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Home Health Agency Prospective Payment System Proposed Rule and DME Competitive Bidding Proposal Summary

Late afternoon on June 30, CMS issued the Home Health Agency PPS proposed rule. In addition to substantive cuts to home health agencies, this proposed rule also includes changes to the competitive bidding program. Comments are due by 5 p.m. on **September 2, 2025**. A summary of the provisions follows.

Home Health Agency PPS

Payment

CMS continues to cut home health agencies with an aggregate 6.4% reduction in payment in 2026. CMS proposed a permanent 4.059% reduction to the 30-day base payment rate to account for differences between assumed and actual provider behavior changes under the Patient-Driven Groupings Model (PDGM). In addition to the permanent adjustment, CMS also proposed a temporary 5.0% reduction to the CY 2026 payment rate to begin recoupment of approximately $5.3 billion in cumulative overpayments from CYs 2020 to 2024. The temporary adjustment would not carry forward into future payment rates but may be followed by additional adjustments in later years. CMS estimates that Medicare payments to home health agencies would drop 6.4% or $1.135 billion compared to 2025 – which is staggering.

CMS proposed a 2.4% payment update for agencies that report quality data. Agencies that do not meet quality reporting requirements would receive only a 0.4% update. The updated 30-day base payment rate for CY 2026 would be $1,933.61 for compliant HHAs and $1,895.85 for non-compliant HHAs.

Comorbidity Subgroups

CMS also proposed 20 low comorbidity subgroups and 100 comorbidity interaction subgroups which reflect diagnoses with statistically significant resource use impacts. These updates aim to better align payment with patient complexity and care needs.

Some of the notable low comorbid subgroups include the following:

- Circulatory 10 – Varicose Veins and Lymphedema
- Neurological 10 - Diabetes with Neuropathy
- Skin 3 – Diseases of the arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers

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- Skin 4 - Stages 2-4 and unstageable pressure ulcers by site

Some of the notable 100 high comorbidity interaction subgroups also include:

- Stages 2-4 and unstageable pressure ulcers by site
- Diseases of the arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers

Functional Level Thresholds for Wounds

CMS provided the proposed CY 2026 thresholds for the functional levels by clinical group. For wound care those thresholds are as follows:

- Low 0-33
- Medium 34-52
- High 53+

Case Mix

CMS proposes to update the case-mix weights used in the Patient-Driven Groupings Model (PDGM) for CY 2026 using the most recent complete data—CY 2024 home health claims and OASIS assessments. These updates are part of CMS's annual recalibration process, designed to ensure that payment weights reflect current patient characteristics and resource use.

dNPWT

The final rate for dNPWT will be published in the final rule since the data being used to calculate the rate was still being collected when this proposed rule was issued. The calculation for the separate payment is to be the payment amount for the previous year updated by the percentage increase in the CPI-U (United States city average) for the 12-month period ending in June of the previous year reduced by the productivity adjustment.

Face to Face Encounters

CMS proposed to allow more provider types to conduct face to face encounters. Specifically, any physician, nurse practitioner, clinical nurse specialist, physician assistant, or certified nurse-midwife can perform the encounter. Further, CMS proposed to allow physicians to perform face-to-face encounters regardless of whether the physician is the certifying practitioner or whether they cared for the patient in the facility from which the patient was referred.

Quality Reporting

Under the Home Health Quality Reporting Program (HH QRP), home health agencies (HHAs) must submit specified data used to assess care quality. Agencies that fail to comply face a 2-percentage-point reduction in their annual payment update. CMS has proposed to remove

reporting measures including (1) the "COVID-19 Vaccine: Percent of Patients Who Are Up to Date" measure, citing declining COVID-19 case rates and high provider burden and (2) four social determinants of health (SDOH) assessment items from the Outcome and Assessment Information Set (OASIS)—one related to Living Situation, two to Food, and one to Utilities—also citing high provider burden. These items would no longer need to be collected for patients discharged on or after April 1, 2026.

Request For Information

CMS is specifically seeking information on three specific areas.
1. CMS is seeking feedback on four potential future measure concepts: interoperability and IT capacity, cognitive function, well-being, and nutrition. While CMS will not respond to comments directly, input will inform future measure development.

2. CMS is evaluating whether to shorten the current 4.5-month data submission window to 45 days to reduce the lag between data collection and public reporting and is specifically requesting information on how a shorter window might affect reporting timelines, data actionability, public display, and provider workflows.

3. CMS is also requesting information on efforts to advance digital quality measurement in home health, particularly through the use of Fast Healthcare Interoperability Resources (FHIR®) for interoperable reporting of patient assessment data. Specifically, CMS seeks feedback on current integration levels, implementation challenges and opportunities, and the potential use of interoperability as a future quality measure concept.

Measures in the HHVBP model

CMS proposed to remove three measures that are currently used in the expanded HHVBP model: care of patients, communications between providers and patients and specific care issues. CMS also proposed to add four measures to the applicable measure set, including three OASIS-based measures relating to bathing and dressing, one claims-based measure and the Medicare Spending per Beneficiary for the Post-Acute Care (PAC) setting measure.

Provider Enrollment Provisions

CMS continues their focus on fraud, waste and abuse in their proposed creation of several new Medicare provider enrollment provisions and well as revisions to others.

Specifically, the proposed rule would increase the grounds upon which CMS can revoke a provider retroactively to the date that the provider's noncompliance began, allowing CMS to collect money that was paid to the provider since the beginning of its noncompliance.

The proposed rule also adds the basis for Medicare provider revocation or deactivation. This change would allow CMS to amend its regulations to revoke providers when beneficiaries say a provider did not provide the services they claimed. It would also allow CMS to deactivate

providers' Medicare billing practices when enrolled physicians and practitioners have not ordered or certified services for 12 consecutive months, which CMS said leaves billing numbers "vulnerable to use by bad actors."

Competitive Bidding

In addition to the home health agency provisions, there are new proposed policies for the next round of the national competitive bidding program. Those provisions include new rate-setting methodologies and a new annual reaccreditation requirement.

While the Agency will provide a list of the product categories and time frames for the next round of competitive bidding in a future announcement, the agency stated that:

- All continuous glucose monitors (CGMs) and insulin infusion pumps be reclassified under the frequent and substantial servicing payment category.
- Ostomy, tracheostomy, and urological supplies are medical equipment items and according to CMS are mandated for inclusion under the program. This includes home health medical supplies such as catheters, catheter supplies, ostomy bags, supplies related to ostomy care, and certain covered osteoporosis drugs.

Furthermore, the agency proposed definitions to two new terms "Remote Item Delivery CBP (RID CBP)" and "Remote Item Delivery Item" to support the creation of competitive bidding programs where suppliers primarily deliver items by mail to Medicare beneficiaries, regardless of their location within a competitive bidding area (CBA). These suppliers may also provide items in person, but only contract suppliers would be allowed to do so. The agency may implement either:

  - A single nationwide RID CBP covering all U.S. states and territories, or
  - Multiple regional RID CBPs across different parts of the country.

Payment

For payment, CMS proposed:

- To have a single payment amount for a lead item furnished under the CBP to be equal to the 75th percentile of bids instead of the maximum bid.
- To estimate supplier capacity using data on actual contract supplier capacity from previous rounds of the DMEPOS CBP.
- For new categories added to the CBP, the number of contract suppliers needed to furnish items and services would be at least 2 and no more than 125% of the number of suppliers

that furnished at least 3% of the total utilization for the lead item in the product category and CBA during the most recent calendar year.

- To apply an annual inflation update when appropriate to help account for unforeseen changes (i.e. public health emergency, inflation). The inflation would be equal to the percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) of the prior year.
- To not award a contract under the DMEPOS CBP if the total amount paid under the program is greater than all payments that would otherwise be made.
- To no longer require the submission of a tax return extract, income statement, balance sheet, and statement of cash flows. Instead, CMS proposed to only require bidding entities to submit a business credit report.
- To require the bidding entity to verify that all the bidding entities included on the bid have a gross revenue that is under the small supplier threshold.
- To codify certain requirements for bid surety bonds.
- A phase in payment on a monthly rental basis for CGMs and insulin pumps and all related supplies under the DMEPOS CBP. CMS proposed to establish bid limits for the first time as these items are phased in as the lead items in a product category under a nationwide or regional CBA(s). CMS proposed to establish payment for CGMs and insulin pumps by adding up the current monthly fee schedule amounts for the base DME item and the supplies. For the base items, using a 5-year reasonable lifetime requirement as a reference, CMS proposed to divide the total fee schedule amount by 60 for the number of months over a 5-year period.
- Bidding entities competing to be nationwide contract suppliers for CGMs and insulin pumps and other items in the same product category would need to submit bids that are lower than the bid limit to be considered. (Note that CMS will determine single payment amounts for lead and non-lead items in a product category after evaluating all the bids it receives from bidding entities)**.** CMS also stated that CGMs and insulin pumps could be included in the same competitive bid product category, with CGM being the lead item.

Accreditation

In terms of the accreditation process, CMS proposed multiple changes in order to address fraud, waste, and abuse problems, including the requirement that DMEPOS suppliers are resurveyed and reaccredited annually instead of every three years. CMS also proposed stricter requirements for becoming and remaining a DMEPOS accrediting organization (AO) including:

- Restructuring language that explains the process by which an entity may apply or reapply to become an AO for ease of comprehension.

- Requirements that mandate the AO to explain, in detail, its policies and procedures for avoiding conflicts of interest involving individuals who conduct surveys or participate in accreditation determinations.
- Requiring the AO to describe its process for identifying and correcting deficiencies within its accreditation program.
- Requiring the AO to describe its data management, analysis, and reporting system for its surveys and accreditation determinations.
- Requiring the AO to explain their procedures for responding to and investigating complaints against its suppliers.
- Requiring the AO to furnish information about its ability to conduct timely reviews of supplier accreditation applications.
- Requiring the AO to describe its decision-making process.
- Proposing modifications to exercise greater oversight and gain a clearer understanding of AOs' corrective action plan (CAP).
- Requiring greater explanation of how an AO defines the term "deficiency" and whether the AO has different levels of supplier deficiencies.
- Outlining of AO application for reapproval of DMEPOS accreditation program.

Prior Authorization

CMS has proposed that suppliers achieving a target approval rate of 90% be offered an exemption from required prior authorization. To determine supplier eligibility for continued exemption:

- The DME Medicare Administrative Contractors (MACs) would complete a post payment medical review sample.
- From this claim sample, suppliers must again meet a claim approval rate of 90% or greater to continue their exemption.

Suppliers who do not meet the compliance rate threshold must continue submitting prior authorization requests as required. The DME MACs would be required to provide suppliers notice of an exemption or withdrawal of an exemption at least 60 days prior to the effective date.

Provider Enrollment

CMS Proposed several provisions within the provider enrollment section. Specifically they proposed to:

- Make suppliers and providers legally responsible for the accuracy and completeness of all information provided with their applications regardless of who completed the application.
- Permit beneficiary attestations that the items or services identified on the claim in question were not rendered or furnished as possible reasons to revoke enrollment.
- Expand the basis for which the agency can apply a retroactive revocation effective date,
- Impose new deactivation authority in terms of billing for certain services,
- Have the authority to require the submission of certain other documentation needed for verification of information included on the enrollment application,
- Amend DMEPOS Liability Insurance requirements

More information will be provided to Alliance members in the weeks to come as we continue to digest the provisions in the proposed rule. If you are interested in reviewing the proposed rule we have provided a link here. If you have any questions please reach out to Karen Ravitz (301) 807 5296 or karen@woundcarestakeholders.org.