HME Payer Advocacy Medicaid & Managed Care

David Chandler
May 21, 2026

The Ripple Effect: Evolving Care at Home 2026

1

Presented By:

David Chandler
Vice President, Payer Relations
American Association for Homecare

2

What is OB3?

The "One Big Beautiful Bill"

- Signed into law by President Trump 7/4/25 *(Public Law 119-21).*
- Extends and modifies several tax changes from 2017 Tax Cuts & Jobs Act that were set to expire.
- Makes significant changes and cuts to health care and other programs, many of which run by the states.

State impacts vary based on each state's fiscal health and exposure to federal programs.

3

Medicaid Federal Spending Cuts

The Congressional Budget Office (CBO) Estimates:

$1 Trillion Reduction in Federal Spending Over 10 Years	10 Million People Will Become Uninsured Over 10 Years	10.5 Million Reduction in Medicaid Enrollment By 2034
This is 15% of federal spending		*Per 6/24/25 CBO House Letter*

**CBO analysis assumption: states would replace half of the reduced federal funds with their own resources*

OF NOTE: Cuts impacting expansion states only account for $526 billion of reductions

4

Medicaid Federal Spending Cuts

How and When Most Significant Medicaid Expenditure Cuts Hit State Budgets

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Work Requirements			$13.1	$19	$39.8	$46.2	$48.4	$50.7	$53.1	$55.6
Provider Tax Freeze & Wind Down		$2.8	$4.7	$7.6	$12.3	$18.6	$26.7	$34.1	$39.3	$45
State Directed Payments Freeze & Wind Down		$5.5	$7.5	$9.3	$13.3	$16.6	$19.6	$22.8	$25.9	$29
Six Month Redeterminations			$5.1	$7.1	$7.5	$7.8	$8.2	$8.6	$9	$9.4
Requirements on Waiver of Uniform Tax		$3.2	$3.4	$3.5	$3.7	$3.8	$4	$4.2	$4.3	$4.5
Reducing the Emergency Medicaid FMAP			$2.5	$3.2	$3.3	$3.5	$3.7	$3.9	$4.1	$4.4
Proportion of Key Provision Cuts Hitting State Budgets	**0%**	**1.4%**	**4.6%**	**6.3%**	**10.1%**	**12.2%**	**14%**	**15.7%**	**17.1%**	**18.7%**

HR 1 will cut $1.02 trillion from federal Medicaid spending to states. However, these six provisions make up more than $792 billion of those enacted cuts.
Source: Estimated Budgetary Effects of An Amendment in the Nature of a Substitute to H.R. 1 (June 26, 2025), Congressional Budget Office.

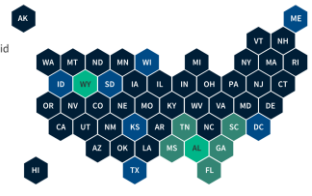
5

Medicaid Budget State Impact

Federal Medicaid Cuts in the Senate Reconciliation Bill, By State

As a percent of 10-year baseline federal Medicaid spending (2025-2034)

- < 7%
- 7% - 10%
- 10% - 13%
- ≥ 13%



Source: KFF analysis of CBO estimates of the Senate Reconciliation Bill

6

Operational Strategies

Verify Eligibility Benefits	*Financial Forecasting*	*Technology Adoption*
Strengthen operational processes to include verifications with every product shipment and monthly claim validation.	Strengthen financial forecasting and scenario planning to anticipate revenue changes and risks. Understand your organization's collection policy for uninsured patients.	Expand telehealth, remote monitoring, and automation to boost efficiency and reduce costs.
Policy Monitoring Importance	***Advocacy Engagement***	***Industry Partnerships***
Tracking Medicaid changes regionally helps suppliers adapt to diverse patient demographics effectively.	Engaging in payer relations and legislative advocacy empowers suppliers to influence supportive healthcare policies. Have key resources ready to go.	Collaborating with associations like AAHomecare and your state/regional association provides coordinated advocacy and resource access.

7

MEDICAID STATE OUTLOOK

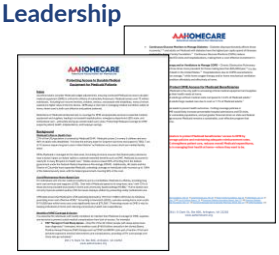
AAHomecare State Scan: Threats from OB3

Tier 1 States (10)	Tier 2 States (32)	Tier 3 States (9)
18-21% cuts of federal funds	10-17% cuts of federal funds	<10% cuts of federal funds
CA, IL, LA, MN, NV, NH, NJ, NY, VA, plus Tx planning additional cuts	AK, AZ, AR, CO, CT, DE, DC, HI, ID, IN, IA, KS, ME, MD, MA, MI, MO, MT, NE, NM, NC, ND, OH, OK, OR, PA, RI, SD, UT, VT, WA, WV	AL, FL, GA, KY, MS SC, TN, WI, WY
6 have lobbyist(s)	*13 have lobbyist(s)*	*4 have lobbyist(s)*
All have work currently happening	*At least 18 have work currently happening*	*At least 7 have work currently happening*

8

Advocacy Leadership

- **Medicaid Federal Funding Scan - Prioritization**
- **Industry Collaboration**
- **Medicaid Departments**
  - *White Paper*
  - *Meetings*
  - *Eliminate/Minimize Rate Reductions*
  - *Administrative Cost Reduction*
  - *Rate Floor-Regulatory*
- **State Legislature**
  - *Rate Stability Legislation*
- **Medicaid MCO Plans**
  - *Industry Talking Points*



9

CRUSH Fraud RFI

AAHomecare's Position on Fraud, Waste & Abuse
Fight fraud without inadvertently harming patients & legitimate DMEPOS supplier community

Recommendations

- Strengthen Provider Enrollment Requirements for New DMEPOS Suppliers
- Improve Quality of Site Visits
- Improve Cross-Program Enforcement
- Monitor Electronic Funds Transfer (EFT) Activity of New Suppliers
- Mandate Targeted Probe and Educate (TPE) on New Suppliers
- Promote Use of Electronic Orders (e-Orders)
- Leverage Technology to Review Claims in Real Time
- Create CMS Tech Liaison
- Improve Medicare Advantage (MA) Oversight
- Expanding Prior Authorization (PA)
- DMEPOS Supplier Surety Bond
- Improve Transparency on Real Fraud Loss
- Timely Filing Timeline
- Participation Status is Not a Fraud Tool
- Expand Beneficiary Solicitation Prohibition
- Improve Oversight and Training of 1-800 Medicare
- Require Sellers to Notify the Enrollment Contractor of a Sale Within 5 Business Days Post-Transaction
- Improve PECOS
- Require Providers to Report Lead Generation Company
- Mandate Healthcare Fraud Prevention Partnership (HFPP) for All Government Healthcare Insurers
- Improve Oversight of Audit Contractors
- Improve Oversight and Reporting of Third-Party Administrators

https://aahomecare.org/anti-fraud-stance

10

Medicaid *aka Medicaid Fee for Service (FFS)*	Medicaid MCO
• No contract – enrollment • Enrollment necessary to obtain Medicaid MCO contract • All providers paid off the same fee schedule • Rate and coverage criteria typically loosely based on Medicare, but with added community access stipulations • Federal requirements, including review of State Plan Amendment for rate changes	• Individually negotiated provider rates/contracts • Federal requirements to adhere to level of benefits/coverage at no less than that specific state Medicaid FFS • No requirement for rate minimum (in most states) • Sometimes use commercial coverage policies instead of FFS • Minimal oversight enforcement by state

11

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is—

(1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or

(2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

i. Makes **the services it provides** to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

ii. Meets the solvency standards of § 438.116.

42 CFR § 438.2 - Definitions. | Electronic Code of Federal Regulations (e-CFR) | US Law | LII / Legal Information Institute (cornell.edu)

12

How do MCOs make money?

- Capitation – per member per month (PMPM) rate
- Profit sharing of spend under PMPM allotment
- Penalty for overage
- PMPM monitored by encounter data provided to state
  - Typically reported as HCPCS/Qty paid/total amount paid

This is impactful on DME providers as MCOs often achieve savings by taking major discounts off the FFS rates.

13

What are the federal Medicaid requirements?

- Reasonable promptness
- Free choice of providers
- Equal access to care
- Comparability of services
- Reasonable standards
- Amount, duration, and scope rule

42 U.S. Code § 1396a - State plans for medical assistance | U.S. Code | US Law | LII / Legal Information Institute (cornell.edu)

14

How do the requirements apply to the MCOs?

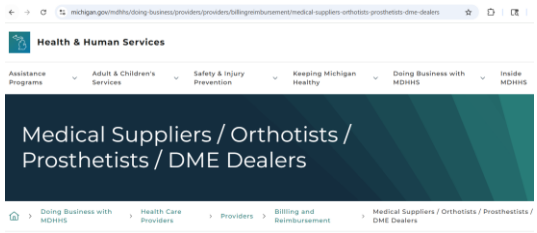
For an MCO that administers the DME benefit, that MCO is required to cover any item covered by FFS in the state and cannot have coverage criteria which is more restrictive than FFS.

- This is not applicable to rates for DME.
- Difficult to apply if there is no written coverage criteria for FFS.
- MCOs cannot apply their own proprietary coverage criteria or medical policies in place of FFS policies.
- Cannot state an item is experimental if that is not an existing policy with FFS in that state.

42 CFR § 438.210 - Coverage and authorization of services. | Electronic Code of Federal Regulations (e-CFR) | US Law | LII / Legal Information Institute (cornell.edu)

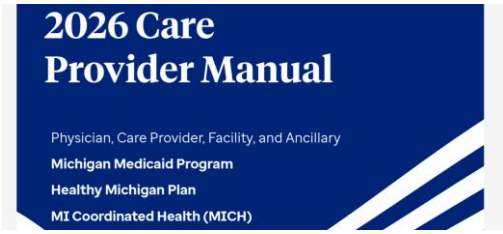
15

How do I find Coverage Criteria?



16

Medicaid MCO Provider Manual/Handbooks. .

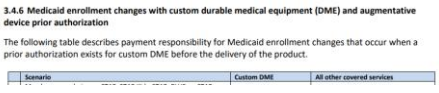


17

What else is in the MCO Provider Handbook?

Information and details on:

- Claims filing, appeals, audit
- Fair hearing information
- Benefit/quantity limits
- Continuity of Care information



3.4.6 Medicaid enrollment changes with custom durable medical equipment (DME) and augmentative device prior authorization

The following table describes payment responsibility for Medicaid enrollment changes that occur when a prior authorization exists for custom DME before the delivery of the product.

	Scenario	Custom DME	All other covered services

18

Ultimate appeals – State Fair Hearings

Federal requirements to states on making information available to Medicaid recipients

§ 431.206 Informing applicants and beneficiaries.

(a) The agency must issue and publicize its hearing procedures.

(b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or beneficiary in writing—

(1) Of his or her right to a fair hearing and right to request an expedited fair hearing;

(2) Of the method by which he may obtain a hearing;

(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman; and

(4) Of the time frames in which the agency must take final administrative action, in accordance with § 431.244(f).

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-E

19

MCO Oversight

- File a complaint with the state FFS Medicaid oversight department
- Reach out to the state Medicaid Ombudsman (if applicable)
- Contact the CMS Regional Office *https://www.cms.gov/about-cms/where-we-are/regional-offices*
- Develop relationships with your State Legislators

20

MCO Contracting Tips

- Payer: "no one else is complaining", how do you fight that?
- AAH Payer Engagement Resources https://aahomecare.org/payer-engagement-resources
- AAH White Paper *https://aahomecare.org/files/galleries/Negotiating_Managed_Care_Contr.PDF*
- Bring up your service model and how it could save money or increase member satisfaction
- How is your service model different/better than others?
- Leverage relationships – clients, clinical partners, facilities like hospitals
- Terms on timely filing, audits, etc.
- Confirm purchase options match what the FFS allows or your business needs
- Are all pertinent modifiers recognized by the MCO?

21

State Regulation/Administrative Code Sample

Mich. Admin. Code R. 418.10913 - Billing for durable medical equipment and supplies

State Regulations | Compare

Rule 913.

(1) DME and supplies must be billed using the appropriate descriptor from the HCPCS Level II codebook, as referenced in R 418.10107, for the service. If the equipment or supply is billed using an unlisted or not otherwise specified code and the

Mich. Admin. Code R. 418.10108 - Definitions; A to I

(q) "Durable medical equipment" means specialized equipment that is designed to stand repeated use, is used to serve a medical purpose, and is appropriate for home use.

22

What about non-covered items?

- Typically occurs when:
  - A product does not clearly fit into an existing "specific HCPCS" (i.e., miscellaneous code is most appropriate); or
  - A state Medicaid does not have all current HCPCS on the fee schedule; or
  - There is a policy on certain equipment being deemed "exercise equipment" or "experimental"
- Further complicated when Medicaid is not the primary insurer

23

How to contest Medicaid non-covered denials

- Federal directive: states cannot have a non-covered DME list
  - States must provide a "reasonable and meaningful procedure for requesting items"
  - "Process for seeking exceptions must be made available to all beneficiaries and may not be limited to sub-classes of the population (e.g. beneficiaries under the age of 21)"
- Use the DeSario letter for supporting arguments & reference to Federal Statute and Regulations:
  https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd090498.pdf

24

Medicaid Co-Pays for Qualified Medicare Beneficiaries (QMB)

- State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost sharing that is due for QMBs according to the state's CMS-approved Medicare cost-sharing payment methodology.
  - *Without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan.*
  - *Even if the service or item is not covered by Medicaid.*
- However, states are permitted to limit payment for QMB cost sharing to the amount necessary to provide a total payment to the provider equal to the amount a state would have paid for the service under the State Plan.
- When the crossover claim is for Medicare-covered services that are not included in the Medicaid State Plan, the state is still liable to pay, but may establish reasonable payment limits, approved by CMS, for the service.

25

Medicaid Co-Pays for Qualified Medicare Beneficiaries (QMB) continued…

- States must furnish all Medicare-enrolled providers, including out-of-state providers, with a means by which they can enroll in the Medicaid program for purposes of having cost sharing claims processed.
- Providers are strictly prohibited under §1902(n)(3) of the Act from seeking to collect any additional amount from a QMB for Medicare deductibles or coinsurance, even if the Medicaid program's payment is less than the total amount of the Medicare deductibles and coinsurance.
- For Full Benefit Dual Eligibles who are not eligible as QMBs, a state may elect to limit coverage of Medicare cost sharing to only those services also covered in the Medicaid State Plan.
- CMS Informational Bulletin:
  https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-07-2013.pdf

26

Leverage Your State Advocacy Resources!

- State, Regional, & National Trade Associations
  WE ARE STRONGER TOGETHER!
- Patient Advocacy Groups
- State Association for Health Plans
- Local Chamber & National Federation of Independent Business (NFIB)
- State Legislators
- Regulators (Agencies/Departments with Relevant focus)
- Online Information – General Assembly, Medicaid, Listserv, public announcements – ***Stay Informed!***

27

State Legislative & Regulatory Resource Toolkit

Tools for a successful state lobbying initiative

Mission - The purpose of the AAHomecare State Legislative and Regulatory Workgroup is to establish proactive and consistent state legislative, regulatory, and payer strategies for the Durable Medical Equipment (DME) Industry. This will facilitate a streamlined and timely response by state and regional associations as well as consistent legislative, regulatory, and payer contract language. These initiatives will benefit the DME community in establishing service and rate sustainability while enabling quality products to be provided, ensuring adequate patient access, and positive patient outcomes.

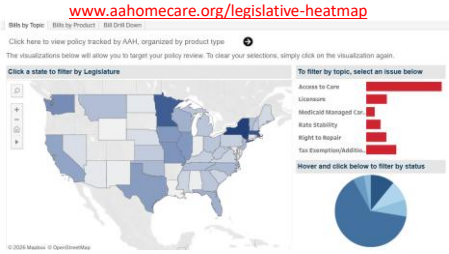
Goal - Each regional/state association to evaluate their legislative, regulatory and payer landscape and to develop legislative, regulatory and payer goals. Associations are encouraged to utilize language already created that can be modified to fit their needs. This will allow for consistency while also creating an efficient process.

28

State Legislative Heatmap

Tools for a successful state lobbying initiative

www.aahomecare.org/legislative-heatmap

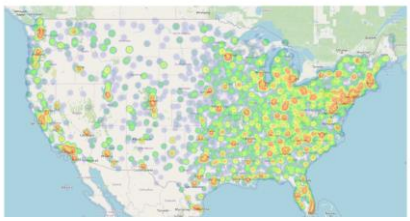


29

National Supplier Location Map

Tools for a successful state lobbying initiative

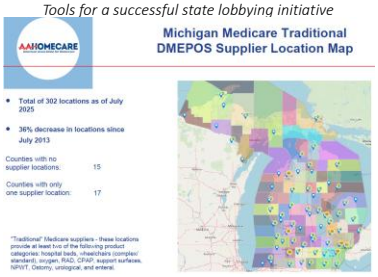
HEAT MAP OF TRADITIONAL DME SUPPLIER LOCATIONS AS OF JULY 1, 2025



30

State Supplier Location Maps

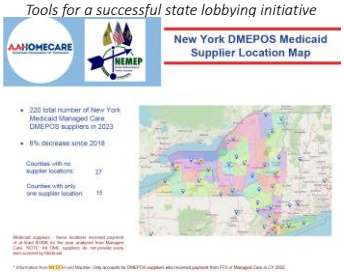
Tools for a successful state lobbying initiative



31

State Supplier Location Maps

Tools for a successful state lobbying initiative



32

What are the issues?

- Supply Chain and Cost Pressure
- Appeals/Claims Project Timeframes
- Consistent medical policy for MCO Plans
- Data transparency
- Payment rate stability
- TPAs
- MCO ownership of a DME company
- MCO transition language

33

What are the issues?

- Medicaid Rates discounted off Medicare
- MSRP Pricing and cost multiplier when no MSRP
- No audits for medical necessity for prior approved items
- No documentation required for secondary
- Prescription Requirements
- Limited Networks
- Proof of Delivery consistency
- Recoupment Timeframes

34

Third Party Administrators

DME Navigator
Partnership between Optum, Parachute & CareCentrix
- BCBS TN – March 6, 2026 (2.4m covered lives)
- CareOregon – May 1, 2026 (533k covered lives)
- Optum Workers Comp/UMWA – May 1, 2026
- Molina – Staggered rollout (3.2m covered lives)
  - SC, WA, OH, IL - June 1, 2026
  - NY/FL Optional

Synapse
- United Healthcare Medicare Advantage Plan Expansion

Integra
- Moda Health – March 15, 2026 (348k covered lives)
- Independent Health – April 1, 2026 (323k covered lives)
- Providence Health Plan – June 1, 2026 (598k covered lives)

35

State Advocacy Best Practices

Best Practices:
- Confront payer directly with your issue
- Consider Regulation before Legislation
- Bring issue to attention of oversight authority
- CMS Regional Office (OPOLE)
- Meet with your State Legislators
- Invite your State Legislators to your facility
- ***Build relationships!***

36

REGULATORY CHANGE

Pros

- Can be less cumbersome to get this type of change implemented.
- If the relationship with the state Medicaid department is strong, then this route more likely to be well received.
- Does not require a lobbyist to be involved and less legal terminology required.
- Any level from policy to medical director can implement regulatory changes.
- Saves Political Capitol for other issues
- Path to regulatory change can be quicker than legislative change.

Cons

- Policy can be changed with little to no notice through budgetary processes or regulatory review.
- Policy could be misinterpreted by MCO plans or by new policy staff or administration.
- Can be more difficult to address misinterpretations.

37

LEGISLATIVE CHANGE

Pros

- Permanent unless additional legislation is passed to overturn.
- Multiple options available to find a champion to support a legislative effort.
- Legislators have an outside view that may not contain preconceived opinions and are often open to change.
- Less opportunity for misinterpretation by MCO plans.

Cons

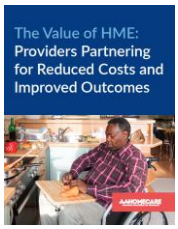
- Often requires a lobbyist to assist in navigating this route.
- Path to legislative change can take longer than regulatory.
- Easier for opposing parties to slow, change, or stop legislative efforts.
- Often requires support from both Medicaid department and General Assembly.
- Still up to Medicaid department to issue guidance based on legislation
- Often adds a fiscal note.

38

Value of HME in the Media

AAHomecare.org/payer-engagement-resources

The supply chain tangle caused by the pandemic has also reverberated into these homes, as required materials are used for longer then intended, according to O'Brien. This also makes the materials more expensive for families and for the durable medical equipment companies that are providing them at a loss because their reimbursements haven't changed either, he said.



- Show what HME is and the importance to the health care continuum.
- Describe the customer satisfaction in care at home.
- Standardize the messaging around what a partnership with HME providers can do.
- Presentation has multiple embedded videos describing:
  - Value of an established HME partnership
  - Reduced Cost
  - Improved Patient Outcomes
  - Enhanced Patient Satisfaction
  - Growing need for HME

39

Social Media Engagement

- Value of HME messaging
- X/Facebook/LinkedIn
- Community engagement
- Legislator engagement




40

Current Efforts and Opportunities

- Value of HME messaging
- Prioritize Issues
- Set Goals
- Implement a Plan
- Public/Media Relations
- Gather Data
- Meet your State Legislators
- Tell your Story!
- State/Regional Associations and AAHomecare are here to help. **We are stronger together!**

41

State Association Collaboration

AAHomecare is proud to work side-by-side with our state association members, both regional and individual. The state executive directors are critical allies in grassroots and relationship building. Their expertise and tireless efforts impact not only the providers they serve but often act as a catalyst to neighboring states for action.

AAHomecare.org/state-and-regional-association-memebers

AAHOMECARE American Association for Homecare

42

How do we get there and what YOU can do to make a difference

- Association Membership
- Support Advocacy Efforts
- Continue to Build Relationships
- **Evaluate your Contracts!**
- Identify Resources Available to You
- Dedicate Staff to Payer/Gov Relations
- Be a Leader-You can make the change happen!
- **Payer Relationships-Sell the value of HME!**
- Know your state and regional environment!
- Share your Outcomes and Successes for the good of all!

43

Price Transparency Tool

44

Transparency in Coverage – Your "private" rates with Payers is now public information…

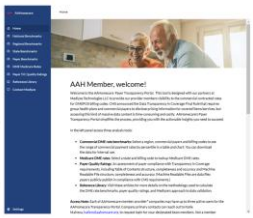
- In 2020, HHS, Dept of Labor, and Dept of Treasury collectively issued a "Transparency in Coverage" final rule. The Rule requires most health plans and insurers in the individual and group markets to disclose in-network provider negotiated rates
- Does not apply to Medicare Advantage or Medicaid Managed Care
- The Rule became fully implemented 1/1/2024, and data must be updated monthly.
- Rates must reflect all negotiated discounts, rebates or incentives.
- Comprehensive files must be posted in Machine Readable Files (MRF)

45

Price Transparency Portal:

How to Access

- Log on through AAHomecare website or **https://portal.aahomecare.org**
- Each provider member company has up to three users
- The primary contact for your organization should have received an email from AAHomecare and they will determine the three users per organization.
- Once approved, the contacts will receive a login email from AAHomecare with the domain name from no-reply@dashboard.assembly.com within 24-48 hours.
- **Questions?** katiem@aahomecare.org.



46

New in the Portal

Changes to the AAH Portal:

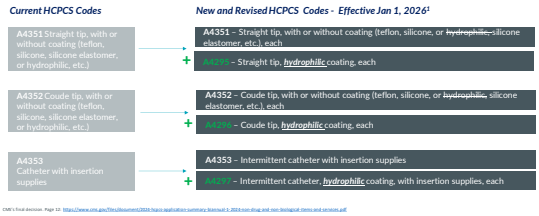
- Rate refresh for commercial payers
- Updated Medicare Allowables
- Elimination of $.00 item
- Elimination of $.01 items
  (if Medicare allowable is higher than $.03)
- Link to Medicaid rates by state

47

Intermittent Catheter Changes

48

CMS CREATED 3 NEW & MODIFIED 2 HCPCS CODES TO DISTINGUISH HYDROPHILIC COATING TECHNOLOGY



1. CMS's final decision. Page 12- https://www.cms.gov/files/document/2024-hcpcs-application-summary-blanchard-1-2024-non-drug-and-non-biological-items-and-services.pdf

49

HYDROPHILIC CATHETERS CAN PROVIDE BETTER OUTCOMES

- Hydrophilic coated technology offers:
  - ✓ Superior clinical evidence compared to non-hydro ICs
  - ✓ Recognition from clinical and professional associations
  - ✓ Reduced risk for complications associated with lower healthcare utilization
  - ✓ Eliminates the cost for lubricant
  - ✓ Improved user outcomes
  - ✓ Improved compliance and quality of life
  - ✓ Access to innovative products

50

TIMELY NEW & REVISED CODE ADOPTION IS CRUCIAL FOR UNINTERRUPTED ACCESS TO INTERMITTENT CATHETERS

Value to the *health plan* [*insert plan name*]:

- Ensure ongoing access to medically necessary hydrophilic ICs
- Support access for members with multiple health plans or members that have Medicare as primary
- Reduce financial and administrative burden for cross-over claims
- Enhance data visibility and data collection
- Provide hydro-IC utilization transparency
- Maintain expected claim processing timeframes

Requests:

- ✓ Implement 3 new hydrophilic HCPCS codes (A4295, A4296, A4297)
- ✓ Revise the definitions of A4351 and A4352 (remove hydrophilic)
- ✓ Assign adequate reimbursement to ensure access to hydrophilic intermittent catheters

51

ANNUAL IMPACT REPORT

The **'25 Impact Report** is more than a recap – it's a roadmap to a brighter future that we're building together.

This report captures the spirit of the Industry in action, and we're grateful for our members who make this possible.

aahomecare.org/impact-report

52

AAHomecare Needs You

- AAHomecare needs members to meet the challenges ahead. All dues to AAHomecare directly support lobbying, research, and public awareness efforts that are part of our advocacy program.
- To join, contact Michael Nicol, Senior Director of Membership Services: michaeln@aahomecare.org or 410-299-7100.

53

QUESTIONS?

HomeCare & Hospice

54


AAHOMECARE
American Association for Homecare
THANK YOU!
David Chandler
DavidC@aahomecare.org
@DavidCHME
aahomecare.org
info@aahomecare.org
LET'S CONNECT
MEMBERSHIP
CONSULTATION
Home Care
& Hospice

55