AAHOMECARE
American Association for Homecare

August 7, 2026

Christy Donohue
Commissioner
State of West Virginia, Department of Health and Human Resources
350 Capitol Street, Room 251
Charleston, WV 25301-3706

Sent via email: christy.d.donohue@wv.gov

RE: Combating Fraud, Waste, and Abuse in the DME Benefit — AAHomecare Recommendations

Dear Christy Donohue,

On behalf of the American Association for Homecare (AAHomecare) and the durable medical equipment (DME) suppliers we represent across the country, we appreciate the opportunity to engage with state Medicaid directors on strengthening program integrity within the DME benefit. Our members share your commitment to ensuring that Medicaid dollars are spent appropriately and that patients receive the equipment and services they need without exposing state programs to fraud, waste, or abuse. As you consider policy and enforcement measures to address bad actors in our industry, we urge that any recommendations be carefully calibrated so they target fraudulent conduct specifically, rather than imposing broad administrative burdens that inadvertently penalize the legitimate, compliant suppliers who work every day to serve Medicaid beneficiaries. We welcome the chance to serve as a resource and partner in this effort, offering our members' front-line expertise to help design solutions that protect program integrity while preserving patient access to essential home-based care.

AAHomecare Position on Fraud, Waste, and Abuse

AAHomecare fully supports the eradication of fraud in the Medicaid program and wants to work with state Medicaid programs to ensure that bad actors cannot bilk the Medicaid program. The services our members provide are essential in keeping beneficiaries safe in their homes while they are being treated. Most patients prefer to be in their home rather than being treated in an inpatient setting. Every day, our members are connecting with patients to ensure they are safely using their DMEPOS products to allow them to live healthily and comfortably.

As the leading voice for the DMEPOS community, AAHomecare is committed to protecting the state Medicaid program and fully supports the Agency's ongoing efforts to eliminate fraudulent activity within the marketplace. We recognize that fraud not only drains critical resources but also creates an unfair "black eye" for the many legitimate, law-abiding suppliers who serve vulnerable patient populations. Fraudulent activity is dangerous to patients who may experience delays in life-saving services. AAHomecare has a number of proposed initiatives that would materially improve state Medicaid program's ability to prevent fraudulent billing in the durable medical equipment, prosthetics and supplies (DMEPOS) program.

To ensure any fraud fighting efforts are successful without inadvertently harming patients and the legitimate DMEPOS supplier community, we urge state Medicaid programs to adopt a more nuanced and strategic approach that targets at-risk and bad actors while minimizing the administrative burden on ethical suppliers.

AAHomecare Recommendations to Effectively Address Fraud and Abuse

AAHomecare recently provided comments to the Centers for Medicare and Medicaid Services (CMS) 's in response to its CRUSH initiative. These targeted and comprehensive recommendations would more effectively address fraud and abuse. Following is a list of our key recommendations (attached are our complete set of recommendations to CMS):

- Strengthen Provider Enrollment Requirements for New DMEPOS Suppliers
- Improve Quality of Site Visits
- Monitor Electronic Funds Transfer (EFT) Activity of New Suppliers
- Mandate Pre-Payment Review for New Suppliers
- Promote Use of Electronic Orders (e-Orders)
- Leverage Technology to Review Claims in Real Time
- Expand Prior Authorization (PA)
- Require Sellers to Notify the Provider Enrollment Contractors Within Five Business Days of Completing a Sale of Their Business
- Mandate Healthcare Fraud Prevention Partnership (HFPP) for All Government Healthcare Insurers
- Improve Oversight of Audit Contractors

Improve Cross-Program Enforcement

If a company's Medicare Fee-for-Service (FFS) status is revoked, that revocation should be applied across all government healthcare programs, including Medicare Advantage (MA) and state Medicaid programs but only after the revocation has reached its final stage and all appeal rights have been exhausted. Establishing cross-program revocation is essential because fraudulent entities often exploit the current lack of communication and consistency between the programs. Applying revocations uniformly across all government healthcare programs ensures that once a company is deemed a bad actor, they are completely removed from the ecosystem, preventing them from simply shifting their fraudulent activity to a different payer.

By creating a unified "red flag" system, the Agency can ensure that a revocation based on fraudulent activity is final and comprehensive, effectively barring bad actors from the entire government healthcare landscape.

State Medicaid agencies and CMS must ensure that revocations and deactivations are warranted. There are many examples where the supplier number is revoked or deactivated in error. Similarly, when a supplier appeals a revocation or deactivation, the revocation or deactivation should not be flagged to other programs until a final determination is made. An appeal signifies that the supplier is actively working to fix the issue in good faith, which is an action that is inconsistent with fraudulent players. Similarly, when a supplier number is reinstated, the update must be instantly communicated consistently across all government healthcare programs.

Risk-Based Audit Framework Would Better Target Improper Activity

In addition, state Medicaid programs should adopt a risk-based audit framework that provides relief for demonstrably compliant suppliers. Establishing a "gold standard" pathway for consistently high performing providers would reduce unnecessary audit frequency and allow program integrity resources to be more effectively targeted toward higher-risk entities. State Medicaid programs should also leverage artificial intelligence and predictive analytics to flag irregular incoming claims prior to payment that would enable the payer to proactively identify suspicious activity and prevent improper payments. Using this approach,

Medicaid should establish baseline utilization threshold by calculating rolling 12-month averages for each supplier, segmented by HCPCS codes. Significant deviations from these baselines, particularly for high-cost, high-risk items should automatically trigger further review, while allowing for appropriate flexibility in lower-risk categories

Conclusion

AAHomecare remains a devoted partner in the shared mission to protect the integrity of state Medicaid programs and its trust fund dollars, while ensuring that its recipients maintain access to essential equipment and related services. We support a comprehensive but targeted strategy that includes strengthening provider enrollment and leveraging technology to identify and prevent fraudulent entities from entering the Medicaid market.

By working together, we can make strides in ensuring bad actors do not take advantage of the Medicaid program while supporting the many legitimate suppliers who are committed to supporting patients in their homes.

We appreciate the opportunity to provide these comments. Please contact me at Cadiem@aahomecare.org for further information.

Sincerely,

Cadie McGonagill
Sr. Director of Payer Relations

Attachment – AAHomecare recommendations to CMS in response to CMS' CRUSH RFI (request for information)