



September 28, 2026

Submitted via electronic mail to insurance@finance.senate.gov

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, DC 20510

**Re: Request for Information, “Health Coverage That Works for Everyone” (July 30, 2026) —
Response of the American Association for Homecare to Section 2, Parts I, II, and III, and
Section 3, Parts II and IV**

Dear Ranking Member Wyden:

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetic, and orthotics (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members furnish the oxygen and respiratory equipment, wheelchairs and complex rehabilitation technology, hospital beds, enteral nutrition, wound therapy, and diabetes, ostomy, and urological supplies that allow patients to be cared for at home. They also perform the work that accompanies the equipment: delivery, in-home setup, training for the patient and caregiver, fitting and adjustment, repair, and ongoing follow-up. We appreciate the opportunity to respond to the Committee’s request for information.

Our comments center on a feature of the home medical equipment benefit that the RFI does not address by name, although much of Section 3, Part IV describes it. In a growing share of health plans, the durable medical equipment (DME) benefit is not administered by the plan itself. It is delegated to a DME benefit manager, sometimes called a DME TPA (third-party administrator) or DME utilization management organization, which performs prior authorization, builds and credentials the supplier network, adjudicates claims, and in some arrangements assumes financial risk for the benefit and acts as the provider of record. These arrangements are expanding across Medicare Advantage, Medicaid managed care, and commercial and self-funded coverage.

Delegation is not itself the problem. The difficulty is that the obligations imposed on a health plan tend to stop at the plan, while the decisions that matter most to a patient are increasingly made one level below it: whether a medically necessary product is authorized, which supplier may furnish it, and what that supplier is paid. Congress confronted a similar structure in the pharmacy benefit and responded with transparency and pass-through requirements for pharmacy benefit managers. Section 3, Part IV asks whether comparable reforms should reach third-party administrators and other middlemen. We believe they should, and the home medical equipment benefit illustrates why any such reform must reach the delegated entity by definition.

Several of the positions that follow are drawn from comments the Association has filed with the Centers for Medicare & Medicaid Services (CMS) concerning Medicare Advantage and Medicaid managed care.¹

¹AAHomecare comments on CMS-0057-P, Advancing Interoperability and Improving Prior Authorization Processes (Mar. 10, 2023); comments to ONC on electronic prior authorization standards (Mar. 24, 2022); comments on CMS-4203-NC, Medicare Advantage Request for Information (Aug. 31, 2022); comments on CMS-4207-NC, Medicare Advantage Data Request for Information (2024); comments on CMS-4208-P, CY 2026 Medicare Advantage and Part D Proposed Rule (Jan. 27, 2025).

Those programs are administered in substantial part by the same carriers that operate in private insurance markets, frequently through the same benefit managers, and the Association offers that experience as evidence bearing on the practices this RFI examines.

Summary of principal recommendations

- Apply network adequacy, prior authorization, reporting, and appeal requirements to the entity actually administering the benefit, including any delegated or subcontracted benefit manager.
- Measure DME network adequacy by product category and geographic area, counting only suppliers that are actively furnishing items.
- Establish firm prior authorization timelines for equipment, treat an approval as conclusive on medical necessity, and limit prior authorization to high-cost items.
- Require public reporting of authorization, denial, and appeal outcomes by product category, including by delegated entities.
- Require transparent, fee-based compensation for benefit managers, disclosure of the economics of capitated arrangements, and plan sponsor access to claims-level data.
- Prohibit spread pricing and require that plan payments pass through to the furnishing supplier, with benefit managers paid only a disclosed flat fee.
- Address common ownership between payers and suppliers, and limit contracting terms that leave suppliers no practical choice but to accept unsustainable rates.

We do not suggest that plans should stop using administrative partners, that utilization review has no legitimate role, or that networks should go unmanaged. Our concern is narrower. Patients and plan sponsors should be able to see who is making coverage decisions and on what terms, and the protections Congress extends to patients should not disappear when a plan hands its benefit to someone else.

I. Network Adequacy (Section 2, Part I)

The RFI asks how to ensure access to broad networks of high-quality providers. For home medical equipment suppliers, the answer begins with how adequacy is measured. AAHomecare has recommended that DMEPOS network adequacy be assessed by product category and geographic area rather than by an undifferentiated count of suppliers. 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 DME/HME suppliers. This leaves a significant gap. 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. Suppliers specialize in a particular product line and do not provide all products that fall under the DMEPOS category. A plan with several respiratory suppliers in a region but no complex rehabilitation supplier has not met the needs of a patient who requires a complex power wheelchair; however, many suppliers appear in its directory.

Directory counts should also reflect suppliers that are actually furnishing items. The Committee's discussion of inaccurate provider directories applies directly here.² A supplier that holds a contract but has not submitted a claim in a year, or a national mail-order operation listed for a category that requires in-home setup and training, creates the appearance of access without its substance. We have seen a 37% reduction in DMEPOS supplier locations nationwide since 2013³, which may not be reflected accurately in the various payer provider directories.

These standards should apply wherever the network is actually built. When a plan delegates the equipment benefit, the benefit manager decides which suppliers are admitted, and in provider-of-record arrangements the manager effectively is the network. Adequacy requirements that bind only the plan leave the entity making those decisions outside their reach.

Recommendations

1. **Measure adequacy by product category and geography.** Count only suppliers that have submitted claims within the preceding twelve months, and do not count mail-order suppliers toward categories that require in-home service.
2. **Require reporting and remediation.** Plans should report beneficiary satisfaction and complaint data for DME, and a plan that falls short of adequacy standards should be required to add suppliers within a specified timeframe. Suppliers should have a clear channel through which to escalate patient access concerns.
3. **Extend adequacy standards to delegated networks.** Standards should be enforceable against any benefit manager that builds or controls a plan's DME network, and enrollees should not be penalized when no in-network supplier can furnish a medically necessary item within a clinically appropriate timeframe.
4. **Preserve patient choice.** Networks should offer enrollees a meaningful choice among qualified suppliers in each product category. When a plan or benefit manager changes its equipment network, a patient who wishes to keep his or her current supplier should be able to do so, provided the supplier accepts the network rate and meets the network's accreditation and quality standards. The patient's cost-sharing should not increase as a result, and patients should be told of this right in plain language before any change takes effect.

II. Prior Authorization, Claims Denials, and Appeals (Section 2, Part II)

Prior authorization

A delayed authorization for home medical equipment rarely remains an administrative problem. It usually delays a patient's discharge from a hospital or skilled nursing facility, at added cost and with added risk to the patient. AAHomecare supports the Medicare Advantage Improvement Act of 2026 (S. 4384 / H.R. 8375), which would require standard prior authorization decisions within 72 hours and expedited decisions within 24 hours.⁴ In comments to CMS, the Association has gone further for equipment, urging that DME authorization decisions be made within 24 hours and that requests for equipment needed on an emergency basis be decided in two hours or less. Oregon's 72-hour requirement for complex

²RFI at 48 (discussing inaccurate provider directories and "ghost networks").

³ AAH analysis of Medicare DMEPOS supplier, Jan '26

⁴AAHomecare, "AAHomecare Supports Medicare Advantage Improvement Act of 2026" (July 20, 2026).

rehabilitation technology, which the RFI cites, shows that equipment-specific timelines are workable in practice.⁵ Plans should also be prohibited from auto-denying authorizations in order to meet timeframes required by policy.

Timelines are only as good as their enforcement. A decision clock that restarts with each new request for information can be extended indefinitely, and a deadline that carries no consequence when it is missed does little for the patient waiting on the equipment.

An approval should also mean something once it is given. An affirmative prior authorization should be conclusive as to the medical necessity of the item. After the patient has taken possession of the equipment, the claim should be reviewable only for technical matters such as proof of delivery and should not be re-adjudicated for medical necessity.

Prior authorization should be reserved for high-cost items such as complex rehabilitation technology and non-invasive ventilators, and other ongoing medical supply needs. It should not be required for most DME items. Where it is required, payers now apply differing processes, formats, and timeframes, and meeting each set separately is a significant burden for suppliers. Uniform requirements across payers would reduce that burden without reducing oversight, and authorization systems should be electronic, operate in real time, and be available to suppliers at no charge.

Finally, the criteria matter as much as the process. When a plan delegates the equipment benefit, the benefit manager sometimes applies coverage criteria that differ from, and are more restrictive than, the medical policy the plan publishes to its enrollees. An enrollee should be able to rely on the criteria the plan discloses.

Reviewers and automated review

AAHomecare has recommended that physicians conducting peer review have substantive experience in the same field as the item under review, and that plans report the credentials and certifications of the individuals who participate in peer-to-peer review. Plans should also disclose and report their use of artificial intelligence in claims processing and prior authorization, and the governing algorithms and technology standards should be publicly available at no cost.

Appeals and denial coding

In the Association's experience, the principal deficiencies of plan appeal processes are a lack of timeliness and a lack of impartiality and objectivity. A related, less visible problem, is when a plan issues a negative determination without a patient-responsibility denial, the supplier cannot bill a secondary payer and cannot bill a patient who has chosen to obtain the item privately or outside of their insurance benefits. Therefore the amount is frequently written off by the supplier. Many patients elect to receive equipment or supplies at their own expense or have secondary coverage that would pay with the appropriate denial. Requiring plans to issue patient-responsibility denials would remove a source of uncompensated cost that current reporting does not capture.

Public reporting

The RFI asks what denial data should be collected. AAHomecare has recommended that plans publicly report, by product category, the number of authorizations requested, approved, denied, and partially

⁵RFI at 53 & n.223 (citing Oregon SB 549 (2025), requiring prior authorization decisions within 72 hours for complex rehabilitation technology).

approved or denied; the number appealed; the number overturned on appeal and the level at which reversal occurred; the share decided within prescribed timeframes; and the denials attributable to technical rather than medical-necessity reasons.

Where a plan uses a third-party administrator or benefit manager, or owns a DMEPOS supplier, that entity should be required to report the same metrics as the plan itself. Reporting obligations that stop at the plan leave the entity actually making the determination outside public view.

Recommendations

5. **Set enforceable timelines.** Require DMEPOS prior authorization decisions within 24 hours and emergency requests within two hours, with safeguards against restarting the clock through serial information requests and a defined consequence, such as deemed approval, when a deadline is missed.
6. **Make approvals final on medical necessity.** Limit post-delivery review of an authorized claim to technical matters such as proof of delivery.
7. **Limit and standardize prior authorization.** Reserve it for high-cost items, and require uniform, electronic, real-time processes available to suppliers at no charge.
8. **Bind delegated entities to published criteria.** A benefit manager should not apply coverage criteria more restrictive than those the plan discloses to enrollees.
9. **Require qualified reviewers and disclosed automation.** Peer reviewers should have experience in the relevant field, reviewer credentials should be reported, and the use of artificial intelligence should be disclosed.
10. **Require patient-responsibility denials** where coverage is denied, so that secondary coverage and patient-pay options remain available.
11. **Require product-level public reporting by plans and delegated entities alike,** covering the metrics described above.

III. Administrative Burden and Payment Practices (Section 2, Part III)

The RFI invites proposals to reduce the administrative responsibilities placed on suppliers and to level the field for small suppliers. Home medical equipment suppliers are overwhelmingly small businesses, many of them in rural areas, and they carry the same exposure to delayed payment and administrative churn that the RFI describes for hospitals with far less capacity to absorb it.

Three practices deserve particular attention. First, prompt-payment standards generally bind insurers but not the benefit managers that adjudicate and pay equipment claims on their behalf. Second, suppliers face post-payment recoupments and offsets taken against claims unrelated to the alleged overpayment, including the kind of cross-plan offsetting at issue in the state action the RFI cites.⁶ Third, suppliers that already hold CMS-recognized accreditation and Medicare supplier enrollment are routinely required to complete separate credentialing and re-credentialing for each payer and each benefit manager, duplicating oversight without adding patient protection.

⁶RFI at 82 & n.366 (describing a state action alleging cross-plan offsetting by the third-party administrator of a state employee health plan).

Recommendations

12. **Apply prompt-payment standards to delegated entities**, not only to insurers.
13. **Prohibit cross-plan offsetting and limit retroactive recoupment**, including offsets against unrelated claims, and establish reasonable audit look-back periods.
14. **Eliminate duplicative credentialing**. Deem CMS-recognized accreditation and Medicare supplier enrollment sufficient for network participation, limiting additional requirements to those a plan can show are materially protective of patients.

IV. Vertical Integration (Section 3, Part II)

Common ownership between a payer and a DMEPOS supplier creates a conflict of interest. The plan benefits financially from its affiliate's market share and from higher cost, and unaffiliated suppliers may be foreclosed from serving the plan's enrollees. AAHomecare has raised this concern with CMS. The Committee's own finding that one large insurer pays its affiliated physician groups roughly 17 percent more than unaffiliated groups describes a structure that operates the same way in the equipment benefit.⁷

The same concern arises when the benefit manager, rather than the plan, shares ownership with a national insurer or with supplier operations. A supplier negotiating its rate with such a manager is often negotiating with an entity affiliated with a competitor, and the patient may be steered toward the affiliate without knowing that a relationship exists.

Recommendations

15. **Require ownership disclosure** of any relationship among a plan, its benefit manager, and suppliers in its network.
16. **Require affiliate rate reporting** comparing payments to affiliated and unaffiliated suppliers for the same HCPCS codes.
17. **Prohibit steering to affiliated suppliers** and contract terms that condition network access on acceptance of affiliated services.

V. Third-Party Administrators and DME Benefit Managers (Section 3, Part IV)

How the delegated equipment benefit works

DME benefit managers operate under several models. Some are paid an administrative fee, per member per month or per authorization, to perform utilization management, network management, and claims processing on the plan's behalf. Others accept a capitated payment for the entire equipment benefit, assume the financial risk, and act as the provider of record, paying contracted suppliers on the manager's own fee schedule. A single manager may administer the benefit for many plans at once, and some combine equipment with home health and home infusion.

The capitated model has grown quickly and illustrates the concerns in this section. When a benefit manager becomes the provider of record, existing suppliers must join its network on its terms or lose access to the plan's members. AAHomecare has documented one such transition in Medicare Advantage

⁷RFI at 73 & n.319.

that initially affected approximately 480,000 enrollees in North Carolina and Georgia, and the Association is tracking several similar network and TPA arrangements emerging across commercial and managed care markets.⁸

The comparison to pharmacy benefit managers

The RFI observes that the practices of insurance middlemen have drawn comparison to those of Pharmacy Benefit Manager PBMs.⁹ The comparison is not exact. DME benefit managers are typically compensated through administrative fees or capitation rather than through a per-claim spread, and the equipment benefit has no rebate system comparable to the one in prescription drugs. In capitated, provider-of-record arrangements, however, the difference between the capitation a manager receives and the amounts it pays suppliers functions as a spread, and neither the plan sponsor nor the supplier can see it. But the features that made PBM reform necessary are present: an intermediary positioned between the payer and the supplier, compensation arrangements the plan sponsor cannot fully see, control over network access, delegated utilization management, affiliation with major insurers, and very little regulation.

	Pharmacy benefit managers	DME benefit managers
Intermediary between payer and furnishing provider	Stands between the plan and the pharmacy; its compensation is not visible to the plan sponsor or the pharmacy.	Stands between the plan and the supplier. In capitated, provider-of-record arrangements, the difference between the capitation received and the amounts paid to suppliers is retained by the manager, and neither the plan sponsor nor the supplier can see it.
Compensation incentives	Spread pricing, rebate retention, and fees tied to drug spend.	Administrative fees, per-member-per-month payments, or capitation. Managers commonly market their services on the savings they produce for the plan, which rewards reducing what reaches the supplier.
Control of network access	Pharmacies contract on the PBM's terms or lose access to the PBM's members.	Suppliers join the manager's network on its terms or lose access to the plan's members, often across every plan the manager administers.
Utilization management	Formulary design, step therapy, and prior authorization performed by the PBM.	Prior authorization and documentation review performed by the manager, sometimes under criteria different from those the plan publishes to enrollees.

⁸AAHomecare, "Emerging DME Network Models and TPA Activity" (June 9, 2026); AAHomecare analysis of capitated DME benefit management in Medicare Advantage (2024–2026).

⁹RFI at 80–84.

	Pharmacy benefit managers	DME benefit managers
Vertical integration	The largest PBMs share ownership with major insurers and operate affiliated pharmacies.	Some managers are affiliated with national insurers, and some plans own supplier operations, creating the conflict AAHomecare has raised with CMS.
Effect on independent suppliers	Independent pharmacy closures and pharmacy deserts.	Supplier attrition, most acute in rural areas and in labor-intensive categories such as home respiratory therapy and complex rehabilitation technology.
Regulatory framework	Subject to licensure and transparency laws in most states, a 2024 FTC staff report, and federal reforms in the Consolidated Appropriations Act, 2026.	Little comparable regulation in any market outside Medicaid managed care subcontracting rules.

Why the equipment benefit is harder to oversee

The codes do not identify products. Drug pricing oversight depends in part on the National Drug Code, which identifies a specific product and allows prices to be compared against published benchmarks. HCPCS codes describe categories. A single code can span products with materially different acquisition costs and service requirements, which makes it difficult for a plan sponsor to compare what it pays with what the furnishing supplier receives after the fact. Contemporaneous disclosure is the only reliable remedy.

The payment covers labor as well as equipment. The manufacturer sets the cost of the device. 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 reimbursement. The fixed-cost nature of DME means that even marginal rate reductions can render continued payer 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.

Patients cannot shop and often cannot switch. A patient discharged on oxygen, a family awaiting enteral formula, or a person who needs a custom seating system is not comparison shopping. The referral is clinical and usually urgent, and rental and continued-use rules then keep the patient with the same supplier for the rest of the episode.

State authority is limited. States have acted extensively on PBM licensure and transparency. Comparable state oversight of DME benefit managers is far less developed, and ERISA constrains what states can do in the self-funded market. Federal action is correspondingly more important here.

Network participation is not evidence that rates are adequate

It would be reasonable to assume that a supplier who joins a benefit manager's network has judged the rate to be workable. Our members consistently report otherwise. They describe joining these networks out of concern about losing business, regardless of whether the rates offered are sustainable. Several features of the market produce that pressure.

- **Access is all or nothing.** A benefit manager often administers the equipment benefit for many plans at once, and in the provider-of-record model it controls all access to the plan's members. Declining the contract forfeits that entire population.
- **Referral relationships do not return.** Discharge planners, physician offices, and case managers direct patients to suppliers they know participate. A supplier that leaves one network is frequently dropped from the referral pattern altogether, including for patients covered by other payers, so the cost of declining far exceeds the value of the contract itself.
- **Terms are not negotiable and can change.** Smaller suppliers are presented with form agreements. A rate accepted at signing may later be reduced by amendment, with continued participation treated as acceptance.

Suppliers therefore remain in these networks and absorb the shortfall from other lines of business for as long as they can. That does not appear in participation data. What eventually appears is a supplier that stops accepting the most complex referrals, a company that sells to a larger competitor, or a community left without a local supplier able to service equipment when it fails. For the same reason, disclosure alone will not resolve the problem. A supplier that can see the terms but cannot decline them is in no better position than before.

Medicaid managed care offers a model

Federal law already follows the delegation in one market. Under the Medicaid managed care rules, a managed care organization retains ultimate responsibility for compliance with its state contract regardless of any subcontracting relationship, and its subcontracts must carry specified obligations, including audit access and record retention.¹⁰ A DME benefit manager serving a Medicaid plan is therefore bound, through that plan, to the same standards as the plan itself. Nothing comparable exists in the individual, small group, or large group markets, and nothing reaches the self-funded market. Several states have also moved their Medicaid PBM arrangements to pass-through pricing with a flat administrative fee, which shows that the tools this section recommends are already in use.

Recommendations

18. **Define the regulated entity by function.** Any transparency, reporting, or fiduciary requirement adopted for TPAs should apply to any entity that administers, authorizes, prices, adjudicates, or builds a network for a benefit on a plan's behalf, including entities to which a first-tier administrator further delegates that work.
19. **Require transparent compensation.** Plan sponsors should be able to see how every benefit manager in the delegation chain is compensated. In capitated arrangements, the plan sponsor should be able to see the capitation paid and the aggregate amounts paid to furnishing suppliers.

¹⁰42 C.F.R. § 438.230(b)(1) (managed care entity "maintains ultimate responsibility" for compliance with its state contract notwithstanding any subcontracting relationship); see also 42 C.F.R. § 438.3(h), (u) (audit and record retention requirements).

Any manufacturer or purchasing-organization payments tied to plan claims should be disclosed and passed through.

20. **Prohibit spread pricing and require pass-through.** No benefit manager should retain any portion of a plan's payment for an item or service, whether structured as a spread between what the plan pays and what the furnishing supplier receives, a fixed percentage withheld from the supplier's payment, or any other reduction, however labeled. Where a plan pays a benefit manager per claim or per service, 100 percent of the plan's payment should pass through to the furnishing supplier. Where a plan pays a benefit manager on a capitated basis, 100 percent of the capitation attributable to items and services should be paid to furnishing suppliers, with any unspent amount returned to the plan sponsor. A plan that chooses to outsource administrative functions such as prior authorization, network management, and claims processing should pay for them from its own administrative budget, through a separate, disclosed, flat fee that does not vary with supplier payments or savings achieved, consistent with the bona fide service fee structure Congress adopted for Part D pharmacy benefit managers in the Consolidated Appropriations Act, 2026. That fee, and any portion of a capitation payment that covers the manager's administration or margin, should be reported as an administrative cost rather than as spending on items and services, so that the plan's medical loss ratio accurately reflects what reaches patients and suppliers.
21. **Guarantee plan sponsors access to their own data.** Sponsors should be able to identify every entity in the delegation chain and its compensation, and to obtain claims-level data showing amounts billed, allowed, and paid to the furnishing supplier. Contract terms that bar a sponsor from auditing its own plan should be unenforceable.
22. **Extend fiduciary accountability through the delegation chain** to any entity exercising discretion over benefit administration, pricing, or medical necessity.
23. **Limit coercive contracting terms.** Prohibit conditioning access to one plan, product category, or line of business on acceptance of others; require advance written notice of material amendments, including rate reductions; and preserve a supplier's right to decline an amendment without forfeiting unrelated participation.
24. **Protect patients during transitions.** When a plan moves its equipment benefit to a new manager, require written notice to enrollees and suppliers and a transition period of no fewer than 120 days before any patient's supplier arrangement changes. During that period, existing authorizations should be honored, and patients should continue to receive equipment and service from their current supplier without interruption, including patients in the middle of a rental period.
25. **Apply MLR-type accountability to ASO and delegated arrangements** and give the Department of Labor the resources to review and act on the data these requirements will produce.

Conclusion

Congress has already concluded, with support from both parties, that an intermediary standing between a payer and the supplier who serves the patient should be compensated transparently and held accountable to the plan it serves. The home medical equipment benefit is increasingly administered through intermediaries of exactly that kind, with less scrutiny, less state authority, and direct consequences for patients waiting at home or in a hospital bed for the equipment they need.

AAHomecare appreciates the Committee's attention to the administrative practices that determine whether coverage actually works for patients, and we would welcome the opportunity to provide additional detail, data, or technical assistance on any of the matters above.

Sincerely,



Cadie McGonagill
Vice President, Managed Care & Government Payers
American Association for Homecare
CadieM@aahomecare.org