analog. Medicare competitive bidding methodology reflects a market structure and beneficiary profile that were not designed with the Medicaid population in mind. Applying that methodology to Medicaid would risk producing rates that are mismatched to Medicaid's distinct cost and utilization realities.

Recommendation: CMS should clarify in the final rule that Medicare's DMEPOS competitive bidding rates and fee schedule methodologies are not appropriate benchmarks for Medicaid DMEPOS payment and should not be used as a ceiling for state Medicaid DMEPOS rates in either FFS or managed care delivery systems. CMS should affirm that states retain full flexibility to set Medicaid DMEPOS rates that reflect the distinct needs of their Medicaid populations.

VIII. CMS Should Avoid Administrative Burdens That Could Reduce DMEPOS Supplier Participation

AAHomecare is concerned that the NPRM's implementation will generate new state reporting and documentation requirements that fall disproportionately on DMEPOS suppliers. The DMEPOS industry is composed predominantly of small and mid-sized businesses—many family-owned—that lack the administrative infrastructure of large hospital systems or physician group practices. When states impose new documentation, reporting, or compliance requirements as part of their SDP restructuring, these requirements frequently cascade to network providers, including DMEPOS suppliers, without regard for their capacity to absorb additional administrative costs.

For DMEPOS suppliers already operating at or below break-even on Medicaid business, new administrative requirements can be the final factor that makes continued program participation economically irrational. The departure of these suppliers from Medicaid networks harms beneficiaries directly, particularly in communities where only one or two DMEPOS suppliers serve Medicaid patients.

Recommendation: CMS should caution states against imposing administrative reporting or documentation requirements that are disproportionate to the size and risk profile of DMEPOS services. The final rule should include a proportionality standard requiring that any new state-imposed administrative obligations be scaled to provider size and the magnitude of Medicaid payments at issue.

IX. CMS Should Include Explicit Protections to Avoid Unintended Consequences for DMEPOS

DMEPOS providers are essential to Medicaid's mission of delivering high-quality, cost-effective, home-based care. AAHomecare is gravely concerned that the proposed rule, absent explicit protections, will trigger a cascade of adverse consequences: reduced reimbursement leading to narrower provider networks; MCOs imposing increased prior authorization requirements and

more frequent claim denials; supplier closures, particularly in rural areas; and longer equipment delivery times that directly compromise patient health and safety.

These consequences are not speculative. The DMEPOS industry has experienced each of them in prior rounds of Medicaid and Medicare payment reductions.[6] Suppliers that cannot sustain losses indefinitely exit the market, and because DMEPOS suppliers require specialized facilities, trained technicians, and equipment inventory, new suppliers do not quickly emerge to fill the gap. The resulting access deserts persist for years. Small business closures and job losses are also predictable consequences.

Recommendation: The Final Rule should include explicit protections ensuring that DMEPOS reimbursement remains adequate, supplier networks remain stable, and beneficiaries continue to receive medically necessary equipment and supplies without unreasonable delays. At a minimum, the final rule should require states to certify that their SDP restructuring will not produce adverse DMEPOS access outcomes and to implement corrective action if access deteriorates following implementation.

X. Managed Care-Specific Concerns: Utilization Management, Network Narrowing, and Coverage Limitations

Approximately 85 percent of Medicaid beneficiaries receive services through managed care. The NPRM's constraints on state directed payments will fundamentally alter the financial dynamics within which MCOs operate. AAHomecare is concerned that MCOs, facing new downstream constraints on their own rates and the services they are required to cover, will respond by further tightening utilization management for DMEPOS, narrowing DMEPOS networks (particularly in rural and remote areas where MCOs already maintain minimal DMEPOS supplier presence), and using the regulatory transition as an opportunity to limit or remove coverage of certain DMEPOS codes.

Of particular concern is the risk to coverage of miscellaneous and unlisted DMEPOS billing codes. DMEPOS suppliers already face extreme difficulty obtaining adequate reimbursement for items billed under miscellaneous HCPCS codes, which are used for medically necessary items that do not have a dedicated billing code. MCOs routinely deny or underpay miscellaneous code claims, and the NPRM's fiscal pressures will intensify this practice. Additionally, in Medicaid expansion states, payers may use the opportunity to classify certain DMEPOS items as "non-essential" and restrict or eliminate coverage, further narrowing the range of equipment and supplies available to beneficiaries.

Recommendation: The final rule should require MCOs to maintain DMEPOS coverage and utilization management policies that do not unreasonably restrict access to medically necessary equipment and supplies. CMS should require states to monitor MCO DMEPOS coverage decisions, including changes to covered codes, prior authorization requirements, and

[6] Specifically, the DMEPOS industry has lost 37.5% of supplier rooftops since 2013.

miscellaneous code reimbursement practices, as part of their managed care oversight obligations.

XI. CMS Should Consider the Cumulative Regulatory and Financial Burden on the DMEPOS Industry

AAHomecare urges CMS to consider the aggregate impact of this proposed rule in the context of the broader regulatory and financial environment facing DMEPOS suppliers. The DMEPOS industry is currently subject to, or facing imminently, an unprecedented confluence of regulatory changes that collectively threaten the viability of many suppliers:

- Medicare's Competitive Bidding Program will exert severe downward pressure on rates that many state Medicaid programs then adopt as their own benchmarks.
- Provider enrollment and accreditation requirements have increased compliance costs.
- Prior authorization requirements continue to expand across both Medicare and Medicaid.
- Medicaid enrollee redetermination processes following the unwinding of the continuous enrollment condition have created administrative burdens on suppliers as beneficiaries cycle in and out of coverage and will only increase with implementation of sections 71101 ("Eligibility Redeterminations") and 71119 ("Requirement for States to establish Medicaid community engagement requirements for certain individuals"). These Working Families Tax Cut requirements threaten to further disrupt beneficiary eligibility and supplier revenue predictability.
- Proposed reductions in Home and Community-Based Services (HCBS) waiver programs under Section 1115 demonstration authority could reduce the populations eligible for DMEPOS.

Each of these policy changes might appear manageable when considered in isolation during the rulemaking process. But DMEPOS suppliers experience them simultaneously, and the combined administrative and financial burden is materially greater than any single rule's regulatory impact analysis captures. Executive Order 12866 obligations require consideration of the cumulative costs of regulation on affected entities.

Recommendation: CMS should include in the final rule's regulatory impact analysis a discussion of the aggregate effects of this rule combined with other recent and pending Medicaid and Medicare policy changes on the DMEPOS supplier community. CMS should also establish a mechanism for monitoring cumulative regulatory impact on DMEPOS suppliers as the various pending rules are implemented.

XII. Response to CMS's Specific Request for Comment on Proposed § 447.381(b)

CMS specifically requests comment on "whether any other existing limits or required payment methodologies, in addition to §§ 447.271, 447.272, 447.321, and 447.325 and sections 1903(i)(7)

and (27) of the Act, should be accounted for in proposed § 447.381(b), and whether they should be accounted for by excluding them from the proposed scope or otherwise."[7]

AAHomecare responds as follows: DMEPOS fee schedules are governed by their own independent Medicaid payment methodology, and DME expenditures are already subject to the existing statutory expenditure limits under sections 1903(i)(7) of the Social Security Act.[8] CMS has already recognized the logic of excluding DME from the new § 447.381(c) FFS targeted practitioner payment limit on the express ground of avoiding "unnecessary duplication of requirements."[9] That same duplication-avoidance rationale compels an equivalent exclusion in the managed care SDP context.

DME payments should not be pulled within the scope of, or otherwise subjected to, the new targeted Medicaid FFS practitioner payment limit framework proposed at § 447.381, nor should DME be subjected to SDP-imposed Medicare-based fee schedule mandates in managed care. CMS should expressly confirm this exclusion in the final rule to avoid regulatory conflict and unintended duplicative or inconsistent payment ceilings on DME. Failure to do so would subject DME to overlapping and potentially contradictory federal payment ceilings (i.e., the existing section 1903(i)(7) limit and the new § 447.381 framework) creating administrative confusion for states, MCOs, and suppliers alike.

XIII. Analysis of NPRM Provisions Specifically Bearing on DME Payment Policy

AAHomecare identifies several NPRM provisions that specifically discuss or implicate DMEPOS payment policy and that require clarification or revision:

The DME Fee Schedule Illustrative Example. The NPRM's preamble, in discussing the phase-out of uniform-increase SDPs, offers an illustrative example stating that "a State that wished to improve access to care and prohibit potentially wasteful spending for durable medical equipment could establish minimum and maximum fee schedules at exactly the payment limit which would require managed care plans to pay the exact payment limit."[10] This example demonstrates that CMS is actively contemplating the direct application of the SDP percentage-of-Medicare payment framework to DME rates in managed care. AAHomecare flags this as a significant and adverse development requiring immediate clarification. If CMS intends to permit or encourage states to impose Medicare-based DME fee schedules through the SDP framework, this would effectively override states' independent authority to set Medicaid DMEPOS rates and would constitute precisely the kind of rigid Medicare-benchmarking that is inappropriate for Medicaid DMEPOS, as discussed in Section VII above.

[7] 91 Fed. Reg. at 30,437 ("We request comment on whether any other existing limits or required payment methodologies…should be accounted for in proposed § 447.381(b).").
[8] Sections 1903(i)(7) of the Social Security Act.
[9] 91 Fed. Reg. at 30,437 (proposing to exclude DME and CDL payments from the § 447.381 FFS limit "to avoid unnecessary duplication of requirements").
[10] 91 Fed. Reg. at 30,430–31 (discussing uniform-increase SDP phase-out and DME fee schedule example).

The Exclusion of DME from § 447.381. As discussed more fully in Section XXII above, CMS proposes to exclude payments subject to section 1903(i)(7) of the Social Security Act from the new § 447.381 FFS payment limit, specifically "to avoid unnecessary duplication of requirements."[11] AAHomecare reiterates that this same duplication-avoidance logic should compel CMS to confirm an equivalence exclusion for DME in the managed care SDP context.

Statutory Basis and the Section 1902(a)(30)(A) Standard. CMS invokes section 1902(a)(4), section 1903(m)(2)(A)(iii), and section 1902(a)(30)(A) of the Social Security Act as the statutory bases for this rulemaking, along with the Working Families Tax Cut legislation. As explained in sections I and III above, AAHomecare maintains that the "efficiency, economy, and quality of care" and "sufficient to enlist enough providers" standards of section 1902(a)(30)(A) cut against rate reductions that would impair DMEPOS access.

Fiscal Integrity Framing and DMEPOS's Relative Role. The NPRM frames this rulemaking as necessary to address rapid, unsustainable growth in Medicaid supplemental payments. CMS's own data demonstrate that this spending growth is overwhelmingly attributable to hospital and physician services, not DMEPOS. SDP spending is projected at $97.8 billion in FY2024, rising to approximately $144.6 billion in FY2026;[12] over 80 percent of SDP preprint submissions in 2024 were for hospital services; the largest SDP recipients were hospitals (87.5%), academic medical centers (4.9%), physicians (3.6%), and nursing facilities (2.5%). FFS supplemental payments for physicians, other practitioners, and non-emergency medical transportation totaled $2.64 billion in FY2024. None of this fiscal integrity concern data is attributable to DMEPOS. AAHomecare shares CMS's fiscal integrity goals, and maintains that DMEPOS is a comparatively small, already tightly regulated, high-value spending category that should not bear collateral damage from reforms appropriately targeted at inpatient hospital, outpatient hospital, nursing facility, academic medical center, and physician supplemental payment arrangements.

Conclusion

For the reasons set forth above, AAHomecare opposes the proposed rule as drafted. The NPRM, while addressing legitimate concerns about Medicaid supplemental payment growth, fails to adequately protect DMEPOS—a cost-effective, essential healthcare category that is not a driver of the spending growth CMS seeks to address and that is already subject to its own distinct statutory payment limitations. AAHomecare respectfully requests that CMS withdraw the proposed rule, and if they proceed with finalizing it, we respectfully request that CMS include in the final rule the explicit DMEPOS protections detailed in this letter, including: express confirmation that DME is excluded from both the FFS targeted payment limit at § 447.381 and from any SDP-imposed Medicare-based fee schedule mandate; requirements that states maintain adequate DMEPOS reimbursement and demonstrate network adequacy by product

category and geography; and safeguards against the cascading adverse effects on beneficiary access that will otherwise result from this rule's implementation.

AAHomecare welcomes the opportunity to work with CMS on alternative approaches that advance the Agency's fiscal integrity objectives without compromising beneficiary access to medically necessary home medical equipment and supplies. Thank you for the opportunity to submit these comments. Please contact us if you would like us to provide further information.

Sincerely,

Tom Ryan
President and CEO
American Association for Homecare