AAHOMECARE
American Association for Homecare

Overview of AAHomecare Recommendations to address Fraud, Waste and Abuse

The American Association for Homecare (AAHomecare) supports aggressive action against fraud, waste and abuse. Fraud drains Medicare resources; delays care for vulnerable patients and unfairly tarnishes the thousands of legitimate suppliers who serve them. AAHomecare has consistently urged CMS to target fraud by risk, prevent it before payment, and measure success by fraud that is confirmed, so that compliant suppliers are not unduly burdened. AAHomecare continues to work directly with CMS on these solutions.

AAHomecare Recommendations

1. Stop Fraud Before Payment

- **Real-time claim review** that automatically matches each claim to its order and flags claims that have no valid order.
- **Require electronic prescriber ordering** so there is a time-stamped digital audit trail.
- **Provide real-time patient-level data for suppliers** to give live visibility into eligibility, coverage criteria, inpatient overlapping stays, same/similar items and prior authorization requirements.
- **Better analytics:** use AI and network analyses to link suppliers, prescribers, owners, bank accounts and beneficiaries. Account for legitimate shifts in billing, such as competitive bidding awards and acquisitions. Ensure human intervention to validate every flag before any adverse action is taken.
- **Turn confirmed schemes into automated edits**, such as volume-spike thresholds by HCPCS code. (This is the approach that stopped most of the intermittent catheter fraud.) Retire edits that flag legitimate claims.
- **Expand prior authorization** to more high-cost or high-risk categories, with workable turnaround times.

2. Enhance Provider Enrollment Oversight

- **Verify identity on several layers** so bad actors can't come back under new company names. Apply extra scrutiny only to unknown or high-risk entities, not all suppliers.
- **Put every new supplier location into Targeted Probe and Educate (TPE)**. Take stronger action if a supplier fails three rounds, and re-review if billing patterns become aberrant.
- **Watch electronic funds transfer setups**, changes and large deposits by new suppliers.
- **Require suppliers to disclose the lead generation companies they contract with.**
- **Expand solicitation ban to beyond phone calls** to email, text, social media and third-party marketers.
- **Improve the provider enrollment system (PECOS) so every enrollment change can be made electronically and timely.** Currently, the PECOS system is incapable of making multiple updates at once, leading to suppliers needing to submit updates and changes via paper applications, leading to lags in up to date and current information.

3. Make Enforcement Consistent Across Medicare, Medicare Advantage and Medicaid

- **Revocations should be carried across all payers** in two tiers. If a Medicare revocation is determined to be based on fraud, notify MA plans and state Medicaid agencies immediately. If it is an administrative or site-visit finding issue, notify them only after appeals have been exhausted. Reinstatements should be communicated in real time.

- **Require MA plans to follow Medicare FFS coverage**, documentation and payment rules.
- **Make the voluntary Healthcare Fraud Prevention Partnership mandatory for all government insurers.** The partnership is intended to help spot fraud across all programs.

4. Keep Fraud Work Separate from Compliance Work

- **Fraud contractors should focus on real fraud indicators,** while other errors, such as documentation compliance, should remain with the DME MACs, RACs or SMRC for education.

5. Fix Fraud Contractor Incentives and Accountability

- **Payments for fraud contractors should be based on identifying real fraud**, such as referrals that law enforcement accepts and on actions that hold up on appeal.
- **Contractor pay should not be tied to overpayments found**, **extrapolated dollars or audit volume.**
- **Remove overturned denials from contractors' savings and credit.** Treat denials overturned without new records as errors made by the contractors.
- **Create an ombudsman for UPICs, or for program integrity contractors generally.**
- **Contractors must have knowledgeable staff** who know the national and local coverage determinations (NCDs/LCDs) and policy articles, applied as of the date the patient was set up.

6. Improve Site Visits

- **Improve the quality of site verifications.** Site verifications must be conducted by qualified, trained inspectors, a standard checklist and time-stamped photos.
- **Provide suppliers with the opportunity to respond to site visits findings before any action is taken.** Suppliers have experienced revocations due to inadequate site visits.
- **CMS should monitor revocations and deactivations that are reinstated to identify systemic issues and address.**

7. Fair Process for Suspensions and Revocations

- **Suppliers should be given a chance to respond to audit findings before any action is taken.**
- **Any supplier suspension should be fully vetted before it is effective.** We have seen suspensions due to inaccurate information that have had cascading effects on other programs and beneficiaries.

8. Apply Standards for Extrapolation

- **Restore the former Program Integrity Manual (PIM) language (§8.4.1.4) that defined a "high error rate" as ≥50%.** CMS removed this definition without notifying stakeholders. The benchmark matters because it is a defined threshold for when contractors can use extrapolation, which is time- and resource-intensive for suppliers.
- **Require audit contractors to have written justification for using extrapolation** and make that decision fully appealable. Withdraw the extrapolation if appeals lower the error rate below 50%.

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