

HME Legislative Update

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The 119th Congress

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VGM's Focus on HME Legislation - 2026

1. HR 2005 - Extending 75/25 blended non-rural, non-CBA Medicare reimbursement rates. These rates influence other payers who peg reimbursements based on these rates, including Medicaid rates in 21 states as well as TRICARE rates.
2. Work with Congress on legislation to include titanium/carbon fiber upgrades for mobility products as a Medicare benefit. (HR 1703/S. 247)
3. Monitor Federal legislation on "right to repair" issues and potential impacts on mobility providers, manufacturers, and patients.
4. Monitor developments regarding expanding telehealth flexibilities and making them permanent. (CONNECT ACT)
5. Work with Congress to encourage CMS to provide clarity on their plans for the Competitive Bidding (CB) program.

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Current HME Legislation & Regulation

HME

- Extending 75/25 blended non-rural, non-CBA Medicare reimbursement rates.(H.R.2005, S.2951)
- These rates influence other payers who peg reimbursements based on these rates, including Medicaid rates in 21 states as well as TRICARE rates.
- H.R. 2005 - 24 Co-Sponsors; Introduced by Miller-Meeks (R-IA), Tonko (D-NY)
- S.2951 - 4 Co-Sponsors; Introduced by Lankford (R-OK), Hassan (D-NH)

Action Items: Working on co-sponsors and Senate Companion

CRT


- Work with Congress on legislation to include titanium/carbon fiber upgrades for mobility products as a Medicare benefit.
- H.R. 1703 - 9 Co-Sponsors; Introduced by Joyce (R-PA)
- S. 247 - Introduced by Blackburn (R-TN) and Duckworth (D-IL)

Action Items: Working with other Industry Leaders on support for House and Senate bills.

Telehealth

- Expands coverage of telehealth services, making the Covid-19 flexibilities permanent. (H.R. 4206/S.1261)
- HR 4206 - Introduced by M.Thompson (D-CA) with 229 Co-Sponsors;
- S. 1261 - Introduced by Schatz (D-HI) with 74 Co-Sponsors

Actions Items: Gain support for S.1261 and H.R. 4206



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Current HME Legislation & Regulation

SOAR ACT- H.R. 2902

- Improve Supplemental Oxygen Access And Medicare Protections
- Electronic template to protect patients and providers against fraud and abuse.
- Creating a stable Medicare reimbursement rate
- Aid-on payment
- 35 Co-Sponsors, Introduced by Rep. Valadao (R-CA)

Action Items: Working with CQRC; additional co-sponsors


NIV

- The proposed National Coverage Determination introduces significant changes, including restrictions on coverage and increased administrative requirements.
- No grandfathering clause for current RAD/NIV users.
- Mandatory re-evaluation after six months of use.
- Usage of at least five hours per day on average is required.
- Devices must be utilized within 24 hours of hospital discharge.

Tariffs

- Hoping for an exception - Letter to White House
- Nairobi Protocol
- Can't pass difference onto customers

Action Items: Talk Tariffs (USM & Nairobi)




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H.R. 2005/S. 2951 DMEPOS Relief Act of 2025

H.R. 2005 - 24 Co-Sponsors; Introduced by Miller-Meeks (R-IA), Tonko (D-NY)
S.2951 - 4 Co-Sponsors; Introduced by Lankford (R-OK), Hassan (D-NH)

- Extends 75/25 Blended rate for reimbursement for nonrural areas under CB
- Due to mounting concerns about the impacts of Medicare's cost-cuts on access to care, Congress and Centers for Medicare and Medicaid Services (CMS) have intervened numerous times through the years to provide additional relief, most recently providing a 75/25 blended rate for non-bid, non-rural areas through 2023 (75% Competitive Bid rate/25% unadjusted Medicare fee schedule rates).
- The expiration of the 75/25 blended rate on January 1, 2024 led to a 20% reduction across the top 25 HCPCS codes,1 dealing a crushing blow to the industry and threatening to decimate the HME infrastructure that enables people to manage their medical needs at home.





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H.R. 2005/S. 2951 DMEPOS Relief Act of 2025

In July 2024, the American Association for Homecare (AAHomecare) launched a nationwide survey on the impact of the expired Medicare FFS 75/25 blended rate for non-bid/non-rural areas on the HME community. Over 100 HME suppliers serving non-bid non-rural areas participated, sharing harsh realities they face under the new rates and their ability to serve patients and communities.


The decrease in reimbursement across non-bid, non-rural areas has made a dramatic impact on the HME community. An overwhelming 93.5% of survey respondents reported having to make company changes in response to the 75/25 rate reduction. Notably:

- a. 65% reduced the amounts and/or types of products offered
- b. 46% reduced their service areas
- c. 53% laid off staff
- d. 35% used personal savings to maintain the business
- e. Over 1 in 10 surveyed are actively considering or planning closing their business entirely


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H.R. 1703/S.247 Choices for Increased Mobility Act of 2025




**H.R 1703 – 9 Co-Sponsors; Introduced by Joyce (R-PA)
S. 247 – Introduced by Blackburn (R-TN) and Duckworth (D-IL)**

1. Requires the Centers for Medicare & Medicaid Services (CMS) to establish specific billing codes under Medicare for certain materials used in ultralightweight manual wheelchairs.
2. Currently, Medicare does not have specific billing codes for different materials used in these wheelchairs, which can lead to inadequate reimbursement and higher out-of-pocket costs for beneficiaries. By establishing distinct billing codes for wheelchair bases made with materials like titanium or carbon fiber, the bill aims to ensure more accurate reimbursement, reduce financial burdens on beneficiaries, and improve access to high-quality mobility aids.
3. No cost to CMS as beneficiary covers the difference in cost




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“Right to Repair” Issues




<p>Step 1- CRT User Repair inquiry <i>Expand CRT user access to non-medical transportation to come to our facility.</i></p> <p>Step 2- Evaluation and Parts Quote <i>Expand CRT user access to non-medical transportation to come to repair facility, could speed up repairs by 2-3 weeks.</i></p> <p>Step 3- Insurance Documentation Collection & Prior Authorization <i>The wheelchairs have already been prior approved prior to initial delivery.</i> <i>For Repairs only- Eliminating prior authorization, prescriptions, and medical documentation will reduce repair times by 3-4 weeks.</i></p>	<p>Step 4- Order and Ship Parts <i>Providers keep the top parts in inventory for repairs, any customized or non-standard parts would take additional time.</i></p> <p>Step 5- Provider coordinates and completes repairs <i>If prior authorization were eliminated and consumers could utilize non-medical transportation to repair facilities, a large percentage of repairs can be completed within 1-2 days.</i></p>
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“Right to Repair” Issues




FACTS/STATS

ADDITIONAL POLICY CHANGES TO SPEED UP REPAIRS

- Insurance coverage of preventive maintenance twice a year would help to avoid catastrophic chair breakdowns and significant, costly repairs during the useful life of the chair.
- If insurance companies reimbursed CRT providers for travel and evaluation time for in-home repair appointments, CRT providers could provide this valuable service at greater levels.

- 5.5 Million Americans rely on CRT Equipment.
- 5-Year - Average "useful life" for a complex wheelchair, though repairs will be needed throughout the lifetime of the chair.
- Medicare/No Prior Authorization - Medicare does not require prior authorization for CRT repairs thereby speeding up repairs for medicare beneficiaries
- 82% of repairs are completed in CRT users' homes
- 98.2% - Nationally, prior authorization is approved 98.2% of the time, meaning CRT users are currently waiting 1-4 weeks for insurance approvals that are almost always




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Telehealth Flexibilities

Congress passed the Consolidated Appropriations Act of 2026 (H.R. 7148), signed into law on February 3, 2026, which extends pandemic-era Medicare telehealth flexibilities through December 31, 2027. These extensions include:

- Home and geographic waivers: Medicare beneficiaries can receive telehealth services in their homes without rural or facility-based restrictions.
- Expanded provider eligibility: Physical therapists, occupational therapists, speech-language pathologists, audiologists, and other eligible practitioners can furnish telehealth services through 2027.
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): These facilities can serve as distant-site telehealth providers for nonbehavioral services through 2027.



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Telehealth Flexibilities

- Audio-only telehealth: Nonbehavioral services may be delivered via audio-only platforms when clinically appropriate, while behavioral health audio-only services are now permanent.
- Mental health and hospice: In-person visit requirements for mental health telehealth are waived through January 1, 2028, and telehealth can be used for hospice recertification encounters through 2027.
- Acute Hospital Care at Home Program: Extended through September 30, 2030, supporting home-based hospital care.
- In-home cardiopulmonary rehabilitation: Flexibilities extended through January 1, 2028.
- Guidance for limited English proficiency: HHS is required to issue guidance within one year on providing telehealth services to individuals with limited English proficiency.




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H.R 4206/S.1261 CONNECT for Health Act of 2025

H.R 4206 - 229 Co-Sponsors; Introduced by Thompson (D-CA)
S.1261 - 74 Co-Sponsors; Introduced by Schatz (D-HI)

This bipartisan bill removes barriers to telehealth and makes many pandemic-era flexibilities permanent:

- Eliminates geographic and originating site restrictions.
- Expands practitioner eligibility, expanded access for FQHCs, RHCs, and Native American facilities.
- Repeals the six-month in-person requirement for telemental health.
- Strengthens program integrity with fraud prevention and billing oversight.
- Supports provider training and beneficiary engagement.
- Mandates inclusion of telehealth in quality metrics.
- Use of telehealth in hospice care and public health emergencies.




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H.R 4206/S.1261 CONNECT for Health Act of 2025

1. Policy Rationale

- a. Improved Access to Care**
 - i. It bridges gaps for rural, elderly, and mobility-challenged populations.
 - ii. It reduces travel burdens and wait times, especially for specialty care.
- b. Cost Efficiency and Quality**
 - i. Studies show telehealth reduces unnecessary ER visits and hospitalizations.
 - ii. It enables proactive chronic disease management and mental health support.
- c. Workforce Optimization**
 - i. Telehealth allows clinicians to serve broader populations and collaborate across regions.
 - ii. It mitigates provider shortages in underserved areas.
- d. Patient Satisfaction**
 - i. In 2023, 90% of telehealth users reported satisfaction with their care experience.
- e. Accessibility**
 - i. Audio-only and multilingual support provisions ensure access for vulnerable groups.
 - ii. Telehealth supports culturally competent care and language accessibility.



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Final Rule/Competitive Bid Program


June 30, 2025 CMS released Proposed Rule (CMS-1828-P), published in Federal Register July 2 with 60 day public comment period

-952,000+ comments with 10,000+ HME specific comments

-Final Rule Published 11/28/25. Summary:

1. New CBP Product Categories

- a. Ostomy, tracheostomy, and urological supplies**
 - i. Definitions were revised to categorize each as medical equipment and thus subject to CBP inclusion
- b. Continuous Glucose Monitoring (CGM) and insulin pumps**
 - i. Class II reclassified under the Frequent and Substantial Servicing (FSS) payment category
 - ii. Payment on a bundled monthly rental basis for both CBP and non-CBP areas
- c. Off-the-shelf Upper Extremity Orthotics**



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Final Rule/Competitive Bid Program

2. Remote Item Delivery (RID) CBP
 Creates a nation-wide remote item competitive bid program for products that are frequently drop shipped, delivered, or picked up at a contracted supplier location

Products announced via the fact sheet for inclusion in the RID CBP are:

- Ostomy
- Urological
- Hydrophilic urinary catheters
- CGM
- Off-the-shelf upper extremity orthotic products
- Off-the-shelf back and knee orthotic products




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Final Rule/Competitive Bid Program

3. DMEPOS CBP
 Product categories not included in the RID program are to be announced early spring/late summer 2026 along with the lead item for each category and the number of contracts to be awarded

4. SPA Calculation

- a. Revises SPA calculation to use the 75th percentile of winning bids for the lead item instead of the maximum winning bid
- b. Revises the ratio for non-lead items in a product category to be based on the 2015 fee schedule rate for each specific CBA (rather than the national average that was used for Round 2021)




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Final Rule/Competitive Bid Program

5. Contract Award Determinations
 Limits the required number of contracts to less than ten(10) per each product category

6. Bid Limits and Conditions for Awarding Contracts if Savings are Not Expected

- Items included for the first time: the bid limits would be the then current fee schedule
- Previously included items: the bid limits would be the most recent SPA for the items plus 10 percent. If it has been more than a year since the SPA was last in effect, the inflation-adjusted SPA plus 10 percent.
- In no event would the bid limit be allowed to exceed the unadjusted fee schedule amount




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Final Rule/Competitive Bid Program

7. Financial Documentation Changes

- a. A credit report with a numerical credit score and/or rating from one of the four approved credit reporting agencies during the bid window; or if not available, a business credit report showing no data or insufficient information to generate a score or rating plus a personal credit report with a numerical credit score or rating from the bidding entity's Authorized Official or Delegated Official in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
- b. Bid surety bond in the amount of \$50,000 for each CBA for which submitting a bid. Bid surety bonds are specific to the CBP and are an additional bond to what is required to maintain billing privileges.




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Final Rule/Competitive Bid Program

8. New Contract Clause
Addition of a new clause allowing CMS to unilaterally terminate or modify supplier contracts if certain conditions are met due to a PHE allowing CMS to revert to the general fee-for-service program requirements.

9. Other Provisions Outside of CBP:

- a) Accreditation
Requires DME suppliers to get reaccredited annually instead of every three (3) years
- b) Provider Enrollment
-Provides several instances in which PTANs may be revoked retroactively
-Requires Authorized Official signature for liability insurance
- c) Prior Authorization
Creates a prior authorization exemption program of certain DMEPOS products for suppliers that reach an affirmation threshold of 90%




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New HME Legislation & Regulations

Diabetes Interventions Addressing Barriers to Enrollment, Technology and Education Services (DIABETES) Act – S.4037

- Designed to improve access to diabetes technologies and education for Medicare beneficiaries
- Particular focus on preventing disruptions in care when individuals transition from commercial insurance into Medicare.
- The bill responds to growing concerns that current Medicare coverage policies—particularly competitive bidding and limited education access—can undermine effective diabetes management and worsen health outcomes.

March 11, 2026 - Introduced by Sen. Shaheen (D-NH); Sen. Collins (R-ME)




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(DIABETES) Act – S.4037

Key Policy Problems Addressed

- Disruptions in access to insulin pumps and continuous glucose monitors (CGMs) when patients enroll in Medicare
- Medicare competitive bidding policies that may jeopardize access to complex, life-sustaining diabetes technologies
- Insufficient access to diabetes self-management training and technology education for Medicare beneficiaries
- Lack of continuity of care standards aligned with current clinical guidelines




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(DIABETES) Act – S.4037

Major Components of the DIABETES ACT

- 1. Five-Year Exemption from Medicare Competitive Bidding
 - Exempts insulin pumps and continuous glucose monitors (CGMs) from the Medicare DMEPOS Competitive Bidding Program for five years.
 - Intended to prevent forced device rental models, supply disruptions, and reduced patient choice that could result from competitive bidding inclusion.
 - Addresses CMS policies that stakeholders warned could negatively affect patient access and outcomes.
- 2. Improved Continuity of Care During Medicare Enrollment
 - Ensures individuals with diabetes do not experience gaps in treatment or device access when transitioning into Medicare coverage.
 - Recognizes diabetes as a lifelong condition requiring uninterrupted access to proven technologies and supplies.




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(DIABETES) Act – S.4037

Major Components of the DIABETES ACT

- 3. Strengthened Access to Diabetes Self-Management Training (DSMT)
 - Builds on the separately introduced Expanding Access to Diabetes Self-Management Training Act.
 - Supports broader Medicare coverage of DSMT services delivered by certified diabetes educators.
 - Aims to improve beneficiary understanding and effective use of advanced diabetes technologies, including pumps and CGMs.
- 4. National Coverage Determination for Insulin Pumps
 - Directs the Secretary of Health and Human Services (HHS) to issue a proposed National Coverage Determination (NCD) for insulin pumps.
 - Requires coverage policy to be based on current clinical guidelines and evidence, promoting consistency and modernized standards across Medicare.



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New HME Legislation & Regulations

HHS HME 6-Month Moratorium

In February 2026, CMS imposed a nationwide six-month moratorium on new Medicare DMEPOS medical supply company enrollments, effective February 27, 2026. While existing suppliers may continue operating, the moratorium introduces significant uncertainty and constraints across the industry.

Implications for Suppliers

- No new Medicare enrollments during moratorium period
- New practice locations prohibited; can open warehouse/distribution sites
- M&A and ownership changes may be delayed or halted
- Disruption to competitive bidding preparation
- Heightened enrollment scrutiny and enforcement risk
- Potential access and impact in underserved markets



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New HME Legislation & Regulations

**CMS Administrative Simplification Final Rule
Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures**

CMS Rule: CMS-0053-F
Agency: Centers for Medicare & Medicaid Services (CMS), HHS
Release Date: March 20, 2026
Effective Date: May 26, 2026
Compliance Date: May 26, 2028

Overview

CMS finalized a landmark administrative simplification rule establishing the first-ever HIPAA-adopted national standards for the electronic submission of health care claims attachments and associated electronic signatures. The rule modernizes claims processing by replacing manual, paper-based workflows—such as fax and mail—with standardized electronic transactions, with the goal of reducing administrative burden, accelerating claims adjudication, and improving overall system efficiency.



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New HME Legislation & Regulations

**CMS Administrative Simplification Final Rule
Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures**

Policy Problem Addressed

- Health care claims attachments (e.g., medical records, clinical notes, imaging, lab results) are often exchanged via fax, mail, or proprietary payer portals, creating inefficiencies and delays
- Lack of uniform national standards has led to fragmented workflows, higher administrative costs, and slower claims payment
- Providers and payers spend significant time and resources managing manual documentation processes rather than patient care

CMS estimates billions of pages of faxed documentation are still exchanged each year, contributing to unnecessary administrative expense and delays in claims processing.



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New HME Legislation & Regulations

CMS Administrative Simplification Final Rule
Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures

Expected Benefits
 CMS estimates the final rule will deliver significant system-wide benefits, including:

- Annual cost savings of approximately \$781 million
- Reduced administrative burden for providers and payers
- Faster claims processing and reimbursement
- Improved data security and auditability
- Greater administrative efficiency and workforce productivity

Implementation Timeline
 Effective: May 26, 2026
 Compliance Required By: May 26, 2028
 CMS provided a two-year implementation period to allow stakeholders to update systems, workflows, and vendor relationships.




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Lessons Learned/Strategy

Medicare Savings 2011-2024
 For every \$ invested in DME

Year	Mobility DME	O2 Therapy	CPAP
2011	\$10.73	\$6.07	\$6.21
2014	\$29.19	\$9.63	\$6.79
2017	\$39.00	\$14.80	\$11.88
2021	\$95.14	\$23.84	\$11.97
2024	\$62.38	\$42.96	\$10.21



- KISS
- Barriers vs Access
 - Closures/Proximity/Amazon
- Savings to CMS
 - HME vs Hospital
 - Increased spend in Part B saves in Parts A & D
 - Invest in HME



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HME – “We Just make Cents”

Potential CMS Savings:

- Mobility - \$76.3B
- Supplemental O2 - \$29.7B
- CPAP - \$23.9B


Total: \$129.9B




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Key Legislator Focus

<p>Representatives</p> <p>Ways & Means</p> <ul style="list-style-type: none"> • Jason Smith (R-MO) Chair • Josely Amington (R-TX) • Adrian Smith (R-NE) • Greg Murphy (R-NC) • Hiron (R-OK) • Moore (R-UT) • Feenstra (R-IA) • David Kustoff (R-TN) • Neal (D-MA) Ranking Member • Carol Miller (R-WV) • Sewell (D-AL) • Arrington (R-TX) • Boyer (D-VA) <p>Energy & Commerce</p> <ul style="list-style-type: none"> • Gohmert (R-TX) Chair • Miller-Meeke (R-VA) • Houston (R-IN) • Hudson (R-NC) • Burgess (R-TX) • Cramer (R-GA) • Pallone (D-NJ) Ranking Member • Tonko (D-NY) • Hironaka (R-TN) • Allen (R-GA) • Torres (D-NY) • Dingell (D-MI) • McClain (D-VA) 	<p>Senate</p> <p>Finance</p> <ul style="list-style-type: none"> • Crapo (R-ID) Chair • Grassley (R-IA) • Thune (R-SD) • Daines (R-MT) • Scott (R-SI) • Cassidy (R-LA) • Lankford (R-OK) • Tillis (R-NC) • Blackburn (R-TN) • Wyden (D-OR) Ranking Member • Warnock (D-GA) • Cantwell (D-WA) • Bennet (D-CO) • Warner (D-VA) 	<p>Strategic Champions</p> <ul style="list-style-type: none"> • Johnson (R-LA) Speaker of the House • Grassley (R-IA) Appropriations • Hironson (R-IA) Appropriations • Adenhotel (R-AL) Appropriations • Bice (R-OK) Appropriations • Carl (R-AL) Appropriations • Zinke (R-MT) Appropriations • Blitt (R-AL) Appropriations • Mullin (R-OK) Appropriations • Cassidy (R-LA) HELP Chair • Baldwin (D-WI) HELP • Hassan (D-NH) HELP • Blackburn (R-TN) HELP • Crapo (R-ID) HELP • Kaine (D-VA) HELP
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Your Legislators

Michigan

- **Senators**
 - Gary Peters (D)
 - Elissa Slotkin (D)
- **Representatives**
 - Jack Bergman (R) 1st District
 - John Moolenaar (R) 2nd District
 - Hillary Scholten (D) 3rd District
 - Bill Huelsenga (R) 4th District
 - Tim Walberg (R) 5th District
 - Debbie Dingell (D) 6th District **House E&C**
 - Tom Barrett (R) 7th District
 - Kristen McDonald Rivet (D) 8th District
 - Lisa McClain (R) 9th District
 - John James (R) 10th District **House E&C**
 - Haley Stevens (D) 11th District
 - Rashida Tlaib (D) 12th District
 - Shri Thanedar (D) 13th District




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Thank you!

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