MEMORANDUM

To: **AAHomecare**

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Date: Updated January 13, 2026

Subject: **Summary of Key Rules for Medicare DMEPOS Competitive Bidding Program**

Introduction

On November 29, 2025, the Centers for Medicare and Medicaid Services ("CMS") posted a final rule making changes to the Medicare durable medical equipment, prosthetics, orthotics and supplies ("DMEPOS") competitive bidding program.[1] This final rule makes significant structural, bidding and other programmatic changes to the next round of competitive bidding. This memorandum summarizes the changes to the competitive bidding program; ("CBP"). In Section 2, we provide information on what has not changed with the CBP.

CMS announced that for the next round of bidding, it will only be implementing Remote Item Delivery ("RID") competitive bidding programs ("CBPs"), which will likely be national contracts for seven product categories, many of which have never been previously subject to competitive bidding. The seven product categories will be:

1. Class II Continuous Glucose Monitors (CGMs) and Insulin Pumps
2. Urological Supplies
3. Ostomy Supplies
4. Hydrophilic Urinary Catheters
5. Off-The-Shelf ("OTS) Back Braces
6. OTS Knee Braces, and
7. OTS Upper Extremity Braces

CMS will not be including any additional product categories in the next round of the CPB, such as oxygen, CPAP, standard wheelchairs, hospital beds, walkers, etc.

This memorandum focuses on the rules applicable to the RID CBPs. We expect that CMS and its contractor, the Competitive Bidding Implementation Contracts ("CBIC" at dmecompetitivebid.com) will issue additional guidance over the next several months. In the past, these "Fact Sheets" provided bidders with details regarding financial documentation, physician authorization, common ownership/control, and other issues.

[1] The final rule was published in the December 2, 2025, *Federal Register* [90 Fed. Reg. 55342 Link]

CMS has also announced that there will be one portal for bidders to use, Connexion, which is CMS' DMEPOS CBP secure portal.

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Section 1: CMS Final Rule – New Rules for the Competitive Bidding Program

A. Single Payment Amounts ("SPAs") (42 C.F.R. §414.416(b)(1))

- The bid payment amount for a HCPCS code is called the "single payment amount" or SPA

- Bidders bid on the "lead item" in each product category (see below, section 2.B., Lead Item Bidding, for a description of the lead item bidding methodology). CMS will array bidders' bids for the lead item in a product category from low to high. Then, starting at the lowest bidder, it will select the number of contractors needed.

- The lead item SPA will be based on the 75th percentile of bids among the contractors (42 C.F.R. §424.426).

- The SPA for non-lead items will be the SPA for the lead item in the same product category multiplied by the ratio of the 2015 fee schedule amount for the non-lead item for the area to the 2015 fee schedule amount for the lead item.

B. Number of Contracts for a Product Category (42 C.F.R. §414.414)

- For product categories that have never been bid before (e.g., urological supplies, ostomy supplies, and continuous glucose monitors), the number of contractors will be 125 percent of the number of DMEPOS suppliers that furnished at least three percent of the total utilization for the lead item in the product category and CBA during the most recent calendar year, rounded to the nearest whole number, with a minimum of two contract suppliers (42 CFR §414.414(h)(3).

- Using 2023 claims data, CMS estimates the following number of contractors for the following product categories (nationwide remote item delivery CBPs). CMS will use 2025 data to determine the number of contractors.

  Urological supplies – 7 contractors
  Ostomy Supplies – 8 contractors
  Continuous Glucose Meters – 9 contractors

C. Adjustments to SPAs (42 C.F.R. §414.408(b))

- CMS will apply annual inflation adjustments to the SPAs beginning in year two of each CBP contract period (previously there was no inflation adjustment to the SPAs for the duration of the three-year contract period).

D. Bid Limits (42 C.F.R. §414.412)

- Bid Limits - For product categories that have previously never been bid, the bid limit will be the current fee schedule amount.

- For previously bid items, the bid limit will be the most recent SPA plus ten percent. If, the SPA was in effect more than one year ago, the bid limit can not exceed the lesser of (1) the most recent SPA for the item adjusted by all the inflation updates since then, or the unadjusted fee schedule amount for the item.

- The bid limit cannot exceed the unadjusted fee schedule amount.

E. Conditions for Awarding Contracts (42 C.F.R. §414.414)

Credit Report Requirement

- CMS will no longer require bidders to submit tax return extracts, income statements, balance sheets, and cash flow statements as part of the required financial documentation submission.

- CMS will continue to require bidders to submit a business credit report (score or rating). If the business does not have a business credit report with a numerical score or rating, the bidder will be required to submit: (1) a business credit report showing there is no data or insufficient information to generate a credit score; and (2) a personal credit report or the rating from the supplier's Authorized Organization or Delegated Official listed in PECOS. The personal credit report must be of the Authorized Official or Delegated Official listed in PECOS; otherwise, the supplier would not be eligible for a CBP contract.

- The credit reports used for bid submissions must be finalized close to when the bid window opens. CMS will publish the applicable scoring list for each bid round in the round-specific Request for Bids (RFB) or in a Financial Scoring Methodology Fact Sheet to assist bidders with clear guidance.

- CMS will continue to use the five-tier scoring system in reviewing supplier credit scores, where a score of 12 or higher is passing. The scores are either 4, 8, 12, 16, or 20 points—with 4 being the worst score and 20 being the best.

- CMS will add a field in the bid application that will require bidders to add their gross revenue. This information will assist CMS in determining if the supplier is a "small" supplier, defined as no more than $3.5 million in annual revenue (See Section 2.D. below, Small Supplier Participation Targets). CMS will review claims data to confirm the accuracy of the submission. Suppliers that falsify their information will be referred to the Office of Inspector General and the Department of Justice for further investigation.

  Financial Documentation Requirements

- Bidders must submit:
  - A copy of its business' credit report showing the approved crediting agency;
  - a numerical credit score or rating;
  - the bidding entity's name; and
  - the date that the credit report was prepared no earlier than 90 calendar days prior to the opening of the bid window.

- If the bidder does not have a numerical score or rating the bidder must submit:
  - A business credit report showing no data or insufficient information to generate a credit score; and
  - A personal credit report or the rating from the supplier's Authorized Official (AO) or Delegated Official (DO) listed in PECOS
    - The personal credit report must be of the AO or DO; otherwise, the bidder is not eligible for a CBP contract

- Commonly owned and/or commonly controlled bidding entities (Bidding Entities)
  - Bidding Entities are prohibited from competing against themselves when submitting bids in the same competition.
    - When bidding opens, Bidding Entities must register one time with a primary Provider Transaction Access Number (PTAN) which designates the primary location in the bidding system and identifies the entity responsible party for all contractual requirements.
      - The bidding entity must attest in the bidding system that it is submitting one bid that includes all commonly owned and/or commonly controlled locations, and that it will furnish the lead item and all non-lead items in the same competition.

- Credit scores will no longer be used to consider capacity

- CMS retains a five-tier financial scoring system but will not use the financial score to determine supplier capacity.
  - The scores are either 4, 8, 12, 16, or 20 points—4 being the worst and 20 being the best.

- The application will require bidders to add their gross revenue
    - This will assist CMS in determining if the supplier is a small supplier, which is defined as having annual gross revenues of $3.5 million or less

Bid Surety Bonds

- CMS is codifying the process it used in the previous round of the CBP where it provides bidders a single, 10-business-day window to fix issues with their bid surety bond by submitting a corrected bond rider. If a bond is found to be incorrect, incomplete, or missing required information, CMS would notify the bidder through the DMEPOS CBP's secure portal. The bidder would then be allowed to submit a corrected bond rider within those 10-business days. CMS would only notify bidders of deficiencies that can be corrected with a bond rider. The rider must be from the authorized surety that issues the original surety bond

- Bidders have previously and will continue to be required to obtain a bid surety bond for the CBA from an authorized surety on the Department of Treasury's Listing of Certified Companies and provide proof of having obtained the bond by submitting a copy to CMS by the bid submission deadline.

F. Inclusion of Medical Supplies (42 C.F.R. §414.402)

- CMS revised the definition of "items" that can be included in the CBP to include "other medical equipment described in section 1861(m)(5) of the Act, including supplies related to ostomy care and urological supplies.

- The final rule specified that ostomy, tracheostomy, and urological supplies are medical equipment items that are authorized to be included in the DMEPOS CBP by section 1847(a)(2)(A) of the Social Security Act.

G. Remote Item Delivery (RID) CBP (42 C.F.R. §414.402)

New Definitions

- Remote Item Delivery CBP – defined as "a competitive bidding program wherein contract suppliers are responsible for furnishing remote item delivery items under a product category to all Medicare beneficiaries regardless of where they live in the CBA. The CBA could be one nationwide CBA that includes all areas (all States, territories, and the District of Columbia) or a CBA covering a specific region of the country."

- Remote Item Delivery Item – defined as "an item falling under a remote item delivery competitive bidding program that may be shipped or delivered to a beneficiary's home, regardless of the method of delivery, or picked up at a local pharmacy or supplier storefront if the beneficiary or caregiver for the beneficiary chooses to pick the item up in person."

  RID CBP Structure

- CMS may implement:
  - One nationwide RID CBP, or
  - Multiple regional RID CBPs
    - If established, it could cover smaller regions such as a State, territory or the District of Columbia or it could cover larger areas such as a group or combination of States, territories, and/or the District of Columbia

- Contract suppliers must furnish items primarily via mail order but may also furnish non-mail order items through a local storefront if they have one.

- Any RID CBP for off-the-shelf Orthotics will only include items that are appropriate for remote delivery.

H. Payment for CGMs and Insulin Infusion Pumps (42 C.F.R. §414.408)

- CMS is changing the payment classification for CGMs and insulin pumps as items requiring frequent and substantial servicing

  - CMS will pay on a bundled monthly rental basis for Class II continuous glucose monitors (CGMs) and insulin infusion pumps (and all necessary supplies), and

  - CMS is eliminating the 5-year replacement rule for CGMs and insulin infusion pumps.

- Non-CBP areas will also use the CBP-established bundled rental amounts.

- **S**uppliers are required to furnish a specific brand of class II CGM or insulin pump included under the product category if the beneficiary requests the item from the contract supplier and the physician authorizes use of a specific brand of CGM or insulin pump as a part of their order (See Section 2.F. below for more details on Physician Prescription for a Particular Brand Item).

- Class II CGMs and insulin pumps phased in under the DMEPOS CBP will be paid for on a monthly rental basis in accordance with the payment rules for DME items requiring

frequent and substantial servicing. Noncontract suppliers with grandfathered rental agreements in place at the time the new rules are phased in under a CBA may be continued under the existing grandfathering rules for items requiring frequent and substantial servicing if the supplier elects to be grandfathered, and will be paid based on the monthly rental amounts established under the DMEPOS CBP. Suppliers may bill for up to three months of rental in advance.

    - The grandfathering rules are located in 42 CFR § 414.408(j).

    - A supplier may elect to be a grandfathered supplier by providing a written notification to CMS of this decision. The grandfathered supplier is required to continue furnishing the grandfathered items to all beneficiaries who elect to continue receiving the grandfathered items from that supplier for the remainder of the rental period for that item

    - A supplier who elects not to become a grandfathered supplier must provide a 30-day, 10-day, and 2-day notice to its Medicare beneficiaries who are currently renting competitively bid DME item(s) who live in a Competitively Bid Area (CBA). The supplier must pick up the item it is currently renting to the beneficiary from the beneficiary's home after the proper notification.

- Payment for replacement supplies and accessories for beneficiary-owned class II CGMs and insulin infusion pumps will be paid for under the DMEPOS CBP in accordance with the special temporary transition rules at 42 C.F.R. § 414.408(m) until the beneficiary-owned equipment is replaced.

    - The language for the special temporary transition rules applies to payments for supplies and accessories necessary for the effective use of beneficiary-owned CGM and infusion pumps. CMS will continue, as applicable, to make separate payments under the DMEPOS competitive bidding program for supplies and accessories for class II CGM or insulin pumps owned by the beneficiary at the time a CBP is phased in for the CGM or insulin pumps for the first time in a CBA where the beneficiary resides until coverage for the beneficiary-owned equipment ends, the equipment is no longer used, or at any point when the equipment has been replaced with rented equipment under the DMEPOS CBP.

- All CGMs and insulin pumps will be classified as items requiring frequent and substantial servicing beginning on the date class II CGMs and insulin pumps are first phased in under the DMEPOS CBP.

- Payment for class III CGMs and insulin pumps used in conjunction with class III CGMs will be limited to the amounts established for class II CGMs and insulin pumps under the

DMEPOS CBP if these amounts are at least 15 percent lower than the fee schedule amounts for class III CGMs and insulin pumps used in conjunction with class III CGMs.

- Suppliers may bill for up to three months of rental in advance for all CGMs and insulin pumps, regardless of whether payment is made under a DMEPOS CBP or under the fee schedule.

- Payment for replacement supplies and accessories for beneficiary-owned class III CGMs and insulin pumps used in conjunction with class III CGMs will be paid for under the fee schedule in the same amounts established for these items under the DMEPOS CBP until the equipment is replaced or the beneficiary elects to obtain new equipment from a contract supplier under the DMEPOS CBP.

I. Covered Document Review Date (CDRD) Process (42 C.F.R. §414.414(d)(2))

- The CDRD process requires CMS to notify bidders when there are missing documents:
- CDRD is the later of 30 days before the final date for the closing of the bid window or 30 days after the opening of the bid window.
- If at least one covered document is submitted by CDRD, CMS will notify the supplier of any missing covered documents within 90 days after the CDRD.
    - In prior competitions, CMS provided the supplier with notice regarding missing or received covered documents by the CDRD and by the close of the bid window. In the Final Rule, is modifying the process so that the notice will only inform the supplier if it has missing covered documents by the close of the bid window.
    - The notification is limited to the timely submission of covered documents and not to the accuracy or completeness of documents submitted or whether the documents meet applicable requirements.
- Suppliers have 10 business days to submit missing documents.

J. Termination Clause for CBP Contracts (42 C.F.R. §414.422(h))

- CMS may unilaterally terminate or modify CBP contracts during a Public Health Emergency (PHE) when:
    - A PHE is declared;
    - CMS finds verifiable access problems;

    - Awarding additional contracts will not resolve access concerns; and
    - Termination/modification would alleviate access issues.
- To determine whether access problems exist, CMS will review data from contract suppliers, CMS's monitoring system, including, for example, complaints, claims data, and beneficiary outcomes), and from other agencies, federal, state, and local.
    - If at least two contract suppliers provide evidence that they can meet beneficiary demand, then CMS may elect not to terminate the contracts.
- CMS may terminate a contract supplier's entire contract if the PHE-impacted items and services in the PHE-impacted area include all competitions in the supplier's contract.
- CMS may modify a contract supplier's contract if the PHE-impacted items and services in the PHE-impacted area include only a portion of the competitions in the supplier's contract.
- Any termination or modification will remain effective for the remainder of the contract term, even if the PHE ends before the contract expiration date.
- After contract termination, CMS reverts affected areas to the fee-for-service program.
    - The contractor is no longer obligated to furnish the specified items and services in the PHE-impacted area, and
    - Payment reverts to the fee-for-service amounts.

K. CMS Timeline for Implementing the Next Round of Bidding

CMS announced in a Press Release the following target dates for the Program as of early December 2025:

<u>Late Spring/Early Summer 2026</u>

- Dates for registration and bidding will be released
- The leading items for the DMEPOS CBP product categories and the number of contracts to award for each product category will be announced
- CMS will begin the bidder education program

<u>Late Summer/Early Fall 2026</u>

- Bidder registration period to obtain user IDs and passwords begins
- Bid window opens

<u>Late Summer/ Early Fall 2027</u>

- Contracts awarded and single payment amounts announced
- Beneficiary education begins

No later than January 1, 2028

- Start of Next Round – Contracts and single payment amounts (SPAs in effect)
- Six-month transition period begins for beneficiaries to switch to contract suppliers

Section 2: Competitive Bidding Program Rules that Have Not Changed

A. Basic Eligibility Rules (42 C.F.R. §414.414(b))

- Bidders must meet basic eligibility rules, including meeting current Medicare enrollment requirements.
- Bidders must be in compliance with all state and local requirements, including licensure
- Suppliers are required to submit "bona fide" bids, meaning that the bid amount must cover the cost of the item, as well as costs to deliver and educate the beneficiary and be in compliance with all Medicare requirements.

B. Lead Item Bidding (42 C.F.R. § 414.412(b))

- Bidders submit a bid price for the lead item in a product category.
- The lead item is the item in a product category with the highest total nationwide Medicare allowed charges of any item in the product category, prior to each competition

C. Commonly Owned or Controlled Suppliers (42 C.F.R. §414.412(d))

- A Supplier must list in its bid all other suppliers with which it is commonly owned or controlled. Commonly-owned or controlled suppliers must submit a single bid to furnish a product category in a CBA.
- If commonly-owned or controlled suppliers are awarded a contract, all suppliers listed in the bid will be considered contract suppliers for that CBA and product category.
- Suppliers are commonly-owned if one or more of them has an ownership interest totaling 5% or more in the other(s). An ownership interest is the possession of equity in the capital, stock, or profits of another supplier.
- Suppliers are commonly controlled if one or more owners of a supplier is an officer, director, or partner in the other supplier(s).

D. Small Supplier Participation Targets (42 C.F.R. §414.414(g))

- Both the Social Security Act and CMS's implementing regulations state that CMS must give small suppliers "the opportunity to participate" in the CBP. There is not a requirement that small suppliers be included in the CBP.

- CMS has implemented this small supplier "opportunity to participate" requirement by setting a target of 30 percent of the number of contractors be small suppliers. However, if there are not this number of small suppliers in the initial array of contractors, CMS will select additional small suppliers whose compositive bids are above the pivotal bid for the product category and offer those small suppliers contracts.

E. Mandatory Assignment (42 C.F.R. §414.422(e))

- Contract suppliers must accept assignment on all competitive bid items under its contract to any beneficiary who maintains a permanent residence in, or who visits, the CBA and who requests those items from that contract supplier.
- Contract suppliers may still use an Advance Beneficiary Notice, per current Medicare rules.

F. Physician Prescription for a Particular Brand of Item (42 CFR §414.420)

- A physician may prescribe a particular brand of item if he or she determines that the particular brand would avoid an adverse medical outcome for the beneficiary.

- When a physician prescribes a particular brand of item, the physician must document the reason in the beneficiary's medical record why the particular brand is medically necessary to avoid an adverse medical outcome.

- When a physician prescribes a particular brand of item, the contract supplier must furnish the particular brand that is prescribed; or consult with the physician to find an appropriate alternative brand of item and obtain a revised prescription, or assist the beneficiary in locating a contract supplier that can furnish the particular brand of item.

- Medicare does not make any additional payment to a contract supplier for furnishing a particular brand prescribed by a physician, and a contract supplier is prohibited from submitting a claim if it furnished a brand of item that is different than what the physician specified.

G. Terms of Contracts (42 C.F.R. §414.422)

- Contracts are for a period of three years.
- Contract suppliers are not allowed to discriminate by providing Medicare beneficiaries different items than it would provide to their non-Medicare customers.

H. Change of Ownership (42 C.F.R. §414.422(d))

- CMS may transfer a contract to a successor entity that merges with, or acquires, a contract supplier if the successor entity (1) meets all the requirements applicable to contract suppliers for the applicable competitive bidding program; (2) submits the documentation described in § 414.414(b)-(d) if documentation has not previously been submitted by the successor entity; and (3) submits to CMS a signed novation agreement acceptable to CMS stating it assumes all obligations under the contract.

I. Furnishing of Items (42 C.F.R §414.422(e))

- Contractors are required to furnish items to any beneficiary who maintains a permanent residence in, or who visits, a CBA and requests those items from that contract supplier.

- Beneficiaries residing in a CBA must obtain competitive bid items from a contract supplier

J. Disclosure of Subcontracting Arrangements (42 C.F.R §414.422(f))

- At the outset of the contract, and during the contract period, a contract supplier must disclose, within ten days of when a supplier enters into a subcontract, information on any subcontracting arrangements and whether each subcontractor complies with the Medicare quality standards and accreditation requirements.
- The supplier must not contract with any entity that is currently excluded from the Medicare program, any state health care programs, or from any other Federal Government Executive Branch procurement or non-procurement program or activity.
- A contract supplier is permitted to subcontract the following duties from 42 CFR §424.57(c): filling orders, delivery of CBP items, and repairing CBP items.

K. Breach of Contract (42 C.F.R §414.422(g))

- Any deviation from the contract requirements constitutes a breach of contract.

- In the event of a breach of contract, CMS may (a) suspend the contract supplier's contract; (b) terminate the contract; (c) preclude the contract supplier from participating in the CBP; or (d) avail itself of other remedies allowed by law.

L. No Administrative or Judicial Review (42 C.F.R. §414.424)

- Both the Social Security Act and CMS' regulations preclude administrative or judicial review of the establishment of payment amounts, awarding of contracts, designation of competitive bidding areas, phase-in of the CBPs, selection of items for inclusion, bidding structure and number of selected contract suppliers.

M. HCPCS Code Changes After Contracts Begin (42 C.F.R §414.426)

- If a HCPCS code for a competitively bid item is revised after the contract period for a competitive bidding program begins CMS will adjust the single payment amount for that item:
    - **i.** If a single HCPCS Code for an item is divided into two or more HCPCS Codes for the components of the item, the sum of single payment amounts for the new HCPCS codes equals the single payment amount for the original item.
    - ii. If a single HCPCS code is divided into two or more separate HCPCS codes, the single payment amount for each of the new separate HCPCS codes is equal to the single payment amount applied to the single HCPCS code.
    - iii. If the HCPCS codes for components of an item are merged into a single HCPCS code for the item, the single payment amount for the new HCPCS code is equal to the total of the separate single payment amounts for the components.
    - iv. If multiple HCPCS codes for similar items are merged into a single HCPCS code, the items to which the new HCPCS codes apply may be furnished by any supplier that has a valid Medicare billing number.

N. Exceptions to the CBP (42 C.F.R. §414.404(b)(1)

- Physicians, treating practitioners and hospitals can furnish only certain items of DME without submitted a bid and being awarded a contract as long as:
    - The items are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors and infusion pumps, and off the shelf orthotics
    - The items are furnished to the physician's own patients as part of his/her professional service, or by a hospital to its own patients during a admission or on the date of discharge
    - The items are billed under a billing number assigned to the hospital, physician or treating practitioner

- Payment for the item is based on the competitive bidding program's SPA