**Key Issues for Comment on DMEPOS/Home Health Proposed Rule**

HME suppliers and other stakeholders can use this plain-language summary of major in the DMEPOS/Home Health Proposed Rule to craft their comments. This list is drawn from the Executive Summary of AAHomecare's comments on the Proposed Rule and is collected in three major category areas.

**You don't have to comment on every issue –- comments that cover just a few issues –** or **even one issue – are helpful and impactful. Pick out the ones that resonate with you the most** – and tell CMS how they will impact your business and your patients.

**Find more materials and where to comment at aahomecare.org/2025-DMEPOS-proposed-rule.**

## Bid-Setting Processes

- **CMS should maintain the bid ceiling at the unadjusted 2015 fee schedule.** The proposal to set the bid ceiling based on SPAs established from a flawed bidding program will continue to depress prices to unsustainable levels, jeopardizing the viability of the DMEPOS industry and access to care.
- **CMS must pay contractors at the amount they bid as commercial payors do.** If CMS moves ahead with a uniform payment amount for all bidders, CMS should maintain the current methodology for determining the single payment amount ("SPA") at the clearing price – and not move forward with the proposal to establish the SPAs for lead items based on 75$^{th}$ percentile of winning bids. Any reduction will jeopardize beneficiary access and will not reflect true market pricing, which is counter to CMS' emphasis throughout the proposed rule.
- **CMS should discontinue the use of lead item bidding and allow bidders to bid on individual HCPCS codes to better reflect market pricing.** The fundamental flaw with the lead item bidding/pricing methodology is that it assumes there is a rational relationship in the relative Medicare payment amounts for items within a single product category. This is simply not true. The lead item bidding results in disproportionate cuts to non-lead items. While we supported the concept of lead item bidding previously years ago, that was before CMS established the non-lead item payment methodology and our members experienced it.
- **CMS must consider DME supplier experience in a geographic area and product category, capacity, and whether the bids are bona fide when awarding contracts.** CMS must require bidders to have sufficient cash flow to expand to fulfill

contracts. Failing to maintain the safeguards put in place due to lessons learned from earlier rounds of the CBP risks a return to the problems of unrealistically low bids that were submitted without viable plans or experience with specific products to serve beneficiaries. To ensure bidders bids are sustainable, CMS should conduct its bona fide bid analysis to lead and non-lead item SPAs.

- **CMS' proposed method for determining the number of contractors is arbitrary and designed solely to eliminate most DMEPOS suppliers from the market.** The proposal looks to claims history to determine who supplied the largest volume and does not take into account beneficiary demand and supplier capacity.

## New Product Categories in the Bidding Program

- **CMS has exceeded its authority by proposing to include certain medical supplies such as ostomy, urological, and tracheostomy supplies in the bid program, potentially impacting patient choice for these products.** CMS inappropriately relies on legal justifications that disregard fundamental principles of statutory construction and inappropriate information to support the revised interpretation. Ostomy and urological supplies are carefully tailored to meet each patient's unique and often complex medical needs. Limiting the number of contract suppliers would limit patient choice and compromise continuity of care. In addition, a prior bidding demonstration that included urological supplies found that medical supplies are not suited for competitive bidding.
- **CMS should exclude liquid oxygen from the Competitive Bidding Program.** It is exceedingly costly to provide and very few beneficiaries have a medical need for this type of oxygen therapy.
- **CMS should exclude continuous glucose monitors ("CGMs") as this is relatively new technology with very limited number of manufacturers.** The addition of CGMs will introduce access barriers, administrative burden on suppliers, and stifle innovation.
- **CMS should exclude moving forward with reintroducing insulin infusion pumps to the bid program.** CMS previously included insulin infusion pumps and determined that they were not suited for competitive bidding, especially considering the fragile patient population that requires such therapy.
- **CMS should not reclassify CGMs and insulin infusion pumps and supplies to the "frequent and substantial servicing" payment category.** The items do not meet the legal requirements or definitions for such a change.

## Re-Accreditation and Provider Enrollment/Revocation

- **Annual re-accreditation is unwarranted, overly burdensome, and simply not feasible or practical.** The accreditation process is designed to determine compliance with Medicare Quality Standards; it is not a Medicare regulatory compliance process.
- **Provider enrollment and revocation proposals are unduly punitive.** The proposals seek to expand its unilateral revocation authority for a number of reasons that are unwarranted and without allowing the supplier to provide explanatory or corrective information.

Aug. 20, 2025