Cannon Clay

POLICY WHITE PAPER

Who Benefits?

Transparency, patient access, and fiscal accountability in home-care and durable medical equipment benefit management

An empirical analysis of the home-care/DME benefit-manager category, with CareCentrix, Synapse Health, and Integra Partners as instances of a single model.

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Abstract

Health plans increasingly delegate their home-health and durable medical equipment (DME) benefits to a third-party intermediary, a home-care/DME benefit manager, that credentials the supplier network, sets reimbursement, performs prior authorization and utilization management, and adjudicates claims. The category has expanded rapidly since 2024, most visibly through CareCentrix's DME Navigator platform (co-developed with Optum), Synapse Health's sole-source Medicare Advantage arrangements with UnitedHealthcare, and Integra Partners' DMEPOS benefit-management contracts. Its architecture closely parallels the pharmacy benefit manager (PBM) model that is now under sustained federal and state scrutiny for opacity, yet the home-care equivalent remains largely unregulated as a distinct category. This paper examines three questions: what patients experience when the layer is inserted at the hospital-to-home transition; the mechanism, reimbursement compressed below public Medicare and Medicaid benchmarks, that produces those effects; and where the resulting savings go. It adds a fiscal dimension that has been absent from the debate: rate compression that delays discharge equipment or hollows out local supply may *raise* total cost of care through avoidable readmissions, so the question is not only whether suppliers are paid less but whether states and plan sponsors are paying more. The paper concludes that the central finding is the absence of transparency itself: the information required to determine who benefits is held by plans, intermediaries, and state agencies and is not disclosed. Policy options that follow from these findings are set out in a companion paper.

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1 Executive Summary

> *A layer of intermediation now sits between health plans and the home, coordinating, authorizing, and pricing the equipment and care patients receive after a hospital stay. It operates almost entirely out of public view. This paper asks a simple question: who benefits?*

Health plans increasingly carve out their home-health and durable medical equipment (DME) benefits and delegate them to a third-party benefit manager. The intermediary credentials the supplier network, sets reimbursement, performs prior authorization and utilization management, and adjudicates claims. Its structural leverage is control of access to a plan's members: a supplier that declines the intermediary's terms loses those patients, and the patient loses that supplier.[1]

This is a category, not a single company. CareCentrix, founded in 1996, owned in turn by private equity, Walgreens Boots Alliance (2022 to 2025), and, since August 2025, Sycamore Partners, is the largest and most visible instance, and its DME Navigator platform (co-developed with Optum) is the vehicle for Molina Healthcare's 2026 multi-state rollout.[2,3,4] Synapse Health, under a capitated, sole-source arrangement with UnitedHealthcare, now manages standard DME for Medicare Advantage members across more than two dozen states.[5,6] Integra Partners, a subsidiary of the health plan company Point32Health, manages the DMEPOS benefit across some 60 payer lines of business covering more than 20 million lives.[7] A 2026 industry poll found 92 percent of responding suppliers reporting that payors are already using or transitioning to this model.[8] The unit of analysis in this paper is therefore the category, not any one firm.

The architecture is the one pharmacy benefit managers built in the prescription-drug supply chain, an architecture that nearly every state legislature, the Federal Trade Commission, and, in February 2026, Congress have now acted to open to scrutiny.[9,10,48] The home-care equivalent has attracted no comparable oversight, even though its decisions determine whether a recovering patient receives the right equipment, in time, from a provider near home. This paper documents four effects, in the order that matters to the public:

- **What patients experience.** An added authorization and fulfillment layer introduces delay precisely at the hospital-to-home transition, where delay can raise readmission risk. Clinicians have reported CPAP delivery times under one intermediary lengthening from weeks to as long as three months, order cancellations without notice, and denials without a clear appeal pathway.[11] Complaint records describe denial notices that allegedly never reached patients, exposing them to surprise private-pay charges.[12] Narrowed networks reduce local choice, most acutely in rural markets.
- **The mechanism behind it.** The reported patient effects point to a single lever: reimbursement compressed below prevailing Medicare and Medicaid benchmarks: about 15 percent in an early Tennessee Medicaid contract, an average of 22 percent in equipment savings that BlueCross BlueShield of Tennessee itself projects from its 2026 arrangement, and a provider-reported 50 to 60 percent below current Medicare and state Medicaid rates under the 2026 Molina rollout.[3,13,14] Cuts of that depth would fall below the cost to serve that many independent and rural providers report, putting at risk the networks patients rely on; no public measurement yet shows how often that occurs.

- **The fiscal flip.** Savings on equipment are small in absolute terms; readmissions are not. The average cost of a 30-day all-cause adult readmission was about $15,200 in 2018 and $17,700 in 2020, and roughly 14 percent of adult hospitalizations are followed by one.[15,56] One avoided readmission is worth about 290 months of CPAP rental at the full Medicare rate. CPAP serves here as the price example; the clinical stakes are highest for oxygen and home ventilation. If rate compression delays discharge equipment or removes the only nearby supplier, a state Medicaid program or plan sponsor may pay more in total, not less. This effect is not currently measured by any party.
- **Where the money goes.** The spread between prior allowed rates and new intermediary rates is marketed to payors as guaranteed savings. There is no public evidence that patient premiums or cost-sharing fall in proportion, no public audit of how "guaranteed savings" are measured, and no visibility into how the spread is divided between the plan and the intermediary. New York's supplier association has documented to the legislature, without rebuttal from the plans in testimony, that managed-care plans pay out in DME claims less than half of what the state pays them for the benefit, and the legislature has twice passed a parity bill in response.[44,45] That opacity is itself the central finding of this paper.

This paper does not argue that benefit management should be abolished; the platforms offer real conveniences, and the paper states that case on its merits in Section 4.5. It argues that the category's effects on patients, suppliers, and public payors cannot presently be measured, because the information required to measure them is not disclosed. The policy options that follow from these findings, together with the principal arguments against them and model statutory language, are set out in a companion paper, *Who Is Accountable?*

2 The Rise of an Invisible Layer

Care is moving from facilities into the home, and the money is moving with it. In 2022, McKinsey projected that as much as $265 billion in care services for Medicare fee-for-service and Medicare Advantage beneficiaries could shift to the home by 2025 without a reduction in quality or access.[16] That year has now passed. No public accounting exists against which the projection can be checked, and this paper does not rely on the figure. What can be observed is the market's response to the shift the projection described: between 2024 and 2026, national health plans delegated their DME benefits to intermediaries at the pace documented in Section 2.1, and by 2026, 92 percent of suppliers surveyed reported that payors were already using or moving to the model.[8] A benefit growing that quickly, administered by plans with no specialized home-care operation of their own, created an opening for a third party to coordinate, authorize, and price the home-health visits, infusion, sleep therapy, and equipment involved. The result is a layer most patients never know is there.

2.1 Three instances of one model

The three firms profiled below differ in ownership, contracting posture, and the intensity of supplier complaint attached to them. They share the defining functions, network control, rate-setting, utilization management, and claims adjudication for a delegated home-care or DME benefit, that make them a single regulatory category.

CareCentrix and DME Navigator

CareCentrix, founded in 1996 as a unit of Gentiva Health Services, independent since 2008, and headquartered in Hartford, Connecticut, generated approximately $1.5 billion in pro forma sales in

fiscal 2021 by its then-acquirer's accounting, supporting roughly 19 million members through more than 7,400 provider locations at the time of the Walgreens investment; the company's 2025 materials cite more than 16 million members and more than 6,000 provider locations.[2] Walgreens Boots Alliance agreed in October 2021 to acquire a 55 percent stake for about $330 million at an $800 million valuation, closed that purchase in August 2022, and acquired the remainder in March 2023; on Aug. 28, 2025, coincident with Sycamore Partners' take-private of Walgreens, CareCentrix returned to standalone private ownership under Sycamore, with the Pessina family reinvesting. Haley Sofiane succeeded Steve Horowitz as the company's president on Oct. 1, 2025.[4,17] In June 2024 it launched DME Navigator, an end-to-end DME ordering and network-management platform operated with Optum (UnitedHealth Group's services arm) on a point-of-care framework built by Parachute Health.[18] Molina Healthcare selected DME Navigator for all lines of business in Illinois, Washington, South Carolina, and Ohio, announced for June 1, 2026, with phased expansion planned across the 18 states Molina serves. The schedule has since slipped: Illinois postponed its launch on May 6, AAHomecare's June tracker listed all four states as tentatively July 1, fall launches announced for Iowa, Nebraska, and Wisconsin were postponed or, in Iowa's case, withdrawn after supplier advocacy, and as of this writing no public confirmation of a go-live in Washington, South Carolina, or Ohio has been located.[3,19,20] Under the arrangement Molina subcontracts the DME network to Optum, CareCentrix contracts and credentials the providers, existing Molina supplier contracts do not carry over, and services rendered outside the DME Navigator process are ineligible for reimbursement.[19]

Synapse Health and UnitedHealthcare

Synapse Health (Skokie, Illinois) entered a capitated arrangement with UnitedHealthcare in 2024 to manage standard DME for Medicare Advantage HMO and PPO members in Georgia and North Carolina, an initial population the American Association for Homecare estimated at about 480,000 members.[5] The model differs from CareCentrix's in an important respect: Synapse is the *provider of record* and subcontracts fulfillment to other DME companies, so patient care and management formally shift to Synapse when a supplier joins its network.[5,6] The arrangement took effect on Sept. 1, 2024 after a one-month delay and has since expanded in waves: four Southeastern states in August 2025; Illinois, Indiana, Kentucky, Michigan, Ohio, and West Virginia in October 2025; 10 Plains and Upper Midwest states announced for April 1, 2026 and implemented June 1, 2026; Florida and Mississippi on Aug. 1, 2026; and nine Northeastern states plus the District of Columbia on Sept. 1, 2026. It now spans most of UnitedHealthcare's individual Medicare Advantage footprint.[6,21] In April 2026 the American Academy of Sleep Medicine wrote to UnitedHealthcare describing a pattern its members attributed to the arrangement: CPAP delivery delays stretching from weeks to as long as three months, order cancellations without notice, denials without a clear appeal pathway, and restrictions preventing suppliers from communicating directly with patients.[11]

Integra Partners

Integra Partners (founded in New York in 2005, now based in Troy, Michigan, and a wholly owned subsidiary of Point32Health, the nonprofit parent of Harvard Pilgrim Health Care and Tufts Health Plan) describes itself as a DMEPOS benefit manager offering network and utilization management across some 60 payer lines of business and more than 20 million covered lives, through a credentialed supplier network and an NCQA-accredited utilization-management program.[7,22] Integra operates an open, IPA-style network and markets to plans a reduction in overall DMEPOS medical and administrative cost of up to 25 percent.[23] It is included here not because it is the subject of the supplier complaints documented in Sections 4 and 5 (it is not), but because it performs the same delegated

functions, and because a category definition that captured only the firms currently in the news would be neither durable nor fair.

2.2 The pharmacy-benefit-manager parallel

The closest analogue is the PBM. The mechanics correspond closely, and so does the central public concern, which is opacity. The comparison also answers the objection most likely to be raised against state action: ERISA preemption. In *Rutledge v. Pharmaceutical Care Management Association* (2020), a unanimous Supreme Court held that an Arkansas statute regulating PBM reimbursement to pharmacies was not preempted by ERISA because it was a form of cost regulation that did not dictate plan design or administration.[24] The same reasoning applies to a state statute setting disclosure, rate-floor, or network standards for DME benefit managers.[25]

Dimension	Pharmacy benefit manager	Home-care/DME benefit manager
Sits between	Payor and pharmacy/manufacturer	Payor and DME/home-health supplier
Core leverage	Formulary placement and network access	In-network status and referral flow
Price mechanism	Negotiated reimbursement, rebates, spread	Negotiated rate versus Medicare/Medicaid benchmark; guaranteed savings
Gatekeeping tool	Prior authorization, step therapy	Prior authorization, utilization management, claims editing, platform-gated ordering
Vertical integration	Three largest PBMs owned by insurers (CVS/Aetna, Cigna/Express Scripts, UnitedHealth/Optum Rx)[9]	DME Navigator operated with Optum (UnitedHealth); Synapse is provider of record for UHC members; Integra wholly owned by Point32Health, a health plan company; CareCentrix under private-equity ownership
Plan-sponsor fiduciary exposure	CAA 2021 fee disclosure; 2024 and 2025 ERISA suits over PBM contracting[26,27]	Same duties apply to self-funded sponsors whose carve-out vendors set rates; no disclosure regime yet
Public concern	Opaque pricing; effect on access and independent pharmacies	Opaque pricing; effect on access and independent suppliers
Regulatory status	Licensure and transparency statutes in nearly every state; NCOIL model act and 2026 NAIC regulator guidance; FTC 6(b) study; federal PBM reform in the Consolidated Appropriations Act, 2026; *Rutledge* confirms state authority[9,10,24,48]	Largely unregulated as a distinct category; no statutory definition in any state; 2026 parity and definition bills introduced in New York, Illinois, and Mississippi, none yet enacted

Table 1. The PBM and home-care benefit-manager models compared.

The strategic point follows directly: the home-care benefit-manager category is following the PBM model roughly a decade behind PBM regulation. That gap, and the record that has accumulated within it, is the subject of this paper.

3 How the Model Works

A health plan "carves out" its home-care and DME benefit and delegates management to a benefit manager. The benefit manager credentials and contracts the supplier network, sets reimbursement, performs prior authorization and utilization management, and adjudicates and edits claims. The plan

compensates the benefit manager, frequently on a guaranteed-savings basis, and the benefit manager pays suppliers at the rates it negotiates.[1] Because the benefit manager controls the path to a plan's covered lives, a supplier that declines the terms loses access to those patients altogether, and the patient in turn loses that supplier as an option. The negotiation is conducted from a position of profound asymmetry, and its outcome is felt at the bedside.

3.1 Defining the category

No state currently defines the entity. Regulation of PBMs began with definition and registration, and the same sequence is available here. For analytical purposes, and drawing on the definitional structure of the NCOIL Pharmacy Benefits Manager Licensure and Regulation Model Act and enacted state PBM statutes, this paper uses the following working definition; model statutory language built on it appears in the companion paper.[10]

> **WORKING DEFINITION: HOME-CARE/DME BENEFIT MANAGER**
>
> A person or entity that, under contract with a health carrier, managed-care organization, or self-funded plan, performs two or more of the following functions with respect to a durable medical equipment, prosthetics, orthotics, supplies, or home-health benefit: (a) establishes, credentials, or manages the network of participating suppliers; (b) sets or negotiates supplier reimbursement; (c) conducts prior authorization, utilization review, or medical-necessity determinations; (d) adjudicates, edits, or pays claims; or (e) acts as provider of record while subcontracting fulfillment to other suppliers.

3.2 How "guaranteed savings" is measured, and who audits it

The commercial promise of the model is guaranteed savings to the payor. Publicly available materials do not disclose the baseline against which savings are measured, and this matters. Three baselines produce three very different numbers: (i) the plan's *prior allowed amounts* for the same codes and volumes; (ii) the *Medicare or state Medicaid fee schedule*; or (iii) a *trend-adjusted projection* of what the plan would have spent absent the carve-out. Only the first is directly observable by the plan; the third is an actuarial construct that the intermediary itself typically supplies. Nor is it public whether any savings guarantee is audited by an independent party, whether it nets the intermediary's administrative fee, or whether it accounts for downstream cost shifted to the medical benefit (readmissions, emergency visits, extended facility stays) when equipment is delayed. In the PBM context, exactly this ambiguity, savings measured against a baseline the intermediary controls, is what state auditors and the FTC ultimately exposed.[9,28]

3.3 The flow of value

Step	Description
1. Value extracted through rate compression	(Prior allowed rate minus new benefit-manager rate) multiplied by volume
2. Distributed to	Payor savings (guaranteed) + intermediary margin (undisclosed) + claimed patient/system savings (asserted, not demonstrated)
3. Cost shifted downstream	Patients: delay, narrowed choice, private-pay exposure from de facto denials. System: readmissions and emergency utilization when discharge equipment is late or unavailable; rural supplier exit; consolidation. Not currently measured by any party.

Figure 1. Value flow in a delegated home-care/DME benefit. Step 3 is the addition this paper makes to the conventional accounting.

Sections 4 through 6 examine each link in turn: what patients experience, the mechanism that produces it, and what neither patients nor plan sponsors, nor, in the case of Medicaid, taxpayers, can currently see.

4 What Patients Experience

> *The analysis begins with the patient. Whatever the model's merits for payors, the test of any care arrangement is what reaches the person receiving care.*

4.1 Delay at the hospital-to-home transition

The home-care sector already reports meaningful delays in starting care; CMS tracks a "timely initiation of care" measure precisely because the first days after discharge are clinically sensitive.[29] Inserting an additional authorization, ordering, and adjudication layer adds friction at that moment. The clinical literature on readmission is unambiguous about the stakes: Jencks and colleagues found that 19.6 percent of Medicare fee-for-service beneficiaries discharged from a hospital were rehospitalized within 30 days, at an estimated cost of $17.4 billion in a single year.[30] The Agency for Healthcare Research and Quality's most recent national estimate counted 3.8 million adult 30-day all-cause readmissions in 2018, a 14 percent readmission rate, at an average cost of $15,200 per readmission.[15] The 2020 estimate put the average at $17,700, so the figure used in this paper is conservative.[56]

The link between equipment delay and readmission is most direct for oxygen, ventilation, positive airway pressure, hospital beds, and negative-pressure wound therapy, items whose absence at home is itself a reason not to discharge, or a reason to return. The clinical evidence is not uniform across those items. Randomized trials show a survival benefit from long-term oxygen in severe resting hypoxemia and, in one trial, fewer readmissions with home ventilation after a COPD exacerbation, while large trials of CPAP have not shown a reduction in cardiovascular events, and no study was found that links a wait of weeks for CPAP to hospitalization.[57] The most specific documented pattern to date appears in a letter dated April 7, 2026 from the American Academy of Sleep Medicine to UnitedHealthcare's medical director, signed by Gabriela de Bruin, MD, chair of the AASM Coding and Reimbursement Advisory Committee. Under the Synapse Health arrangement, AASM members reported CPAP delivery delays lengthening from a few weeks to more than a month and sometimes up to three months; a portal that repeatedly requested already-submitted documentation; order cancellations without notice, leaving patients and clinicians unaware until delivery was overdue; and denials without appeal guidance.[11] Under the Molina rollout, providers reported limited communication during ramp-up, with some suppliers unaware the change was occurring.[3]

The letter is notable for the standard it invokes. AASM measured the delegated arrangement against Medicare's own DMEPOS Quality Standards and supplier standards, which require responsive consumer service, timely delivery and set-up, beneficiary instruction, and follow-up, and it asked UnitedHealthcare to confirm that its delegated vendor processes meet those Medicare-aligned expectations, to ensure that orders are not cancelled without transparent notice, that every denial carries appeal guidance, and that restrictions on supplier-to-patient communication be reviewed as a source of access barriers.[11] Those five requests, made by a national clinical society with no commercial stake in the supplier market, address network adequacy, the timeliness and transparency of

authorization decisions, and communication with patients, the same areas in which this paper finds the public record thinnest.

4.2 Denials and de facto denials

Complaint records describe repeated instances in which patients or facilities did not receive timely denial notices, notifications allegedly sent to wrong fax numbers, or calls never made, leaving patients exposed to private-pay charges they did not see coming.[12] This pattern maps to a recognized regulatory concept. The NAIC Utilization Review and Benefit Determination Model Act requires that adverse determinations be communicated in writing, within specified timeframes, with the clinical rationale and appeal rights.[31] The CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) requires Medicare Advantage organizations and Medicaid and CHIP fee-for-service and managed-care programs, from Jan. 1, 2026, to decide expedited requests within 72 hours and standard requests within seven calendar days, to give a specific reason for any denial, and to report prior-authorization metrics publicly, beginning March 31, 2026, including approval, denial, and appeal-overturn rates; Exchange plans are subject to the rule's other provisions but not to the decision timeframes.[32] A request that is neither approved nor formally denied within those windows is, functionally, a denial (a *de facto* denial) that shifts financial and clinical risk onto the patient without triggering the appeal rights a formal denial would.

The scale of the problem in the broader managed-care context is documented. The HHS Office of Inspector General found that 13 percent of Medicare Advantage prior-authorization denials it sampled met Medicare coverage rules and would have been approved under fee-for-service.[33] KFF's analysis of 2024 data found that Medicare Advantage insurers denied 7.7 percent of 52.8 million prior-authorization requests (up from 6.4 percent in 2023), that only 11.5 percent of denials were appealed, and that 80.7 percent of appealed denials were overturned in whole or in part, a pattern indicating that a large share of denials are not sustainable on review but are never reviewed.[34] The first independent figures for one of the companies examined here appeared in June 2026, when the Inspector General reported prior-authorization outcomes for post-acute facility admissions in June 2024. CareCentrix denied 10.8 percent of skilled nursing requests against 11.0 percent for plans' own staff, 42.4 percent of long-term acute care requests against 64.2 percent, and 52.0 percent of inpatient rehabilitation requests against 46.0 percent, with 77.3 percent of its appealed rehabilitation denials overturned.[54] Those figures do not place the company outside the range of the plans themselves, and they concern facility admissions, not equipment. There is no equivalent public data for the DME decisions of any delegated benefit manager, and no regulator currently requires that it be produced.

For balance: CareCentrix's published utilization-management policy states that decisions are based on appropriateness of care and existence of coverage, that it does not reward staff for issuing denials, and that financial incentives do not encourage under-utilization. Its patient-rights materials affirm rights to clinical rationale, peer-to-peer review, and appeal.[35] The burden of analysis is to test those stated safeguards against the lived complaint record, which requires the data those safeguards presuppose.

A note on the complaint record is warranted, with its denominator. As of Nov. 5, 2026, the Better Business Bureau profile for CareCentrix, Inc. (Hartford, Connecticut) records 74 complaints closed in the preceding three years and 23 in the preceding twelve months; the company is not BBB accredited and carries an A+ rating, which under BBB methodology reflects responsiveness to complaints rather than their substance.[12] The profile also carries a standing advisory: in October 2018, following an inquiry by an investigative reporter, BBB opened an investigation into the company's billing practices after multiple consumers reported receiving repeated invoices for the same equipment each month

despite having been told they were covered or would not be billed, and reported that promised corrections were followed by further bills or referral to collections.[12] The complaints filed since cluster around the same three themes: denial notices that the patient or facility states were never received, continued billing after the insurer had paid, and inability to reach a representative able to resolve the matter. Complaint records of this kind are self-selected and unaudited, and 74 complaints against a company that serves roughly 16 million members is a small absolute number. They establish that a pattern exists, that it has persisted across eight years and two ownership changes, and that it merits investigation; they do not establish its prevalence, and this paper does not treat them as doing so.

4.3 Surprise billing (litigation)

A proposed class action, *Brown v. CareCentrix, Inc. and DJO Global, Inc.*, filed in Miami-Dade Circuit Court on July 2, 2025 and removed to the U.S. District Court for the Southern District of Florida (No. 1:25-cv-23534), *alleges* that after a patient's insurer has paid a device maker in full, payments are routed through CareCentrix and patients are then billed additional amounts, and further *alleges* concealed kickback arrangements between the defendants.[36] CareCentrix has denied the allegations; DJO moved to dismiss for lack of personal jurisdiction.[37] These are allegations that have not been proven, and the matter is unresolved. It is nonetheless directly on point for the question of whether patients bear hidden costs, and it should be tracked through resolution. The docket was last reviewed in December 2025, when CareCentrix's motion to dismiss and the plaintiff's motion for leave to file a second amended complaint were pending.

4.4 An illustrative case

The following composite is constructed from the AASM clinician letter, the Better Business Bureau complaint record, and the Molina implementation reports cited above.[3,11,12] It does not describe an identified patient, and it is offered to make the pattern concrete rather than to serve as evidence of any single event.

> **COMPOSITE CASE: DISCHARGE OXYGEN UNDER A DELEGATED BENEFIT**
>
> A 74-year-old Medicaid managed-care member is admitted with an exacerbation of chronic obstructive pulmonary disease and, after four days, is clinically ready for discharge on home oxygen. The hospital discharge planner places an order for a stationary concentrator (HCPCS E1390) through the plan's delegated DME platform. The supplier the hospital has used for a decade is no longer in network; the nearest in-network supplier is 60 miles away. The platform requests documentation the discharge planner has already uploaded, and the order sits in a pending status for two days. The patient's discharge is held one additional day at a cost of roughly $2,500 per inpatient day, then proceeds when a family member agrees to transport the patient home while oxygen is arranged. The concentrator arrives on the fourth day after the order. The patient is readmitted on day six with worsening hypoxemia. The plan's equipment expenditure on this episode was compressed by approximately $50; its readmission expenditure was approximately $15,000.[15]
>
> The arithmetic is illustrative, but each element of the sequence, including out-of-network exclusion of the incumbent supplier, repeated documentation requests, multi-day pending status, and delivery measured in days rather than hours, appears in the documented record.

4.5 The benefit case, fairly stated

The intermediaries assert genuine patient benefits from their platforms: a single digital ordering experience, electronic-health-record integration, real-time eligibility checks, automated prior authorization, and order tracking intended to reduce the delays and fragmentation the legacy fax-

based process creates.[18,38] UnitedHealthcare describes the Synapse arrangement as a response to provider and member feedback aimed at modernizing DME ordering.[21] Integra points to faster supplier payment, days-sales-outstanding materially better than the industry average, as a supplier-side benefit.[23] The relevant question is not whether these conveniences exist but whether, netted against narrowed access, denial friction, delivery delay, and billing exposure, the patient is better off. On the present public record that case cannot be confirmed either way, and that inability is the deficiency this paper identifies.

5 The Mechanism: Rate Compression and Network Erosion

The patient effects in Section 4 are not random. They trace to a single lever: the compression of supplier reimbursement and the network narrowing it causes. We examine it here not to defend any provider's margin, but because it determines whether a patient has a nearby, timely, in-network option at all.

5.1 Below-benchmark reimbursement

The central mechanism is paying suppliers less than the prevailing Medicare or Medicaid fee schedule or the prior contract rate. The documented instances:

Plan/program	Year	Reported rate change	Source
TennCare (Volunteer State Health Plan, a BlueCross BlueShield of Tennessee subsidiary) via CareCentrix	2010 to 2011	About 15% average reduction effective Nov. 1, 2010; at least one provider stopped serving TennCare rather than absorb the cut	HME News[13]
BlueCross BlueShield of Tennessee (all lines of business) via DME Navigator	Mar. 2026	Payor projects an average of 22% savings on equipment; supplier rates not disclosed; implementation March 5, 2026 (HME News reports March 6); AAHomecare meeting weekly with BCBS-TN on access and continuity	BCBS-TN; HME News; AAHomecare[14,20]
Molina Healthcare (IL, WA, SC, OH; phased to 18 states) via DME Navigator	2026	Announced for June 2026 and postponed in several states; provider-reported 50 to 60% below current Medicare and state Medicaid rates; "take it or leave it" posture	HME News; MAMES[3]
UnitedHealthcare Medicare Advantage via Synapse Health	2024 →	Capitated to Synapse; subcontracted supplier rates not public; access and delay concerns documented by AASM	HME News; AASM[5,11]

Table 2. Documented rate changes under delegated DME benefit management. Rate figures are provider statements to trade press, except the BlueCross BlueShield of Tennessee figure, which is the payor's own projection; none has been confirmed against rate cards; see Appendix A.

The Molina figures, if borne out by the actual fee schedules, are the most consequential. A 50 to 60 percent reduction sits below the level at which many independent suppliers can recover the cost of acquiring, delivering, fitting, and servicing equipment, and a provider that cannot cover cost cannot keep serving the patient. Molina's own provider bulletins state that reimbursement is "dependent on your agreement with CareCentrix," which is to say that the offered rate is confidential by design.[19]

The cost side of the comparison is documented. The only published industry-wide cost study, conducted in 2016 for AAHomecare by the health economics firm Dobson DaVanzo and Associates, found that Medicare fee-schedule reimbursement covered on average 88 percent of suppliers' total

cost of furnishing equipment and related services, with coverage by product category ranging from 67 percent to 94 percent; cost of goods accounted for only 58 percent of total cost, the remainder being the delivery, set-up, training, follow-up, and compliance work that the Medicare supplier standards require.[43] The study is now a decade old, rests on usable responses from 27 of the 609 suppliers surveyed (representing 12.7 percent of Medicare spending on the products studied), has not been repeated, measured costs against competitive-bidding-derived Medicare rates, and its figures should be updated, but its structure is the relevant point: if the public benchmark itself leaves roughly 12 cents of every cost dollar unrecovered, a contract offered at 40 to 50 percent of that benchmark cannot be reconciled with any cost of service, and a supplier accepting it is either cross-subsidizing from other payors or reducing the service components the standards require.

The strongest evidence on the other side is Medicare's own. Competitive bidding cut Medicare's rates for core home equipment by an average of 45 percent in the areas bid in 2013, and from 2016 Medicare extended bid-derived prices nationwide, an average cut of 46 percent for the highest-spending items.[49] The first bid areas lost 27 percent of their suppliers against 5 percent in comparison areas, and areas outside the program lost a further 8 percent in 2016 and 11 percent in 2017, extending a decline already running at about 8 percent a year.[50] Yet GAO could not substantiate reports of widespread access problems, CMS's monitoring showed little change in health outcomes, and a 2024 study of 5.75 million beneficiaries with chronic obstructive pulmonary disease found no detectable change in oxygen use, hospitalization, or death.[51] That record deserves weight, with three limits. GAO cautioned that outcome measures may not capture whether patients received equipment on time, and one analysis of Medicare claims found patients 7.8 percent less likely to have equipment within seven days of a hospital discharge after bidding began.[52] The reductions suppliers now report start from rates that already reflect Medicare's cuts, a depth no study has tested. And Medicare's cuts were published and tracked, while intermediary rates are private and no one is tracking their effects. When Medicare next sought bids for the same equipment, for 2021, the prices produced no savings and no contracts were awarded in 13 product categories, a result suppliers read as a price floor and CMS attributes to the design of the auction.[53]

New York offers the clearest public record of what happens to the spread between what a state pays and what suppliers receive. Under Medicaid managed care, the state pays each plan a capitated premium calculated against the state's own DME fee schedule, but nothing in the contract required the plan to pass that amount through. The Northeast Medical Equipment Providers Association (NEMEP) testified to the legislature that some managed-care organizations reimbursed DME providers at half of the fee-for-service rate for identical items, and that of roughly $539 million the state paid plans in premiums for the DME benefit, the plans paid out less than half, about $235 million, in DME claims.[45] A New York supplier writing in August 2026 put the share reaching suppliers at 60 to 70 cents of each state dollar and the loss of DME suppliers since 2013 at roughly 24 percent.[46] In June 2025 both houses of the legislature passed, unanimously, a bill requiring managed-care organizations to pay DME providers, directly or indirectly, no less than 100 percent of the state fee schedule; the Governor vetoed it in October 2025, citing an estimated $145 million cost, an estimate NEMEP disputes on the ground that the state already pays the full amount to the plans. The legislature passed the measure again in June 2026, and it awaits the Governor as this paper is released.[44] That record, in which a state pays in full for a benefit and a fraction of it reaches the point of care, is the fiscal question this paper puts to every state in which a DME carve-out operates.

5.2 Quantifying the gap against public benchmarks

The benchmark side of the comparison is public; the offered side is not. Medicare's DMEPOS fee schedule is published annually, the CY2026 update (CR 14326, transmittal R13519CP) applied a 2.0 percent update factor to most items and 2.8 percent to items in former competitive-bidding areas.[39] State Medicaid DME fee schedules are likewise public. Because Molina is predominantly a Medicaid managed-care story, a Medicare-only comparison invites the objection that the wrong benchmark was used; the table therefore carries both.

HCPCS	Item	Medicare CY2026 monthly amount (non-rural, contiguous states)	Payment basis	State Medicaid benchmark
E0601	CPAP device	About $50 to $53 per month	Capped rental, 13 months	Published by each state Medicaid agency; generally at or below the Medicare amount
E1390	Oxygen concentrator	Approximately $95 to $101 per month	Monthly rental, 36-month cap	Published; generally at or below Medicare
E2402	Negative-pressure wound therapy pump	Approximately $780 to $1,050 per month, varying by rural status	Monthly rental	Published; generally at or below Medicare
K0001	Standard manual wheelchair	Per CY2026 file	Capped rental, 13 months	Published; generally at or below Medicare
E0260	Hospital bed, semi-electric	Per CY2026 file	Capped rental, 13 months	Published; generally at or below Medicare

Table 3. Public benchmarks for representative discharge equipment. Medicare amounts are the range of non-rural fee schedule amounts across the contiguous states, rounded; rural and former competitive-bidding-area amounts differ, and the K0001 and E0260 amounts are not reproduced here and appear in the CY2026 file. The complete CY2026 amounts for every code, and the corresponding state Medicaid fee schedules for Illinois, Washington, South Carolina, and Ohio, are public documents and are the appropriate reference for any code-level comparison.[39]

ILLUSTRATIVE CALCULATION USING A HYPOTHETICAL OFFERED RATE

The offered rate below is hypothetical and is used only to demonstrate the calculation. Applying the provider-reported 50 to 60 percent reduction to a single verified benchmark shows the magnitude. Consider CPAP (E0601), at a representative CY2026 Medicare non-rural amount of $52 per month. At the 55 percent midpoint the implied offered rate is roughly $23 per month, a reduction near $29 per device per month, or about $343 per device per year. Across a 1,000-unit CPAP census that approaches $343,000 in annual revenue compression on a single code, before oxygen, wheelchairs, or beds are counted.

The fiscal flip, on the same numbers. One 30-day readmission at the AHRQ average of $15,200 equals the annual compression on roughly 44 CPAP devices, or about 290 device-months of rental at the full Medicare rate.[15] If delay or supplier exit attributable to the carve-out produces even one additional readmission per 44 devices per year, the payor's equipment savings are fully consumed on the medical side of the ledger. Whether that threshold is crossed is an empirical question no current disclosure regime allows anyone to answer.

5.3 "Take it or leave it"

Suppliers describe negotiations with little real latitude. One provider involved in the Molina rollout characterized the posture as offering no room to move.[3] CareCentrix's stated position is that it benchmarks against regulatory, federal, and local Medicaid rates and negotiates rates that are

contractually agreed with every provider in its network.[1] Both statements can be true: a rate can be "agreed" by a supplier for whom the alternative is the loss of every patient in a plan.

5.4 Network erosion and patient access

Deep cuts mechanically favor high-volume national suppliers and push out small and rural independents. Industry compliance voices warn that steep reimbursement reductions produce very narrow networks and reduced local access.[3] Translated to the patient's side: fewer in-network options, longer distances, and slower delivery, the access problems described in Section 4. The market effect is a transfer of volume from many local businesses to a few large ones, a consolidation pressure that outlives any single contract. Nearly 80 percent of the national trade association's members are small businesses.[40]

Attrition can be measured rather than asserted. We propose the following method for any carve-out market: count DMEPOS suppliers enrolled in Medicare (NPPES/PECOS supplier files) and in the relevant state Medicaid program by county, at the carve-out effective date and at six and twelve months after, and compare against a matched set of counties in the same state not subject to the carve-out. State associations (MAMES, PAMES, ATHOMES) and AAHomecare's payer-relations team hold member-level data that can corroborate exits.[20] The BlueCross BlueShield of Tennessee implementation, live since March 2026, is the most mature natural experiment available.

There is a precedent for what concentration of this kind can mean. In Florida, Univita Health administered home care and equipment for 10 of the state's 14 Medicaid managed-care plans beginning in 2014, and suppliers reported being offered half of the Medicaid fee schedule. In late July 2015 the company lost its plan contracts and stopped processing orders at once; it laid off 1,002 employees and filed for Chapter 7 liquidation on Aug. 28, 2015. The documented harm fell on suppliers left unpaid and on a disorderly handover of open orders; no agency finding or count of patient harm was located. The episode does not show that any current intermediary is at similar risk. It shows that when one intermediary carries most of a state's home-care supply chain, its failure is a continuity-of-care event for every plan at once.[55]

5.5 Operational friction

Beyond price, the system introduces friction that reaches the patient: slow payment, improperly denied claims, and difficulty reaching decision-makers are longstanding supplier complaints.[1] AAHomecare's tracking of the DME Navigator implementations lists hospital-discharge delays, referral-workflow changes, provider operational burden, and beneficiary choice as its standing watch items, and notes that the platform's automated tier requires a separate paid Parachute Health contract while the free tier requires duplicate data entry.[20] CareCentrix counters that network retention is high, it has cited that more than 90 percent of its network remains in-network for at least three years, which it presents as evidence the terms are workable.[1]

> **THE RETENTION REBUTTAL, EXAMINED**
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> High retention may reflect the *absence of alternatives* rather than satisfaction. A supplier that cannot afford to walk away from a plan's covered lives is captive rather than satisfied, and a captive network is not evidence that patients are well served. Two further points: the cited retention figure dates to 2018, before the 50 to 60 percent cut era it is now used to defend; and the exit examples, such as the TennCare provider who left rather than absorb a 15 percent cut, show what happens only when the math becomes impossible.[1,13]

5.6 Reconciling the rollout record

The Molina rollout has been described variously as a four-state launch and an 18-state expansion; both are correct. Molina's March 2026 bulletin announced Illinois, Washington, South Carolina, and Ohio effective June 1, 2026, with all 18 Molina states to follow; Illinois postponed its launch on May 6.[19] AAHomecare's June 2026 tracker recorded the four-state Phase 1 as tentatively July 1, and listed tentative subsequent phases: Idaho, Michigan, Nevada, and Utah (August); Arizona, Iowa, Kentucky, New Mexico, and Wisconsin (September); and Texas, Massachusetts, California, Georgia, Mississippi, and Nebraska (October), all subject to change based on readiness.[20] Molina subsequently announced fall launches in Iowa, Nebraska, and Wisconsin, then postponed Wisconsin's Aug. 1 and Nebraska's Sept. 1 starts and, after sustained advocacy by the Midwest Association for Medical Equipment Services, excluded Iowa from the program altogether, offering Iowa suppliers direct contract amendments that providers report also carry significant reductions.[3,19] The Midwest association has called the pauses "a temporary reprieve" rather than a reversal, and Molina has not publicly explained them.[3]

6 Follow the Money: What Patients, Plan Sponsors, and States Cannot See

> *This is the most important question and the hardest to answer with public data. We state plainly what is known, what is inferred, and what remains hidden.*

The thesis: the savings extracted from rate compression are not demonstrably returned to patients as lower cost or better care. They are captured by the payor as guaranteed savings and by the benefit manager as its management margin, and the division is invisible to the people the system is meant to serve. This paper argues the point as a structural incentive and reasonable inference, supported by the documented rate cuts, rather than asserting a profit figure it could not defend.

6.1 The spread

If a benefit manager pays a supplier substantially less than the prior allowed rate while the plan's premium and the patient's cost-sharing remain unchanged, the difference is captured upstream. The guaranteed-savings model markets cost reduction to the payor explicitly, the value proposition *is* the spread between what was paid before and what suppliers receive now. Whether any of it reaches the patient is undisclosed. Whether any of it is consumed downstream by the readmissions and emergency utilization described in Section 5.2 is unmeasured.

6.2 The Medicaid MLR classification question

For Medicaid managed care, the spread has a regulatory home. Under 42 CFR § 438.8, managed-care organizations must calculate and report a medical loss ratio; since 2016 the rule has required any third-party vendor performing claims adjudication to furnish the underlying data, CMS guidance in 2019 addressed the accounting of subcontractor payments, and the 2024 managed-care rule tightened the treatment of provider incentive payments within the numerator.[41] When an MCO pays a carve-out vendor a capitated or guaranteed-savings amount, the classification of that payment, as *incurred claims* (which count toward the MLR numerator) or as *administrative expense* (which does not),

determines whether the intermediary's margin is visible to the state, whether it is subject to remittance if the MLR floor is missed, and whether the state is effectively paying medical-benefit dollars for administrative intermediation. This paper has not been able to determine from public filings how Molina or other MCOs classify DME benefit-manager payments in any state; that is a question state Medicaid agencies can answer directly and should.

Ohio provides the precedent for what such disclosure uncovers. In 2018 the Ohio Auditor of State examined the PBMs serving Ohio's Medicaid managed-care plans and found that, in a single year, the PBMs retained $224.8 million in spread between what they billed the plans and what they paid pharmacies (about 8.8 percent overall and 31.4 percent on generic drugs), figures that had been invisible to the state under the prevailing contract structure.[28] Ohio subsequently moved its Medicaid pharmacy benefit to a single transparent PBM. The DME carve-out is structurally identical and has never been audited.

6.3 Following the dollars through public records

The question of where the spread goes is answerable in part through public records, because in Medicaid managed care the payor of first instance is a state. Two lines of inquiry are open as this paper is released.

Tennessee. BlueCross BlueShield of Tennessee, through its BlueCare and TennCareSelect subsidiaries, is a TennCare managed-care contractor as well as the state's largest commercial insurer, and its DME Navigator implementation with CareCentrix took effect on March 5, 2026 across its lines of business.[14,20] For the TennCare lines, the state's capitation payments to the contractor include an actuarially determined component for durable medical equipment, and the contractor's encounter and financial reporting to the Division of TennCare records what was in turn paid to suppliers. Requests under the Tennessee Public Records Act to the Division of TennCare for (i) the DME component of the capitation rate development for the BlueCare and TennCareSelect contracts for rate years 2025 and 2026, (ii) the contractor's reported DME expenditure to suppliers for the same periods, and (iii) the classification of payments to the delegated benefit manager in the contractor's medical loss ratio reporting under 42 CFR § 438.8, would establish whether the state is paying for a benefit at one level and suppliers are receiving it at another, and where the difference is recorded. Comparable requests are appropriate to the Medicaid agencies of Illinois, Washington, South Carolina, and Ohio for the Molina contracts.

New York. The New York record described in Section 5.1 is the template. There, the delta between the state's fee-schedule-based capitation and the amounts actually paid to DME suppliers was surfaced by a state supplier association, was not disputed by the plans in legislative testimony, and became the factual predicate for a parity bill the legislature has now passed unanimously twice.[44,45] The Ohio pharmacy audit did the same for PBMs in 2018.[28] In neither case did the intermediary's margin become visible until a public body compared the two sides of the ledger, and in both cases the comparison, once made, was decisive.

Requests to this effect have been prepared and are pending as this paper is released. Their results will be published as a supplement. The paper does not delay for them, because the structural question they address does not depend on their answer: whatever the Tennessee or Illinois figures turn out to be, a benefit financed by public capitation at one rate and delivered at another warrants disclosure of the difference.

6.4 Plan-sponsor fiduciary exposure

Self-funded employer plans face a parallel question under ERISA. The Consolidated Appropriations Act, 2021 imposed new compensation-disclosure duties on brokers and consultants to group health plans (ERISA § 408(b)(2)(B)) and prohibited gag clauses that block sponsors from accessing their own cost and quality data.[26] A series of suits filed in 2024 and 2025 against large employers, including *Lewandowski v. Johnson & Johnson* and *Navarro v. Wells Fargo*, alleged breach of fiduciary duty in the selection and oversight of PBM contracts; those cases were dismissed at the pleading stage on standing grounds and are on appeal to the Third and Eighth Circuits, but the theory that a sponsor must prudently monitor an intermediary that sets prices on its behalf remains live and is the reason sponsors are now demanding PBM transparency contractually.[27] A self-funded sponsor whose DME carve-out vendor guarantees savings against a baseline the vendor controls, retains an undisclosed spread, and narrows the network its employees rely on has exactly the same exposure, and, today, no data with which to discharge it.

6.5 What is known versus what is needed

Available today	Needed for the public to judge
Documented below-benchmark rate cuts (Section 5)	The benefit manager's actual take-rate/margin
The guaranteed-savings model, in the company's own marketing	The savings baseline, the audit party, and the payor/intermediary savings-share split
Prior-owner scale (~$1.5B pro forma sales, FY2021)	Whether patient premiums/cost-sharing fell in proportion
Private-equity ownership implying a return-on-capital mandate	MLR classification of carve-out payments in each Medicaid state (42 CFR § 438.8)
AHRQ readmission cost benchmarks	Readmission and ED-visit rates for members before and after carve-out, by equipment category

Table 4. The evidence gap.

AN HONEST LIMIT

The precise division of the spread cannot be proven from public sources today. The absence of transparency is itself the finding, and the reason the public cannot answer the question on the cover. Only disclosure can supply the answer.

7 Conclusion

> *The question on the cover can now be answered in part. The part that cannot be answered is itself the finding.*

Four findings emerge from the public record. First, the delegation of home-care and DME benefits to third-party managers is no longer an isolated contracting choice but an established category, spanning Medicaid managed care, Medicare Advantage, and commercial lines, and expanding through 2026 across most of the states in which the largest plans operate.[3,6,8,20] Second, its effects on patients are concentrated where delay is most costly, at the transition from hospital to home, and the most specific clinical documentation available describes delivery delays measured in weeks to months for therapy that is ordinarily initiated within days.[11,15,30]

Third, the reported effects point to a single mechanism. Reported reimbursement under the newest arrangements sits well below public Medicare and Medicaid benchmarks, and those benchmarks themselves recover less than the full cost of furnishing equipment and the services that the Medicare supplier standards require.[3,14,39,43] If the reported rates are accurate, reimbursement at that level is unlikely to sustain a local network, and the consequences of narrower networks, longer distances, and slower delivery would fall on the patient. Medicare's own rate reductions thinned the supplier base without measurable harm to health outcomes, but they were shallower, public, and monitored; whether deeper private reductions do harm is the question the undisclosed data would answer. Fourth, the savings produced by that compression are marketed to payors and are not shown to reach patients, while the cost the arrangement may shift to the medical benefit through readmissions and extended stays is measured by no party.[15,28]

What cannot be determined from public sources is how the spread is divided, whether total cost of care falls or rises, and how payments to the intermediary are classified in public reporting. These are not matters of opinion. They are answerable with data that plans, intermediaries, and state agencies already hold: rate cards measured against published fee schedules, the baseline and audit terms of guaranteed-savings arrangements, medical loss ratio filings, authorization and appeal statistics, county-level supplier enrollment, and readmission rates before and after a carve-out. In Ohio, comparison of the two sides of the ledger proved decisive once a public auditor undertook it, and in New York a supplier association's comparison has twice moved the legislature.[28,44] The public-records requests described in Section 6.3 begin that comparison for the carve-outs examined here.

The answer to the question on the cover therefore depends on disclosure that does not yet exist. The policy options that follow from these findings, the principal arguments against them, and model statutory language are examined in the companion paper, *Who Is Accountable?*

8 Methodology, Limitations, and Data Availability

8.1 Method

This paper synthesizes publicly available trade reporting, trade-association implementation tracking, benefit managers' and plans' own published materials, federal regulatory and statutory sources, peer-reviewed and government readmission data, complaint records, and one unresolved civil filing. Where a claim is critical of a company, it is paired with the company's stated position. Provider-reported figures are labeled as such. Litigation is described in the alleged tense.

8.2 Limitations

Five limitations are stated openly. (1) The headline rate-reduction figures are reported by suppliers to trade press or, in the Tennessee case, projected by the payor, and have not yet been corroborated against actual fee schedules or rate cards. (2) The litigation referenced is unproven. (3) The analysis of where savings go (Section 6) is a structural inference rather than a quantified finding, and it will remain so until the underlying payment data are disclosed. (4) The documentary record of supplier complaint is concentrated on CareCentrix and, to a lesser extent, Synapse Health; Integra Partners is included as a category instance, not as a subject of documented complaint, and the paper should not be read as attributing the documented practices to every firm in the category. (5) The paper is diagnostic. It does not evaluate policy options, which are addressed, together with the principal counterarguments, in the companion paper.

8.3 Data-availability statement

All sources cited are publicly available at the locations given in the reference list. The CMS CY2026 DMEPOS fee schedule file and state Medicaid fee schedules are public. Rate cards offered by benefit managers to suppliers are not public, and this paper reports rate terms only as suppliers have described them to trade press and trade associations or as payors have publicly projected them. Public-records requests to the Division of TennCare and to the Medicaid agencies of Illinois, Washington, South Carolina, and Ohio, described in Section 6.3, are pending at release; their results will be published as a supplement. Appendix A grades the principal claims of the paper by the strength of the evidence behind each, and Appendix B sets out the diligence questions a plan sponsor should put to a benefit manager before delegating the benefit.

8.4 Funding and independence

This analysis was supported by the Center for Health Abundance and Innovation, a project of the Main Street Foundation. Cannon Clay Advisors retained full editorial control over the research design, methods, findings, and conclusions of this paper, and the supporting organization did not review or approve the findings prior to release. Because the paper's thesis is that intermediation in the benefit should be visible, the fact of that support is stated on the cover and here. The views expressed are those of the authors.

A Appendix A: Evidence Status

The claims on which this paper rests are graded below by the strength of the evidence behind them. The grading is intended to let a reader weigh each claim independently rather than accept or reject the paper as a whole.

Claim	Basis	Evidence grade
Health plans are delegating DME and home-care benefits to third-party managers at an accelerating rate	Plan and vendor announcements; AAHomecare implementation tracker; HME News industry poll	Established
CareCentrix, Synapse Health, and Integra Partners perform the defining functions of the category	Company-published materials; provider handbooks; plan bulletins	Established
BCBS-TN projects an average of 22 percent savings on equipment under DME Navigator	Payor statement, March 2026; supplier rates not disclosed; implementation live since March 2026	Payor-stated; not confirmed against rate cards
Molina reimbursement under DME Navigator is 50 to 60 percent below current Medicare and Medicaid rates	Supplier statements to HME News and state associations	Provider-reported; not confirmed against rate cards
CPAP and respiratory delivery delays of weeks to months under the Synapse arrangement	AASM letter to UnitedHealthcare, April 2026	Documented by a national clinical society; not independently quantified
Denial notices not received; billing after payment	Better Business Bureau complaint record; Brown v. CareCentrix (alleged)	Complaint-level; unadjudicated
Delayed discharge equipment raises readmission risk and cost	AHRQ HCUP; Jencks et al. (NEJM 2009); CMS timely-initiation measure	Established for readmission generally; link to DME delay is inferential
Supplier attrition and rural access loss follow deep rate cuts	Industry compliance statements; TennCare exit	Anecdotal; measurable by the method in Section 5.4
Savings are retained upstream and not passed to patients	Guaranteed-savings marketing; ownership structure; Ohio PBM audit as precedent	Structural inference; not quantified
Medicare fee-schedule reimbursement covers on average 88 percent of supplier cost	AAHomecare/Dobson DaVanzo DME Cost Study	Established for the study year; figures should be updated
New York MCOs paid DME suppliers substantially less than the state paid plans for the same items	NEMEP legislative testimony; sponsor memoranda; unanimous passage of parity bills in 2025 (vetoed) and 2026 (pending)	Association testimony, unrebutted in the record; not a legislative finding; plan-level figures not public
Tennessee and Molina-state carve-out payments and MLR classification	Public-records requests pending	Not yet available
State regulation of DME benefit managers is not preempted by ERISA	Rutledge v. PCMA (2020); enacted state PBM statutes	Established, subject to drafting within the Rutledge boundary

Table A-1. Evidence grading for the paper's principal claims.

B Appendix B: 10 Diligence Questions for Plan Sponsors

Regulatory measures, examined in the companion paper, will take time. Plan sponsors, by contrast, can act at the next contract cycle. The 10 questions below are offered to a health plan, a self-funded employer, or a state Medicaid agency considering whether to delegate a home-care or DME benefit. Each is paired with the elements of a well-governed answer. A vendor that is unable or unwilling to answer any of them in writing has, in effect, answered it.

1. What baseline measures the savings guarantee?

The plan's prior allowed amounts for the same codes and volumes, a public fee schedule, or the vendor's trend-adjusted projection, and who supplies the data.

A well-governed answer. Savings measured against the plan's own prior allowed amounts, with codes, volumes, and methodology fixed in the contract rather than in a projection the vendor controls. An accurate baseline also protects the network: savings targets set against an inflated baseline are what drive rates below cost.

2. Who audits the guarantee, and with what access?

The identity and independence of the auditor, the frequency of audit, and the level of data to which the auditor has access.

A well-governed answer. Annual audit by a plan-selected independent auditor with claim-level data access, and no contractual provision restricting the plan's access to its own cost and utilization data, which is already a Consolidated Appropriations Act compliance requirement for group health plans.[26]

3. Will total cost of care be measured, and not only equipment spend?

Whether guaranteed savings are netted against downstream medical cost (readmissions, emergency visits, discharge delays) for members in the carve-out.

A well-governed answer. Pre- and post-implementation readmission and emergency-visit rates by equipment category against a matched baseline, reported quarterly, with the guarantee reconciled against attributable medical cost. This is the question that aligns the plan's ledger with the patient's outcome.

4. What is the vendor's full compensation, and what conflicts sit behind it?

Administrative fee, capitation, savings share, any retained spread between what the plan pays and what suppliers receive, any revenue collected from suppliers (platform fees or paid ordering tiers required to participate), and any ownership or affiliate relationship with a plan, supplier, or manufacturer, including whether order volume is steered to affiliated suppliers.

A well-governed answer. Every revenue stream disclosed and warranted, no undisclosed spread, no pay-to-participate requirement, and referral routing on objective criteria rather than affiliation.

5. Where do supplier rates sit against public benchmarks, and can qualified suppliers join?

For the top 25 HCPCS codes by spend, the percentage of the applicable Medicare or state Medicaid fee schedule that contracted suppliers will receive, whether the vendor will commit to a floor, and the objective criteria for network participation.

A well-governed answer. The rate card disclosed to the plan under confidentiality; a contractual floor expressed as a percentage of benchmark, with advance written justification before any reduction below

it; and published, objective credentialing criteria under which any qualified supplier, including the plan's incumbents, may contract.

6. What network adequacy will the vendor guarantee, and what happens when it is missed?

Time-and-distance standards by equipment category, delivery windows for discharge-critical items (oxygen, PAP, hospital beds, wound therapy), a rural availability test, and continuity for incumbent suppliers at go-live so that existing patient-supplier relationships are not severed by default.

A well-governed answer. Contractual service levels with penalties; automatic out-of-network authorization at plan-equivalent rates when the network cannot deliver on time; qualified incumbents offered participation before launch; and quarterly county-level adequacy reporting.[41]

7. What are the turnaround commitments on authorizations and on payment?

On authorizations, the CMS-0057-F windows (72 hours expedited, 7 calendar days standard) applied to the vendor as delegate, with monthly reporting of approval, denial, appeal, and overturn rates. On payment, defined prompt-pay windows, a clean-claim definition fixed in the contract, and a stated lookback cap on retroactive claim edits and recoupments.

A well-governed answer. Requests not decided within the window are deemed approved; adverse determinations go in writing to both the member and the ordering clinician; overturn rates above a stated threshold trigger corrective action; and supplier payment performance is reported alongside authorization metrics. Slow payment removes suppliers from a network as surely as low rates, and every exit is a patient's lost option.[32]

8. How does the plan remain compliant while the vendor operates?

Delegation must satisfy 42 CFR § 438.230 for Medicaid subcontracts, Medicare Advantage delegation requirements, and NCQA delegation standards; the plan retains regulatory accountability in every case. For Medicaid, how payments to the vendor will be classified under 42 CFR § 438.8, as incurred claims or administrative expense, and whether the vendor will support state reporting and audit.

A well-governed answer. Annual delegation audits, a written MLR classification methodology, full cooperation with regulators, and cure and revocation rights that do not require terminating the entire contract.[41,47]

9. How are members protected and kept informed?

The contractual mechanisms, as distinct from policy statements, that prevent members from being billed for amounts that are the plan's or the vendor's obligation, and that preserve the member's ability to communicate with the supplier serving them.

A well-governed answer. A contractual prohibition, backed by indemnification, on collecting from members any amount that is the plan's or the vendor's obligation; no restriction preventing a contracted supplier from communicating with a patient about that patient's own order and equipment; member choice among in-network suppliers; real-time grievance and complaint feeds to the plan; and shared accountability for the member-experience measures (CAHPS, Star ratings) that the arrangement can affect.[42]

10. What happens at entry and at exit?

The treatment of open rental periods, existing authorizations, and member data at go-live and at termination.

A well-governed answer. At go-live, open rental periods and existing authorizations honored for a defined transition period, so that no member loses equipment or a pending order in the cutover. At termination, continuity of care through open rentals and authorizations; return of member, authorization, and claims data in usable form at no charge; transition cooperation with successor networks; and no supplier restrictions that strand the plan's network after exit.

> **READING THE 10 QUESTIONS ACROSS THE THREE PARTIES**
>
> For the plan, questions 1, 2, 4, and 8 determine whether the savings are real and the arrangement governable. For the patient, questions 3, 6, 7, 9, and 10 determine whether the right equipment arrives on time from a supplier the patient can reach. For the supplier network, questions 5, 6, 7, 9, and 10 determine whether serving the plan's members remains viable. A carve-out that fails any one of the three parties eventually fails the other two, which is why diligence must cover all of them.

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Where a trade-press report is cited for the content of a plan bulletin, clinician letter, or supplier statement, the underlying document is described as reported by that source.

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