MEDPAC | Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Betty Rambur, Ph.D., R.N., F.A.A.N., Vice Chair
Paul B. Masi, M.P.P., Executive Director

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Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

**Attention: CMS-1828-P**

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies," *Federal Register*, vol. 90, no. 125, p. 29108 (July 2, 2025). We appreciate your staff's efforts to administer and improve the Medicare program for beneficiaries, taxpayers, and providers, particularly given the considerable demands on the agency.

Our comments address proposals in the rule related to Medicare payment policies for home health agencies (HHAs), including:

- Proposed calendar year (CY) 2026 home health payment update
- Proposed CY 2026 permanent and temporary budget-neutrality adjustments

We also comment on several of the proposed changes related to the DMEPOS Competitive Bidding Program (CBP) and other policies.

## Home health prospective payment system: Proposed CY 2026 payment update and permanent and temporary budget-neutrality adjustments

The proposed rule includes a 2.4 percent annual payment update to the home health prospective payment system (PPS) base payment rate, which is offset by a base rate reduction mandated by the Bipartisan Budget Act of 2018 (BBA of 2018). The combined

effect of these adjustments would result in a net 6.0 percent reduction to the home health base payment rate in 2026 compared to the prior year.[1]

The base rate reduction relates to a requirement of the BBA of 2018 that CMS implement certain changes to the home health PPS in a budget-neutral manner, ensuring that spending from 2020 to 2026 is equal to what it would have been had the changes not been enacted.[2] The statute directs CMS to apply permanent adjustments to the base payment rate when projected future spending deviates from the budget-neutrality target, and temporary adjustments when actual spending in prior years exceeds or falls short of the target.

For the permanent adjustment, CMS proposes a 4.059 percent reduction to the base rate in 2026 and future years. CMS has previously implemented only half of the permanent adjustment identified as necessary based on utilization data from 2020 to 2023. Additionally, the proposed adjustment also reflects results from a review of 2024 utilization that indicate that the gap between future expected spending and the budget-neutrality target has increased.

For the first time, CMS also proposes a temporary adjustment to the base rate. After reviewing spending from 2020 to 2024, CMS reports that expenditures exceeded the target by $5.301 billion. To begin addressing this higher spending, CMS proposes a 5 percent temporary reduction in 2026, which the agency estimates will recover $786 million—approximately 14.8 percent of the estimated higher spending from 2020 to 2024. CMS notes that further reductions will be necessary in future years to recover the remaining $4.515 billion. In future rulemaking, CMS will update the temporary adjustment target to reflect utilization data for 2025 and 2026, the final years covered under the BBA of 2018 requirements.

## *Comment*

The Commission supports the proposed 6.0 percent reduction in the home health base payment rate for CY 2026, as it is generally consistent with our recent recommendation calling for a 7 percent reduction in the base rate.

In our March 2025 report to the Congress, we assessed the adequacy of Medicare's fee-for-service (FFS) payments under the home health PPS, examining Medicare beneficiaries' access to care, quality of care, and the relationship of FFS Medicare payments to home health agencies' costs.[3] Our analysis showed that 98 percent of beneficiaries had access to two or more HHAs and quality indicators remained stable, while the average FFS Medicare margin for freestanding HHAs was 20.2 percent in 2023, indicating that FFS Medicare's payments remain substantially higher than providers' costs. In light of our analysis, we recommended that the base payment rate be reduced by 7 percent to better align

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[1] Table 26 of the proposed rule indicates the base rate will decline 6.0 percent in 2026 relative to the prior year.
[2] BBA of 2018 required CMS to implement two changes on January 1, 2020: The unit of payment in the home health PPS was shortened from 60 days to 30 days, and the number of therapy visits provided during the 30-day period was removed as a factor that determined payment for a 30-day period.
[3] Medicare Payment Advisory Commission. 2025. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare's payments with the costs of care. In the proposed rule, CMS's findings for 2024 further support the Commission's conclusion, indicating that the FFS base payment rate exceeded the estimated cost of a typical 30-day home health episode by about 33 percent.

CMS's proposed reduction is similar to the Commission's recommendation. We therefore support the proposal; we do not expect it to have adverse effects on FFS Medicare beneficiaries' access to home health care.

## DMEPOS Competitive Bidding Program: Determining payment amounts and the number of contracts

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated the phase-in of a CBP for selected durable medical equipment, prosthetics, orthotics, and related supplies (DMEPOS), starting in 2008. Under the CBP, suppliers that seek to participate are vetted for financial stability and must meet licensure and accreditation requirements. The DMEPOS CBP has several defining policies that have remained unchanged since the initiation of the program. Suppliers submit bids indicating the quantity of a given product that they can provide and the price that they are willing to accept. CMS estimates demand for a product in a competitive bidding area (CBA) and then awards contracts to suppliers, starting with the lowest bid and continuing until enough suppliers are selected to meet projected demand. The bid at which cumulative capacity meets or exceeds demand is referred to as the pivotal bid. Only suppliers with bids at or below the pivotal bid are awarded contracts, and the final payment amount, called the single payment amount (SPA), is based on their bids. The Medicare statute mandates that the DMEPOS CBP reduce Medicare expenditures. Accordingly, a key objective of CBP policy is to foster robust competition that leads to SPAs generating savings for both Medicare and its beneficiaries. FFS Medicare beneficiaries pay 20 percent coinsurance for DMEPOS items, highlighting the importance of appropriate prices.

CMS launched the first CBP round in 2011, followed by four rounds through 2018 that expanded it to new areas, added more DME items, and re-competed earlier rounds. In 2019 and 2020, there was a temporary gap period during which no rounds of competitive bidding were active.

In 2021, CMS held a CBP round covering 15 product categories in 130 CBAs. Of the 15 product categories, 13 had been included in prior rounds, and two—off-the-shelf back and knee braces—were newly included items. This round introduced a key change: The SPA was set at the pivotal bid rather than the median, effectively raising the SPA to the highest accepted bid. (Before 2021, the SPA was the median of accepted bids.)

After reviewing the 2021 bids, CMS did not award new contracts for the 13 previously included categories because the resulting SPAs would have increased Medicare spending by $1.2 billion, inconsistent with the statutory goal of achieving savings. However, bids for off-the-shelf back and knee braces produced lower SPAs than the existing fee schedule, so CMS awarded contracts estimated to save $934 million for these items. For categories without new contracts, the payment rates were set based on SPAs from prior rounds of competitive bidding, increased by inflation, and any licensed supplier could provide these

items. After the 2021 round, CMS announced it would study the results for the unsuccessful items to refine the program. Since then, payment rates for items that have been included in a previous round of the CBP are paid the prior year's rates, updated for inflation. Items that have not been included in any rounds of the CBP continue to be paid using a fee schedule that is based largely on 1986–1987 supplier charges (adjusted for inflation) and undiscounted list prices.

In this proposed rule, CMS's analysis of the unsuccessful 2021 DMEPOS competitions focuses on its methodology for estimating DMEPOS demand and provider capacity, which has not changed substantially since the initiation of the program. As noted earlier, CMS used these estimates to determine the number of contracts awarded in a competition. According to CMS, the methodology followed in CBP rounds from 2011 to 2021 was designed to overestimate demand and underestimate supplier capacity, and the rule cites several examples of this intended bias:

- Projected quantities of DMEPOS needed in a CBA were increased when the Part B FFS Medicare population was expected to grow in the area but not decreased for CBAs expected to experience a population decline.

- Demand was not reduced for items likely to be provided by "grandfathered" suppliers. (A grandfathered supplier is one that was not awarded a contract in a competition, but which elects to continue to furnish products to beneficiaries it served prior to implementation of the new round of bidding the CBP.)

- New suppliers' capacity wasn't included in pivotal bid calculations.

- Suppliers were capped at 20 percent of projected demand if they bid higher quantities.

Setting the SPA at the pivotal bid—that is, at the highest bid among selected bidders—rather than the median also made competitions more vulnerable to outlier bids. For example, the proposed rule notes an example from an unsuccessful competition in 2021 where the pivotal bid for an item was 26 percent higher than the next lowest bid.

CMS also found that many 2021 bids included limited or very low quantities. For instance, 47 percent of oxygen equipment bidders said they would not be willing to provide any additional concentrators (a type of oxygen equipment) than they had historically, and 8 percent submitted the minimum bid of one item per month. CMS reports that prior to the round of competitive bidding in 2021, an industry consultant advised suppliers that low-quantity bids could increase the number of contracts awarded and raise SPAs, reducing the risk of a supplier losing a competition while potentially raising the price they received. Importantly, the quantity portion of a supplier's bid is not binding. Once CMS awards a contract to a supplier, the supplier is not obligated to adhere to the capacity specified in their bid and may deliver more or less of the item. CMS notes that low-quantity bids would inflate SPAs regardless of whether the median bid or pivotal bid was used.

In this proposed rule, CMS concludes that the CBP methodology needs revisions to ensure that future competitions result in the savings required by Medicare statute.[4] CMS now contends that achieving lower SPAs will require reducing the number of selected bidders by about 25 percent, and that access to DMEPOS should remain adequate even with fewer suppliers. In addition, CMS has determined that future CBP rounds should not rely on estimates of the quantity of items that suppliers report being willing to provide, given the difficulty of validating and using such data to reliably estimate aggregate supplier capacity.

Instead of using estimated supplier capacity to determine the number of winning contracts needed to meet beneficiary demand, CMS now proposes to set the number of winning contract suppliers in a competition at twice the number of suppliers who provided at least 5 percent of the item or service in the previous competition, adjusted for Part B enrollment changes. CMS proposes to limit the number of contracts based on suppliers with at least 5 percent of the market because such suppliers have historically accounted for most of the supply, and CMS expects that adequate access can be maintained with fewer suppliers. CMS proposes to select double the number of suppliers that furnished at least 5 percent of the market to mitigate the risk of awarding too few contracts. CMS also proposes a floor and ceiling for the number of winning contracts, such that the number of contracts can be no lower than 50 percent and no more than 75 percent of the total suppliers awarded contracts in the prior competitions. The proposed rule outlines multiple instances in which CMS can award additional contracts, such as if a contract is declined or if the agency deems it necessary to meet beneficiary demand.

CMS also proposes reducing the SPAs from the pivotal bid, or highest bid among accepted bids, to the 75th percentile of accepted bids. Using data from the 2017 round of DMEPOS CBP, CMS simulated how these reforms would affect the number of suppliers and SPAs if suppliers did not adjust their bids in response to the new system. For example, for oxygen and oxygen equipment in Pittsburgh, PA, CMS's simulations found that, under the proposed rules, the SPA would decline modestly (by 9 percent), and the number of contracts awarded would decrease from 28 to 20.

## *Comment*

The Commission has long supported competitive bidding for DMEPOS items in FFS Medicare.[5] The program has reduced Medicare spending and beneficiary cost sharing and premiums by setting payment rates based on supplier bids rather than on an outdated fee schedule. For example, CMS estimates in the proposed rule that the second round of CBP

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[4] Medicare statute requires that the CBP result in lower spending than what Medicare would have paid under the traditional DMEPOS fee schedule. For items new to competition, this requirement means that spending must be below the legacy rates; for items previously included in CBP, the benchmark is the adjusted fee schedule based on prior bidding rounds. The proposed rule would raise this benchmark to 110 percent of the adjusted fee schedule. CMS justifies this increase by noting that earlier CBP rounds led to reduced DMEPOS utilization, suggesting that total spending should still decline even if bid prices rise slightly.

[5] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf.

saved Medicare $2 billion in 2013 and significantly lowered beneficiary cost sharing and Part B premiums.

The DMEPOS CBP promotes market-based pricing that encourages competition and efficiency among suppliers. Previous evaluations by CMS and the Government Accountability Office found no systematic negative effects of the program on beneficiary access to care or on quality of care.[6] Resuming competitive bidding as soon as practicable would improve Medicare DMEPOS payments and protect beneficiaries and taxpayers from fraudulent or inefficient suppliers.[7]

CMS's analysis of the 2021 round aligns with our 2018 comments on the pivotal bid methodology.[8] We noted that setting SPAs equal the pivotal bid would ensure that no supplier was paid less than their bid but that this approach could lead to higher-than-necessary SPAs if demand were overestimated or supplier capacity underestimated. The Commission appreciates that the proposed policy reflects our concerns with CMS's estimates of the quantity demanded and supplier capacity. We also concur that preventing artificially low quantity bids is challenging and that CMS should not use quantity bids when they are not reliable. However, we are concerned that CMS's proposed method for identifying the number of suppliers does not have a direct relationship to the expected beneficiary demand for DMEPOS in an area. CMS should not delay the resumption of the DMEPOS CBP to address this issue, but we encourage CMS to explore alternative approaches in the future that more directly align expected demand and supplier capacity.

Ensuring adequate access to DMEPOS is critical. We note that CMS's methodology includes a review of the capacity of bidders that are awarded contracts, and that CMS can add additional suppliers if it concludes that the selected suppliers will not have adequate capacity to satisfy beneficiary demand for DMEPOS. This approach will provide an additional safeguard. We also urge CMS to continue its health status monitoring, which tracks outcomes for beneficiaries subject to CBP. Though CMS has reported no negative outcomes to date, continued monitoring protects the interests of beneficiaries and the Medicare program.[9]

The Commission cautions that achieving savings in future CBP rounds may be more difficult, due to the success of earlier rounds rather than flaws in CMS policy. As

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[6]Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Durable medical equipment, prosthetics, orthotics, and supplies competitive bidding program health status monitoring summary of findings thru the second quarter of 2024. https://www.cms.gov/medicare/medicare-fee-for-service--payment/dmeposcompetitivebid/downloads/dme-summary-of-findings.pdf.
Government Accountability Office, 2014. *Medicare: Second year update for CMS's Durable Medical Equipment Competitive Bidding Program Round One Rebid.* GAO–14–156. Washington, DC: GAO.

[7] Government Accountability Office. 2016. *Medicare: CMS's Round 2 Durable Medical Equipment and National Mail-order Diabetes Testing Supplies Competitive Bidding Programs*. GAO-16-570. Washington, DC: GAO. https://www.gao.gov/assets/gao-16-570.pdf.

[8] Medicare Payment Advisory Commission. 2018. Comment on CMS's proposed rule on the ESRD PPS update for CY 2019 and DMEPOS Competitive Bidding Program. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08312018_esrd_cy2019_dme_medpac_comment_v2_sec.pdf

[9] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025. Health status monitoring. https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding/health-status-monitoring.

Medicare's legacy DMEPOS fee schedule is based on antiquated fees increased by inflation, achieving savings is relatively easy in initial rounds when items are first competed. In later rounds, when Medicare's SPAs reflect the market-based bids from earlier rounds, it may be more challenging for suppliers to produce lower bids, though the bid amounts will likely still be lower than Medicare's legacy DMEPOS fee schedule. The experience of later CBP rounds in 2014 through 2018 indicates that the program can benefit from lower SPAs over repeated competitions.

## DMEPOS supplier accreditation

CMS has concluded that its accreditation process for DMEPOS suppliers must be strengthened to help address fraud, waste, and abuse. Under Medicare statute, DMEPOS suppliers are required to be accredited by a CMS-approved accrediting organization (AO) to participate in the program. These AOs are responsible for ensuring supplier compliance with Medicare requirements across several domains, including administrative operations, financial management, staffing, beneficiary services, and patient rights. Currently, DMEPOS suppliers must undergo an unannounced survey once every three years following initial accreditation.

In the rule, CMS reviewed several recent cases of fraud involving DMEPOS suppliers and found that the scope of the problem is substantial, varied in the aspects of the Medicare program being exploited, and geographically widespread. These cases included activities such as furnishing items that were not medically necessary and billing Medicare for more expensive items than those actually provided. One notable case involved a contractor for a DMEPOS AO who accepted bribes to expedite accreditation, established DMEPOS suppliers that concealed the contractor's ownership, and held direct or indirect ownership stakes in suppliers the contractor was responsible for surveying. These findings led CMS to conclude that both the accreditation process and oversight of AOs require significant strengthening.

The proposed rule introduces several changes to the accreditation process. Examples of the proposed changes include:

- Enhanced documentation requirements for AO policies and procedures
- Additional information requirements for organizations applying to become Medicare-authorized accreditors
- A new "re-approval" process for renewing AO authority with CMS
- Stricter conflict-of-interest management protocols for AO surveyors and staff
- New authority for CMS to suspend or place AOs on probation (current regulations only allow CMS to terminate an AO for ineffectiveness)

Additionally, CMS proposes increasing the frequency of supplier surveys and reaccreditation to at least once every 12 months.

### *Comment*

The Commission supports CMS's efforts to improve program safeguards by increasing oversight of DMEPOS suppliers and improving the efficacy of AO. As the rule notes, there have been significant instances of fraud in Medicare DMEPOS in recent and past years, increasing expenditures for the Medicare program and beneficiaries. Changes to ensure that AOs serve their expected role will give CMS additional tools to ensure the integrity of the Medicare DMEPOS benefit. We also support the proposal to increase the survey frequency to once a year. More frequent surveys, coupled with the changes to improve the efficacy of AOs, will provide Medicare with additional tools to protect the interests of beneficiaries and taxpayers. The proposed changes address vulnerabilities identified by CMS in the rule and increase the utility of AOs and accreditation for Medicare.

## Revising the definition of "item" related to medical supplies

Medicare statute gives the Secretary authority to determine the DMEPOS items included in the CBP, and in the rule CMS proposes to add ostomy, tracheostomy, and urologic supplies to the types of items that can be subject to CBP.

### *Comment*

In our June 2018 report to the Congress, the Commission supported applying CBP to a broader range of items, and so we support the proposal to add ostomy, tracheostomy, and urologic supplies.[10] Our June 2018 report to Congress noted that payments for two common ostomy supplies were significantly higher than private payer rates, making them strong CBP candidates. As noted in the proposed rule, the Office of Inspector General found that Medicare payments for urinary catheters in 2020 were over three times higher than suppliers' estimated acquisition costs.[11] Overpaying for these and the other proposed items unnecessarily increases both Medicare spending and beneficiary cost sharing. The proposed rule also notes a recent case where DMEPOS suppliers allegedly billed Medicare for catheters that physicians did not order and that beneficiaries did not need.[12] CMS should implement the proposed change and review other items currently excluded from CBP as potential candidates for the program.

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[10] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf.
[11] Office of Inspector General, Department of Health and Human Services. 2022. *Reducing Medicare's payment rates for intermittent urinary catheters can save the program and beneficiaries millions of dollars each year*. OEI-04-20-00620. Washington, DC: OIG. https://oig.hhs.gov/reports/all/2022/reducing-medicares-payment-rates-for-intermittent-urinary-catheters-can-save-the-program-and-beneficiaries-millions-of-dollars-each-year/.
[12] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. *Urinary catheter case study: CMS' swift action saves billions*. Washington, DC: CMS. https://www.cms.gov/files/document/cpi-urinary-catheter-case-study.pdf.

## Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair