National Alliance for Care at Home

March 30, 2026

VIA ELECTRONIC SUBMISSION

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: CMS-6098-NC, Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)

Dear Administrator Oz:

The National Alliance for Care at Home (the Alliance) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI): Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH).

The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, system-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million individuals and families nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. The Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, those with chronic and serious illnesses, and Americans at the end of life who depend on those supports.

The Alliance appreciates CMS's continued leadership in strengthening program integrity and addressing persistent vulnerabilities in Medicare. We strongly support efforts to combat fraud, waste, and abuse, and we encourage CMS to advance a framework that is precise, targeted, and focused on holding bad actors accountable. Fraud should be distinguished as intentional misconduct by bad actors seeking financial gain. Efforts to address fraud should focus on early identification and removal, ideally preventing bad actors from becoming Medicare certified and/or Medicaid enrolled. Efforts to address waste and abuse, however, should focus on prevention and education so that program integrity is strengthened without imposing unnecessary burden on legitimate providers that deliver vital care in the home. As CMS continues to refine its oversight strategies, we

encourage the agency to adopt measures that are analytically rigorous, operationally feasible, and consistent with a targeted, risk-based approach.

Most recently, on March 25, 2026, the Alliance joined LeadingAge, LeadingAge California, and the California Association for Health Services at Home (CAHSAH) in a letter to you urging CMS to take targeted action to address the concentrated fraud crisis in Los Angeles County and the surrounding Southern California region, while ensuring that a carefully calibrated federal response protects patient access and preserves the ability of trustworthy providers to continue serving their communities.[1] As that letter makes clear, the crisis in California is the result of a subset of bad actors exploiting regulatory and operational gaps—not a failure of the home health or hospice models of care. The Alliance urges CMS to keep that distinction central to its CRUSH rulemaking.

The regulatory authority to address these issues already exists under 42 CFR Parts 424 and 455, the Conditions of Participation at Parts 418, 484, and 489, and Section 1866(j) of the Social Security Act. The challenge lies not in expanding this authority, but in ensuring consistent, well-resourced enforcement. CMS's most immediate opportunity to strengthen enforcement lies in prioritizing in-person verification at the time of enrollment. Enhanced site visits, particularly in high-risk geographic areas where fraud has historically been concentrated, should become a standard front-end safeguard rather than an exceptional measure. Additional direct observation validation surveys and on-the-ground checks in documented and emerging fraud hot spots should be increased and are essential for ensuring appropriate oversight of accrediting organizations and compliance with federal standards.[2] A more targeted, data-driven, and physically present approach to oversight will do far more to deter and detect fraud than broad, paperwork-heavy requirements imposed uniformly across the field. This approach should also reinforce the importance of preserving access in rural and lower-density markets, where even modest additional burdens can disproportionately limit service availability.

DISCUSSION

A. Modifications to Program Integrity Requirements

Program Integrity Oversight

The Alliance and its members have consistently emphasized that CMS's most effective path to combating fraud is to better leverage and enforce the authorities it already has,

[1] https://allianceforcareathome.org/wp-content/uploads/Joint-PI-Letter-3.25.26-1.pdf
[2] https://www.cms.gov/files/document/mln7867599-period-enhanced-oversight-new-hospices-arizona-california-nevada-texas.pdf

rather than creating new administrative requirements that burden compliant providers. In our December 2025 letter to CMS submitted jointly with LeadingAge,[3] we outlined a comprehensive set of recommendations for strengthening program integrity in home health and hospice that are directly relevant to this RFI. Those recommendations are grounded in the recognition that fraud in home-based care has historically been concentrated in identifiable geographic hot spots and that CMS's enforcement tools, such as time-limited enrollment moratoria, provisional periods of enhanced oversight (PPEO), and the home health Review Choice Demonstration (RCD),[4] are underutilized and insufficiently targeted. We stress that most home health agencies and hospices operate in good faith and are committed to delivering high-quality, compliant care to beneficiaries. CMS should adopt a risk-based approach that exempts these providers from additional enrollment requirements and medical review activities to focus agency resources on those providers at highest risk for fraud, waste, and abuse.

Accordingly, we offer the following recommendations to strengthen CMS's ability to target areas at elevated risk of fraud, waste, and abuse:

- **Shift oversight dynamically to evolving high-risk areas, rather than keeping RCD or other oversight mechanisms locked in the same states indefinitely.** CMS's Market Saturation Tool identifies "extreme values" in agency enrollment density and spending per Medicare fee-for-service (FFS) beneficiary.[5] In our comment letter response to the CY 2026 Home Health Proposed Rule (90 FR 29108),[6] the Alliance highlighted that the rapid increases in home health agency enrollments and aberrant billing patterns in Los Angeles County, California are impacting CMS's rate-setting calculations and are highly indicative of fraudulent activity. This data should be used proactively to trigger targeted oversight before widespread fraud takes hold.

- **Use existing authority under 1866(j)(3) of the Social Security Act to institute a provisional period of enhanced oversight (PPEO) in areas of the country meeting the same criteria for imposing an enrollment moratorium at 42 CFR § 424.570(a)(2)(i): i.e., a "[h]ighly disproportionate number of providers or suppliers in a category relative to the number of beneficiaries; or [r]apid increase in enrollment applications within a category[.]"** CMS can quickly implement a PPEO through program instruction, rather than through a lengthy Federal Register notice

[3] https://allianceforcareathome.org/wp-content/uploads/Final-Alliance-and-LeadingAge-Home-Health-and-Hospice-Program-Integrity-Recommendations.pdf
[4] https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/review-choice-demonstration-home-health-services
[5] https://data.cms.gov/tools/market-saturation-utilization-state-county-mapping-tool
[6] https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf

process. CMS has leveraged this authority for hospice services in six states and could expand PPEO to home health and other areas of the country that are at high risk for fraud, waste, and abuse. We note that CMS must also address issues with review consistency, responsiveness, and due process among the Medicare Administrative Contractors (MACs) that are responsible for carrying out medical review activities under the PPEO authority.

- **Ensure the integrity of the CMS Market Saturation Dataset and work to update the data on a more timely basis (the current tool only has data through 2024).**[7] This data has the potential to be very useful and accessible for the general public, but we have noticed discrepancies between the Market Saturation dataset and our analysis of claims data. CMS should use the Market Saturation metrics to identify areas at risk of oversaturation and currently oversaturated where more proactive, targeted oversight actions should be deployed – before widespread issues emerge.

- **Use section 402 demonstration authority under the Social Security Amendments of 1967 (or future rulemaking) to require newly-enrolling home health agencies and hospices to undergo more frequent surveys and training in areas at high-risk of fraud, waste, and abuse.** By targeting increased surveys commensurate with provider risk, oversight could be both effective and efficient. Specifically, for home health agencies and hospices in areas at high risk for fraud, waste, and abuse CMS should:
    - Conduct surveys once per year for the first three years.
    - Require home health agencies and hospices to complete training from the respective MACs each year for the first three years. Topics should include coverage basics of the Medicare home health or hospice benefit, billing for the new provider, and other provider-specific education and resources available and provided by the MAC. Providers should be required to pass the self-assessment evaluation of the minimum required training modules within this three-year period.

- **In targeted areas, require home health agencies and hospices to undergo more frequent enrollment revalidations under 42 CFR § 424.515.** Rather than once every five years, revalidations should occur once every three years (to align with a three-year cycle for surveys) and annually for newly-enrolling home health agencies and hospices for the first three years in areas at high risk for fraud, waste, and abuse. We believe this can be done using the existing CMS-855A form without requiring new forms or administrative infrastructure.

[7] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

- **Conduct targeted off-cycle revalidations for home health agencies and hospices that exhibit billing patterns associated with elevated program integrity risk (discussed above).**

- **Evaluate whether RCD has been successful in reducing fraud, waste, and abuse through a formal evaluation that is made public.**[8] If RCD is successful, consider whether it could be expanded geographically to other areas at high-risk of fraud, waste, and abuse, and potentially apply to hospice services in a manner that minimizes burden for hospices that are acting in good faith and acknowledges issues that result from very short lengths of stay. If CMS considers expanding RCD to hospice, there should be consultation with stakeholders and opportunity for public comment due to the unique aspects of this benefit. As part of this effort, CMS should ensure that the medical review staff have the necessary experience and training to accurately review home health and hospice claims, RCD is targeted to only the highest-risk areas of the country, and compliant home health agencies and hospices are quickly identified and exempted from the RCD process. Agencies undergoing a change in ownership should be required to return to RCD. The highest-risk areas for fraud, waste, and abuse may not be entire states but could be specific metropolitan areas within states.

- **Reevaluate the home health agency capitalization requirements in 42 CFR § 489.28, which have remained unchanged since 1998, and consider whether comparable standards should apply to hospices.** Undercapitalization is a known indicator of potential fraud, and updating these requirements in collaboration with industry stakeholders would help strengthen program integrity but should be undertaken carefully to ensure that they do not limit market competition. CMS could, for example, establish clearer parameters for acceptable financial institutions providing proof of operating funds (e.g., requiring FDIC or NCUA insured entities) and direct MACs to conduct enhanced verification of financial attestations. CMS should also assess whether cost report information should be reviewed and audited during changes of ownership to ensure sufficient capitalization.

- **Re-establish the Program for Evaluating Payment Patterns Electronic Report (PEPPER) and work with providers to revise and improve the target areas.**[9] CMS should review these reports as part of a risk-based approach for targeted medical review activities, including identifying providers that do not access their PEPPER reports.

[8] https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/review-choice-demonstration-home-health-services

[9] https://pepper.cbrpepper.org/index.html

Our members stressed during our listening sessions that any analytical tools or methodologies CMS deploys must be informed by clinical expertise to avoid misclassifying providers or flagging clinically complex cases as fraud. **We recommend that CMS establish a Home Health and Hospice Program Integrity Workgroup,** with involvement from the industry (including providers), CMS, and contractor staff, to develop a comprehensive, risk-stratified set of indicators that paint a complete picture of program risk, identify new and emerging risk factors earlier, and align program integrity modernization efforts with provider capabilities.

We recognize that CMS has statutory authority under section 1866(j)(7) of the Social Security Act to impose temporary enrollment moratoria in geographic areas where there is significant potential for fraud, waste, or abuse. However, the historical record of enrollment moratoria in high-fraud home health markets has produced mixed results. We urge CMS to approach any moratorium decision with a careful analysis of likely effectiveness, potential unintended consequences for access to care, and the availability of other tools that may be better calibrated to the problem. As outlined in the Consolidated Appropriations Act 2026, Section 6209 (f)(1)(B), the ability for a hospice to complete the face-to-face encounter via telehealth does not apply if an "individual [beneficiary] is located in an area that is subject to a moratorium on the enrollment of hospice programs under this title pursuant to section 1866(j)(7)." Hospice providers, both urban and rural, depend on telehealth flexibility for completing the required hospice face-to-face encounter. This is especially helpful with physician and nurse practitioner shortages and those areas with extensive drive times that make it difficult to make in-person visits often under very short regulatory timeframes.

Contractor and Accrediting Organization Oversight and Coordination

The Alliance also recommends that CMS strengthen consistency and accountability among MACs, other contractors, and Accrediting Organizations (AOs). Our members report significant variation across MACs in the interpretation of coverage and documentation policies, processing timelines, communication practices, and audit procedures, creating a disparate compliance landscape that disadvantages providers operating across jurisdictions and undermines confidence in the fairness of CMS oversight. CMS should establish national standards for MAC procedures, create clear timeframes and accountability mechanisms for contractor performance, and actively monitor MAC review consistency and accuracy.

Sharing of information between the contractors and with State Agencies (SAs) is a first step towards strengthening consistency and accountability among the MACs, other contractors and AOs. The SAs and other contractors are dependent on information exchange to process provider enrollment applications, changes of ownership and changes of

information, etc. Therefore, it is essential that these entities have full visibility into the applicant/provider information. This would support early identification of discrepancies and gaps which would help with keeping fraudsters from entering Medicare as well as early identification if already certified.

With respect to AOs, CMS finalized significant changes to strengthen oversight of the DMEPOS accreditation process and the AOs that approve DMEPOS suppliers in the CY 2026 Home Health final rule (90 FR 55342). Under the final rule, CMS is enhancing its supervision of AOs by requiring more frequent and detailed data submissions, expanding its ability to monitor AO operations, and strengthening its authority to respond when an AO is performing inadequately. We recommend that CMS consider implementing similar AO oversight policies for AOs with deeming authority to determine whether home health agencies and hospices meet the Medicare Conditions of Participation. Expanding this oversight model would improve accountability, reduce program integrity risks, and protect beneficiaries and Medicare funds.

CMS should also strengthen its oversight of all contractors that review and approve enrollment applications and conduct audits and reviews, including MACs, Supplemental Medical Review Contractors (SMRCs), Recovery Audit Contractors (RACs), and Unified Program Integrity Contractors (UPICs). CMS should undertake reviews, similar to the medical review accuracy checks currently conducted, to evaluate MAC performance in completing required verifications at enrollment and revalidation and to ensure accuracy and consistency in the provider enrollment process. Our members report inconsistent and inaccurate application of laws and regulations not only across contractors, but also within the same contractor when different staff are conducting reviews.

Specific recommendations related to MACs, AOs, and public transparency include:

- **Update MAC contracts to include defined timelines for review and approval or denial of CMS-855A changes.** Providers often do not get timely confirmation that requested changes have been accepted, which creates confusion for compliant providers and leaves room for bad actors to operate without clear CMS awareness.

- **Develop MAC-specific public dashboards that report the volume and status of pending provider enrollment applications by provider type and state, including information on whether certification will be conducted by an accrediting organization (and identifying which one) or the State Survey Agency.**

- **Improve transparency around ownership by making ownership data more accessible and user-friendly.** This could also include making the ownership files available on Data.CMS.gov more accessible for the public by integrating ownership

(and identifying co-ownership) and licensure information with Medicare Care Compare. We also encourage CMS to validate the ownership information reported, as often the information is incomplete.

- **Require the AOs and State Survey Agencies to track the patients that each agency or hospice uses to obtain its initial Medicare certification so that fraudulent providers are not recycling the same patients to fraudulently obtain certification.** CMS (not the AO or State Survey Agency) could also do spot checks in identified high-risk areas of the country to validate whether patients received services to prompt further review and investigation.

- **Revise the interpretive guidance and surveyor instruction in Appendix M of the State Operations Manual to require AOs and state agency surveyors to implement new procedures to scrutinize whether a hospice is truly able to provide all four levels of hospice care—specifically general inpatient and respite care—as required by the Hospice Conditions of Participation.**[10] Revisions should require surveyor contact with at least some contracted facilities for hospices not providing inpatient care directly, including questioning those facilities about the education the hospice has provided, the frequency of communication regarding bed availability, and other evidence of genuine operational capacity.

- **Implement consistent, risk-based procedures across all contractors conducting medical reviews and investigations and ensure that staff have the appropriate experience and training to carry out their responsibilities effectively.** CMS should also publicly provide appeals data, particularly information on denials overturned on appeal, to improve transparency and accountability.

- **Evaluate whether CMS can leverage the RAC Data Warehouse and other data-sharing tools to coordinate contractor activity, limiting multiple contractors from conducting simultaneous audits in the same geographic areas or on the same providers.** Coordinated, standardized contractor activity will allow CMS to focus resources on high-risk areas while minimizing unnecessary disruption for providers operating in good standing.

B. Enhanced Identity Proofing and Ownership Requirements

[10] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_m_hospice.pdf

The Alliance recognizes the legitimate program integrity concerns driving CMS's interest in enhanced identity proofing and expanded background check requirements, and we support targeted measures that address genuine fraud risks. In our December 2025 letter with LeadingAge,[11] we made several specific recommendations on these issues, which we reiterate here.

We recommend that CMS require home health agencies and hospices to provide additional documentation at the time of enrollment to demonstrate they are legitimate businesses, consistent with the existing regulatory authority at 42 CFR § 424.510(d)(2)(iii)(C), which permits CMS to require submission of any documentation needed to validate enrollment application information. This additional documentation could include:

- Proof that the provider has a comprehensive liability insurance policy, as is currently required for DMEPOS suppliers under 42 CFR § 424.57(c)(10)
- Proof that the provider maintains a primary business telephone at the appropriate site, as is currently required for DMEPOS suppliers under 42 CFR § 424.57(c)(9)
- A copy of the lease or deed for the provider's office location
- A legitimate business email address and a public-facing website.
- Copies of tax returns and/or audited financial statements (for changes of ownership, revalidation, and reactivation)
- Credit reports (for changes of ownership, revalidation, and reactivation)
- Proof that the provider employs the required clinical staff, such as payroll tax records
- Disclosure of any managing employees (e.g., Medical Director, Administrator) who are employed or contracted with another Medicare-certified entity

CMS should also conduct enhanced site visits prior to approving any home health agency or hospice enrollment application. Building on CMS's 2023 nationwide hospice site visit initiative,[12] these visits should include additional verification steps similar to those used during DME supplier site visits.[13] The national site visit contractor should be required to run a pre-visit report to identify whether other certified agencies or hospices are registered at the same address, given the demonstrated link between shared addresses and fraudulent activity. Members also recommend requiring a photograph of the physical facility as part of the application process as a basic and cost-effective verification measure.

[11] https://allianceforcareathome.org/wp-content/uploads/Final-Alliance-and-LeadingAge-Home-Health-and-Hospice-Program-Integrity-Recommendations.pdf
[12] https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care
[13] https://www.cms.gov/files/document/provider-enrollment-site-visits-npec-aug-2024.pdf

On fingerprint-based background checks, the Alliance's position is that any expansion to managing employees should be targeted to high-risk or fast-growth markets and provider types, not universally applied across the field. CMS should clarify the "managing employee" definition with MACs and State Survey Agencies to ensure consistent application. Members noted discrepancies between state and federal background check requirements and recommended that CMS work toward minimum national standards — for example, defining the timeframes for conducting background checks, the minimum criteria for an acceptable background check, and by directing MACs to identify approved vendors for background check services.

C. Preclusion List and Medicare Advantage Enrollment Requirements

The Alliance supports CMS's efforts to close gaps in the preclusion list that allow providers revoked from Medicare FFS to continue billing Medicare Advantage (MA) plans. Under current policy at 42 CFR § 424.535(a)(3)(i), providers revoked from Medicare FFS for reasons not considered "detrimental to the best interests of the Medicare program" are not included on the preclusion list, which is a gap that bad actors have exploited by shifting billing operations to MA plans where they can continue to submit claims and receive payment. We encourage CMS to examine the full scope of revocation reasons that should trigger preclusion list inclusion and to work with MA organizations to ensure the list is actionable, complete, and regularly updated.

At the same time, any requirement for providers to enroll in Medicare FFS as a condition of billing MA plans should be evaluated carefully for its operational and financial impact on home health and hospice providers that currently serve only MA beneficiaries. We encourage CMS to consult with home-based care providers before finalizing any such requirement and to consider phased approaches or targeted exemptions where the administrative burden would be disproportionate to the program integrity benefit.

F. Reducing Fraudulent Medicare Parts A and B Claim Submissions

The Alliance has serious concerns about proposals to shorten Medicare claim filing deadlines for home health and hospice providers, and we urge CMS to exempt these provider types from any such requirement.

Alliance members noted that home health and hospice billing is subject to unique complexities. For hospice this includes sequential billing requirements, overlapping hospice elections, and retroactive corrections. For home health, agencies are dependent on the patient's independent physician/practitioner to sign orders, plans of care and certifications, which often cause billing delays. For both home health and hospice, delays in provider number issuance for new enrollees also make shorter filing windows

operationally unworkable. A 90- to 180-day deadline does not account for these realities and could create automatic compliance failures for providers acting entirely in good faith. As one member noted during our listening sessions, new providers cannot bill until a provider number is received (a process that can take months), making any shortened deadline particularly harmful for new enrollees.

Currently, billing privileges for home health and hospice providers can be deactivated if the provider does not submit any Medicare claims for six consecutive calendar months. The Alliance believes this deterrent for fraudulent actors in the home health and hospice space can be more effective than reducing the claim filing deadline.

G. Artificial Intelligence in Medicare Advantage Coding Oversight and Hospital Billing

The Alliance supports CMS's interest in leveraging artificial intelligence and advanced data analytics to strengthen fraud detection, and we believe these tools hold real promise for improving the accuracy and efficiency of program integrity oversight. We applaud CMS's Chili Cook-off Competition as an innovative initiative to leverage AI to detect anomalies and trends in Medicare claims data and we encourage CMS to continue investing in this direction.[14]

However, our members strongly emphasize that AI tools used in program integrity must be transparent, validated, and informed by clinical expertise, particularly in home-based care settings, where patient complexity and clinical nuance can be misread by algorithms trained primarily on institutional data. Billing patterns that may appear anomalous, such as high utilization or extended lengths of stay, can reflect genuine clinical complexity rather than fraud. Without embedded clinical advisory input in algorithm design and oversight, AI tools risk misidentifying compliant providers and generating inappropriate adverse actions.

As members noted during our listening sessions, it is essential not only to define what AI can do in this context, but also what it cannot do. As we noted in our comment response to the RFI, Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care (90 FR 60108), without appropriate human oversight, AI tools could have an undue influence on reviewers in coverage decisions, where clinical expertise is important.[15] Clear boundaries must be established on both sides, and clinical advisory expertise should be embedded in the design, testing, and ongoing oversight of any AI-driven audit or fraud detection methodology. The Alliance urges CMS to invest in modern AI tools while ensuring they are subject to rigorous independent validation, ongoing monitoring, and meaningful human review before being used to trigger adverse actions against providers.

[14] https://www.cms.gov/priorities/crushing-fraud-waste-abuse/overview/crushing-fraud-chili-cook-competition
[15] https://allianceforcareathome.org/wp-content/uploads/Alliance-RFI-AI-Health-Care-2.23.26.pdf

H. Beneficiary Solicitation

The Alliance supports CMS's efforts to protect Medicare beneficiaries from unsolicited and potentially fraudulent outreach, and we agree that strengthening existing prohibitions on beneficiary solicitation is a warranted program integrity measure. We encourage CMS to ensure that any expansion of these requirements is clearly defined, with bright-line standards that distinguish prohibited solicitation from legitimate outreach, such as care coordination, follow-up on referrals, or patient education, so that compliant home health and hospice providers can continue to connect patients with the services they need. CMS should consider a regulatory definition of coercive outreach and provide clear guidance on what is acceptable versus prohibited marketing practices.

Related to beneficiary solicitation is the referral process from a healthcare provider or practitioner to a home health agency or hospice. Under 42 CFR § 482.43(d)(1)(i), hospitals must include in their discharge plan a list of home health agencies, skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), or long-term care hospitals (LTCHs) that are available to the patient, participate in the Medicare program and serve the geographic area (as defined by the HHA) in which the patient resides. CMS should consider such a list for hospices.

Additionally, CMS should consider strengthening transparency requirements related to hospice access in SNFs and nursing facilities (NFs). Consistent with residents' existing right to choose health care providers under 42 CFR § 483.10(f)(1), CMS should consider requiring the SNF/NF to provide a list of hospices with which it contracts and allow the patient to choose one of the contracted hospices in which to enroll. Where an ownership or management relationship exists between a facility and a contracted hospice, disclosing that relationship should be required.

I. Beneficiary Contact

The Alliance supports efforts to make it easier for Medicare beneficiaries to identify and report potentially suspicious claims, and we appreciate CMS's commitment to exploring new communication tools to advance this goal. We also support the pilot program testing beneficiary notifications in Nevada and California,[16] which represents a meaningful step toward helping individuals better understand their enrollment status and spot irregularities. Ensuring that beneficiaries are clearly informed when they are enrolled in Medicare will help those receiving care in the home use their benefits with confidence and reduce the risk of fraudulent claims being submitted under their information.

[16] https://www.cms.gov/files/document/sample-beneficiary-hospice-notification.pdf

The Alliance recommends that CMS require all hospice personnel communicating in person with individuals prior to hospice election to provide identification, such as an employee badge or business card, that clearly includes the name of the hospice or home health agency as it is stated in the PECOS record (legal title or DBA) as well as the name of the individual and their title.

J. Surety Bonds

While the Alliance supports the conceptual use of surety bonds as a program integrity tool, we reiterate the concern raised in our December 2025 letter with LeadingAge. CMS has struggled to enforce existing surety bond requirements effectively, and bond companies often lack accountability when fraud is found. CMS should improve oversight of bond entities and demonstrate effective enforcement of the existing framework before expanding bond obligations to home health, hospice, or other home-based care settings. Strengthening the existing requirement is a prerequisite to any meaningful expansion.

K. Medicaid and CHIP

The Alliance welcomes CMS's attention to program integrity in Medicaid and CHIP, and we particularly appreciate the emphasis on addressing instances of fraud that diverts services and funding away from the Medicaid program. Fraudulent activity is not a 'victimless crime,' as it severely impacts the provision of care to those with the highest level of need. Nationwide, Medicaid operates under significant resource constraints, leading to waiting lists for home and community-based services (HCBS) waivers that, in aggregate, exceeded 600,000 individuals in 2025.[17] Fraud that extracts resources from an already limited program results in less available care for those who legitimately need services. Ensuring the integrity of these programs is essential to protecting both beneficiaries and the providers who serve them in good faith.

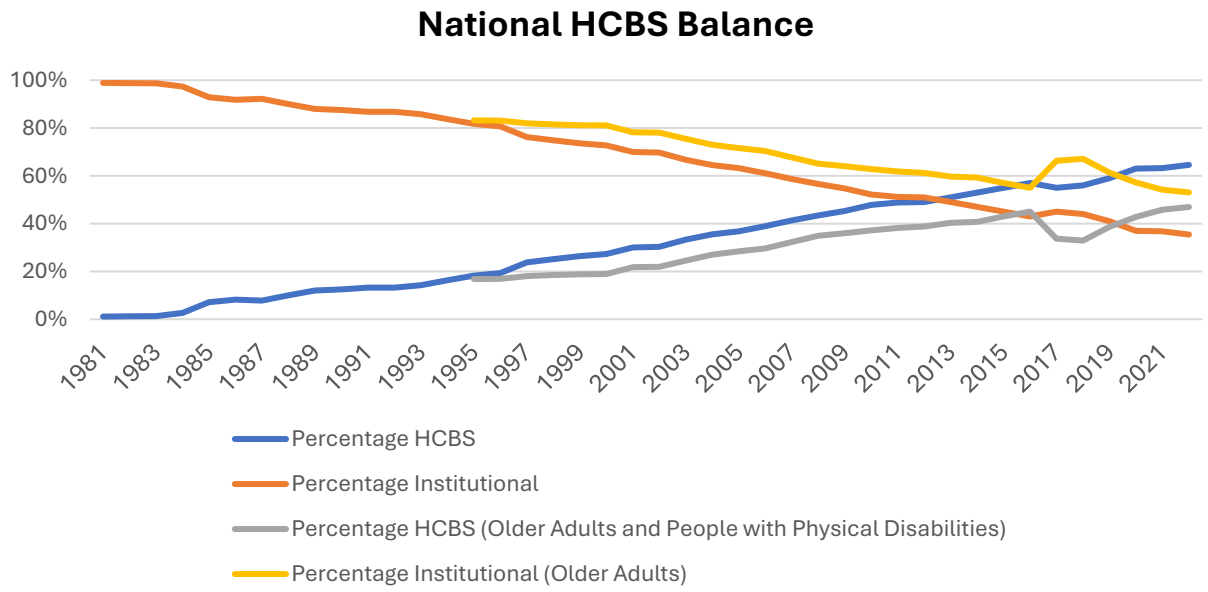
At the same time, we must stress the need for collaborative, targeted approaches that focus on areas of immediate fraud concern and do not impact the provision of legitimate, necessary, services. Personal care assistant (PCA) services and other HCBS programs serve individuals with some of the most significant chronic conditions and functional limitations in our healthcare system, and it is crucial to preserve access to care for these beneficiaries. Without these services, participants will see a significant decline in quality of life and will be placed at risk of adverse outcomes such as hospitalization and institutionalization. CMS must therefore ensure that these individuals are not negatively impacted by overly broad approaches to program integrity.

[17] https://www.kff.org/medicaid/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2025/

In addition to our formal recommendations, we believe that there are several policy and operational considerations that should be considered as CMS contemplates how to advance actions.

Utilization vs. Fraud

We want to highlight that there are many dynamics at play underlying the much-discussed growth in personal care services utilization and overall HCBS spending. Many of the factors leading to the increase in expenditures were deliberate policy choices and are not indicative of fraud among providers and beneficiaries. Decisions to advance HCBS in lieu of institutional care have historically been bipartisan in Congress and embraced by every Administration dating back to Medicaid's inception in 1965. It is extremely important that we do not conflate the results of policy decisions with fraudulent activities. For example, as the country has worked to prioritize the provision of care in noninstitutional settings, HCBS enrollment and spending have necessarily increased.



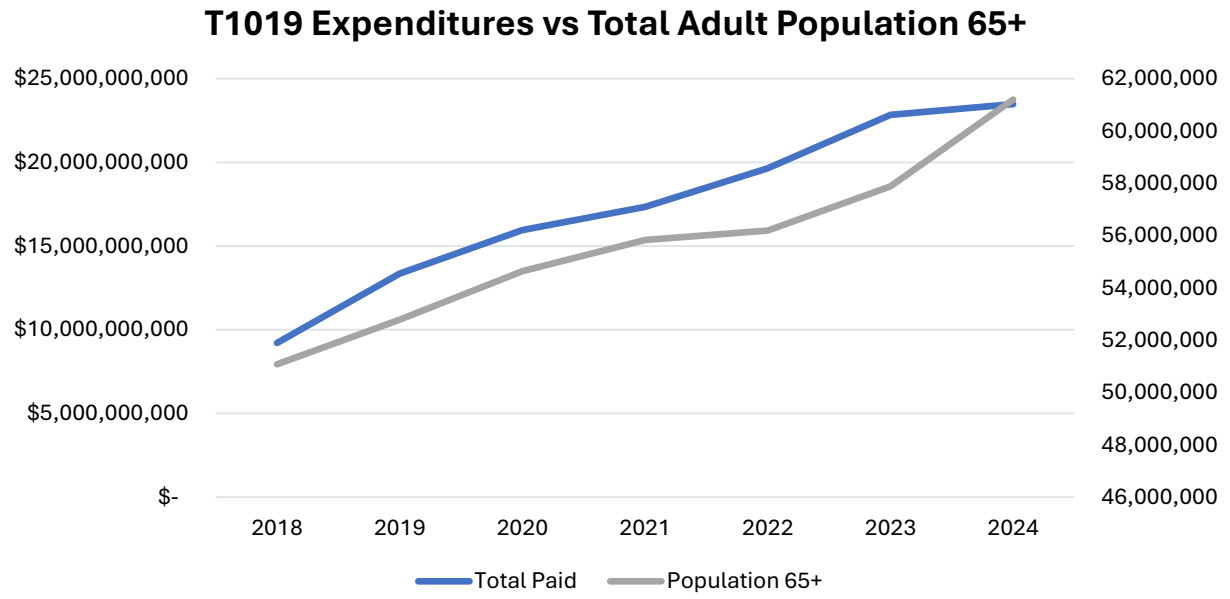
Source: CMS' Medicaid LTSS Data, available at: https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations

Similarly, the overall population of individuals who are likely to use HCBS is expanding rapidly. Not only is there a growing share of adults older than 65, the number of individuals greater than 70 or 80 is also increasing. These groups account for some of the highest utilization, and the demographic trends can explain some of the growth in expenditures. For example, when plotting aggregated annual expenditures for the "T1019" HCPCS code from the 2026 HHS Medicaid Data Release,[18] which represents a 15-minute increment of

[18] https://opendata.hhs.gov/

Personal Care services[19] and is one of the most commonly used home care codes in Medicaid, we can see how the broader demographic trends are increasing utilization.

The following chart reflects T1019 expenditures, aggregated into total spending per year, compared to the total population of adults older than 65 in the United States as reported by the United States Census. We want to stress that there are many other HCPCS codes included in HCBS, that not all HCBS users are 65 or older, and that not all adults over 65 are enrolled in Medicaid or use HCBS. However, mapping the increase of T1019 expenditures (one of the most common HCBS services) against the growth in the number of adults age 65 and older (one of the most common utilizers of personal care and HCBS) can be informative:



Some of the most significant expansions of HCBS since the program's inception have also occurred in the past 5 years. Section 9817 of the American Rescue Plan Act of 2021[20] provided states with an additional 10% Federal matching rate for HCBS expenditures, provided that the additional money was reinvested into the HCBS system and that states did not reduce existing benefits, payment rates, or participant eligibility. The subsequent projects, rate increases, and service and eligibility expansions were estimated to result in an additional $37 billion of HCBS spending across the country. This funding was utilized by

[19] There are many different ways that states operationalize T1019, including with specific modifiers for intensity level, different timeframes than 15 mins, supporting one or more individuals, or other dynamics; however, at its core this is a 15-min personal care code.
[20] Pub. L. 117-2

all 50 states and the District of Columbia to expand their programs.[21] Contrary to arguments about waste or concerns about partisanship, the projects were utilized to address a broad range of bipartisan priorities, including reducing HCBS waiting lists; increasing provider reimbursement and direct care worker wages; and expanding service options for participants.

The prior examples are not intended to dispute that there are legitimate needs to strengthen oversight and enforcement in the Medicaid program; however, we strongly believe that this context is crucial when the Administration evaluates Medicaid programs across the country and assesses concerns regarding fraud, waste, or abuse.

There may also be some instances where authorized hours are not appropriate for the needs of an individual. This is a separate discussion from fraud, though we recognize that concerns about whether utilization and spending trends are appropriate, even if they are not instances of fraud, are woven into the broader conversation regarding program integrity occurring around the country. As discussed below, there are mechanisms where this can be addressed in tandem with actions to strengthen fraud prevention.

Finally, we are concerned about any narrative framing HCBS services as 'inherently fraudulent.' While we recognize the need for program scrutiny and targeted reforms, we also urge recognition that the vast majority of providers and beneficiaries are providing and receiving services in good faith and that it is critically important to protect and preserve the ability for participants to access this crucial source of care.

Information Technology and AI

A significant portion of the RFI focuses on implementing technology, including Artificial Intelligence (AI), as a remedy for structural deficiencies in oversight. While AI presents opportunities for certain efficiencies, it is also important to recognize that fraud can flourish in a high-technology, low human touch environment. Unfortunately, individuals and entities seeking to defraud the system will be able to move more quickly in thwarting Government-implemented technology, by virtue of the fact that they are not subject to the rules and protections in place for the government and legitimate providers. Government procurement requirements, coupled with data security, privacy, and transmittal requirements, will necessitate slower, deliberate development, installation, and upgrades. Providers are subject to HIPAA requirements governing data use and transmission, which will place similar restrictions on the speed of new technological adoption.

The applicability of AI and analytic-based oversight will be even more challenging in Medicaid and HCBS than in some other programs or service categories. Even more so than

[21] https://www.medicaid.gov/medicaid/home-community-based-services/downloads/arp-sec9817-overview-infographic.pdf

other services, HCBS vary widely from state to state and can even differ significantly across different waivers and state-plan options within each state. The populations eligible, covered services, amount allowed, assessment tools, payment rates, and providers delivering care are vastly different within each specific HCBS program. Any AI or IT oriented solutions will be unlikely to identify aberrations in national data because, by definition, every state program *is its own aberration*. On a limited basis, AI algorithms may be useful in flagging providers that are aberrations from others within a distinct program for further follow-up.

Technology can be used to identify areas of potential concern but will require actual individuals following up to verify what is occurring at the service-level. Similarly, local, community-based, entities who are aware of the service and provider dynamics will be better suited to report potential irregularities than a computer algorithm, particularly once fraudsters become attuned to the types of inconsistencies that the technology flags and change behavior accordingly. If CMS seeks to leverage AI and advanced data analytics to strengthen Medicaid program integrity, it should be consistent with the principles outlined in our comments on Section G. This includes ensuring that any tools deployed are properly informed by the nature of support provided and population served, validated, and subject to meaningful human oversight.

In other words, we strongly encourage CMS to view technology and AI as a viable, but extremely limited, tool as part of a larger strategy.

Managed Care

Some policymakers and stakeholders have suggested that increasing managed care arrangements would assist with program integrity oversight. We disagree. States that CMS has cited as experiencing high rates of fraud, including Minnesota, California, New York, and Florida, all have robust managed care programs for primary and acute care as well as for post-acute care and HCBS. Our experience is that the use of managed care or state-run fee-for-service models of care does not make a difference in overall ability to combat fraudulent activity. Managed care provides a different approach to administration and oversight of services, but fraud operates independently of those delivery system choices.

One specific recommendation for managed care models is that plans should have an opportunity to report suspected instances of fraud directly to CMS and should be given greater ability to coordinate their own investigations with law enforcement and other oversight entities. While we believe that States are fully vested in ensuring program integrity, there may be statutory, regulatory, or operational issues that slow their responsiveness. Engaging Federal agencies, law enforcement, Medicaid fraud control units, and other outside entities earlier in the process will improve transparency and

coordination to ensure that identified issues are addressed in a more timely manner than may currently occur.

Further, states have extensive ability to build strong oversight requirements into health plan contracts. CMS should provide guidance regarding model language to incorporate into health plan contracts that establishes strong requirements for detecting, mitigating, and remediating fraudulent activity. Such guidance should include both upside and downside risk to health plans in order to properly incentivize these oversight activities.

Additional HCBS Policy and Operational Context

We also want to highlight the Medicaid program's core statutory and regulatory underpinnings, which are based upon a strong partnership between the state and Federal government. States are accountable to the same electorates and have similar laws, requirements, and fiduciary stewardship responsibilities as the Federal government. When fraud prevention and remediation is approached from the Federal-state partnership framework, cooperation is enhanced and solutions are advanced. We encourage CMS and state Medicaid agencies to pursue this partnership approach to strengthen the collective efforts to crush fraud in the Medicaid program.

Lastly, we reiterate our belief that fraud can be effectively prevented and addressed without punishing legitimate providers furnishing critical services in the home. We are concerned that some of the recent actions caused damage to legitimate providers and are further weakening an already overtaxed and under-resourced service system. Medicaid HCBS is a low margin/high volume service for providers. In other words, due to the way HCBS is financed and delivered, providers must provide a very large number of services with relatively low payment rates. This dynamic means that many smaller providers do not have reserves necessary to meet payroll when Medicaid reimbursements are halted or delayed, such as via blanket prepayment reviews, and may ultimately close their doors. Given the workforce shortages that already exist today are causing serious challenges with access to care, it is extremely important to not further erode the network of available service providers. These examples are not hypothetical; they have already been occurring as CMS and states move to address program integrity concerns around the country.

We stress that we are not suggesting or recommending that CMS and Medicaid agencies should refrain from higher scrutiny of HCBS providers. Rather, CMS and states should use technological efforts combined with the knowledge of communities, partners, case managers, and other related entities to flag claims and providers for further review and then deploy investigators, auditors, and/or licensure staff (as appropriate) to assess the legitimacy of the services and claims.

In summary, CMS must work closely with states and local communities to identify areas of concern, assess potential operational and financial shortcomings in the programs, and close the gaps that bad actors exploit.

Specific Medicaid Program Integrity Recommendations

With that background and context, we have several recommendations to strengthen the ability of CMS, states, and law enforcement to oversee Medicaid HCBS programs. We note that some of these suggestions will require Congressional legislation – which we hope can be achieved on a bipartisan basis – whereas others are already feasible within the statutory and regulatory framework. Where necessary, we encourage CMS and the Administration to advance legislative proposals for implementation and for Congress to swiftly enact proposals that will make a meaningful difference in service delivery and program integrity. Wherever appropriate, we provide commentary on needed changes to Federal law.

Collaborative Approach to Improvement

As discussed above, entities at the local level will have the greatest insight into the dynamics of care delivery. Providers, case managers, social service agencies, beneficiaries, and their advocates have ground-level knowledge of the potential vulnerabilities and irregularities occurring in specific programs. CMS should work with state and local governments to convene workgroups of these entities and individuals to help identify hot spots, areas of concern, and issues for further inquiry. These workgroups should contain a wide variety of stakeholders, including providers, case management agencies, law enforcement, CMS, state Medicaid, and other key partners. Proactively engaging the community to help identify fraud can improve the ability of regulators to focus on areas of highest concern and greatest impact.

Provider Licensure

We believe that appropriate and effective licensing is one of the most significant actions that CMS can take to address fraud in HCBS. There is a wide range of licensure requirements around the country, including some that have not been updated in several decades. More than a dozen states do not even require licensure prior to enrollment as a Medicaid personal care provider. Strong state licensure is an important component of program integrity. It would likely require a statutory change, but establishing some form of Federal minimum licensure requirement would be a significant step towards improving the safeguards in place.

As part of improving licensure oversight, the Federal government should mandate that the licensing and survey agencies are sufficiently staffed to fulfill their mission. On-site surveys and audits can provide one of the most effective ways to identify fraud as it occurs. Issues have occurred around the country partially due to a lack of capacity for oversight. State licensure and survey agencies are overwhelmed with workload and often are several years

behind the optimal survey and verification schedule. This will also likely require Congressional authorization.

Improving program integrity in jurisdictions across the country will necessarily require increased surveying resources. Further, any required staffing increases should also include a mandate to perform an onsite visit to providers upon enrollment in the Medicaid program as well as a review of locations with multiple registered agencies at same address. We strongly encourage states, CMS and, if necessary, Congress, to increase staffing to allow these important functions to occur on a timely and routine basis.

Establishing Additional Provider Enrollment Standards

CMS should also work with State agencies to establish consistent documentation and verification requirements for providers at the time of enrollment, potentially as part of the licensure requirements discussed above, to demonstrate that they are legitimate businesses. This information could include the furnishing of:

- Proof that the provider has a comprehensive liability insurance policy
- A copy of lease/deed for provider's office location.
- A legitimate business email address that is HIPAA compliant, a public-facing website, and an active phone number.
- Copies of tax returns and/or audited financial statements (for changes of ownership/revalidation/reactivation).
- Credit reports (for changes of ownership/ revalidation/reactivation)
- Proof that the provider employs staff, especially any required clinical and DCW staff (e.g., payroll tax records).
- Disclosure of any managing employees (e.g., Medical Director, Administrator) that are employed or contracted with another Medicaid-enrolled and/or Medicare-certified entity.
- Mandatory pre-enrollment training requirements for owners and managing employees, such as:
    a. Fraud, Waste, and Abuse and Compliance Program fundamentals
    b. Medicaid billing basics and claims integrity
    c. Core regulatory requirements for HCBS operations

Revalidation

CMS could consider requiring states to mandate more frequent revalidations for high-risk Medicaid home health and HCBS providers, consistent with the recommendations the Alliance made for Medicare, with annual revalidation for newly-enrolling providers in high-risk areas for the first three years. We note, however, state revalidation processes in Medicaid are already overburdened and frequently experience delays due to lack of sufficient staffing. Any efforts to enhance revalidation or increase the frequency must be

accompanied by procedural improvements and policy changes that reduce the burden of the revalidation process and reduce the delays inherent in the process.

Recovery Audit Contractors

Recovery Audit Contractors (RACs) often focus on improper payments and documentation errors rather than actual fraud due to their payment incentives coupled with the easier nature of finding documentation issues. CMS should evaluate changing the RAC compensation structure to incentivize fraud findings rather than non-recurring and minor documentation errors.

Transparency

CMS could also require states to conduct risk analyses, and associated corrective action plan for identified deficiencies, including items such as:

- Statistics on the number of providers and recent provider enrollment trend
- Evidence of active participant enrollment and service provision
- Survey and/or oversight activity for providers identified as inactive

Though we recognize that there are risks in publishing items that may provide specific details on vulnerable areas for malicious entities to exploit, transparency around steps taken to remediate identified concerns or active fraudulent activities will be important when strengthening trust in the Medicaid program. We also believe that states should make the corrective action plan publicly available.

We further believe that transparency is necessary regarding the costs associated with the various Federal and state contracts and activities to address program integrity issues and the results of those contracts. Given the significant resource constraints that Medicaid agencies operate under, ineffective or overly costly contracts should be terminated. Successful initiatives should be shared with other states to promote adoption. Transparency regarding costs and outcomes will help to ensure that limited resources are targeted to areas of most return on investment.

We also stress that accuracy is just as important as transparency. Publishing or highlighting unverified allegations raised can be harmful to the reputation of the entire industry of providers and can lead to individuals foregoing needed support. CMS and states must ensure that their efforts for transparency do not unfairly condemn individuals and entities that are not guilty of any improper activities.

Lastly, state contractors and state officials will often perform a provider audit but never share the results with those providers. Making aggregate information available publicly, and privately sharing specific findings, deficiencies, and recommendations with the entity subject to an audit would help those providers strengthen their own internal controls.

Electronic Visit Verification

Home health and personal care services are designated as particularly high risk by CMS and are cited in letters sent to Medicaid agencies requesting information on efforts to prevent fraudulent activity. We note that these services are already subject to the electronic visit verification (EVV) requirements contained in section 1903(l) of the Social Security Act; however, EVV has not been effective in preventing instances of organized and deliberate fraud. Issues with EVV are pervasive and those who seek to deliberately defraud the system can easily overcome the 'safeguards' it establishes. For example, a simple Google search can find multiple online tutorials about how to provide false location information to the systems.

Despite its ineffectiveness, EVV causes significant hardship to those legitimate providers who are attempting to comply with the rules and requirements of the Medicaid program. As just one example, the EVV infrastructure does not align with standard Medicaid billing practices, as the exact check-in/check-out times may vary due to the realities of a service delivery system compared to the 15-minute increments required by claims processing systems. Providers must therefore not only enter into costly contracts with EVV vendors, but they must also employ administrative staff to ensure that claims and billing are not rejected due to the challenges with EVV data alignment. States also spend millions of dollars across the country each year on purchasing and operating statewide EVV aggregators. These are not simply one-time sunk costs, as reprocurement requirements and ongoing operational and maintenance costs continue to draw resources away from Medicaid administrative budgets for this ineffective technology.

We therefore recommend that CMS and Congress revisit the EVV mandate and instead aim to reinvest those state and federal resources on infrastructure that will have a greater impact on fraud prevention, such as enhancing staff for licensure and certification oversight as well as enforcement.

Risk-Based Approach to Prioritization of Investigations

Modern forensic accounting approaches can identify suspicious and concerning billing patterns within the state MMIS claims records. CMS should work with states and outside firms with expertise in these strategies to categorize specific providers into tiers of risk for fraudulent behavior. Auditors and investigators can then prioritize enforcement with those entities in the highest tier and proceed according to risk. For example, an illustrative and non-exhaustive list of things that could be considered include:

- Tracking the participants that each agency serves can identify fraudulent providers that are recycling beneficiary ID numbers to defraud the Medicaid agency;
- Annual claims growth exceeding 500% (or a state-defined unusually high amount) for any single provider; or

- Claims submitted for same Medicaid member by different providers in mutually exclusive settings (such as HCBS and nursing homes) on the same day over multiple successive days.

Prepayment Audits

We understand and appreciate CMS' desire to move towards prepayment audits in lieu of "pay and chase" infrastructure given the challenges associated with recovering funds once they have been paid by Medicaid agencies. This model could be beneficial if it is deployed in targeted manners or instances without substantial existing prepayment controls. However, we reiterate our earlier comments about the realistic business operations of HCBS providers. As high-volume, low-margin businesses, there are often not sufficient reserves available to cover payroll and business expenses when reimbursements are significantly delayed. Experience around the country indicates that claims frequently are caught in non-fraud related delays or audit issues that focus more on administrative or clerical errors rather than true program integrity. As CMS evaluates potential prepayment reviews, we encourage you to ensure that program integrity efforts do not unintentionally restrict access to care by creating excessive administrative burden, delaying provider payments, or forcing closures of legitimate agencies.

Increased Data Sharing and Availability

We believe that CMS and states should strengthen the excluded provider requirements, specifically as they relate to provider agencies reporting issues with direct care workers. This information should be adequately collected by states and properly shared with CMS. Our members report that they frequently verify excluded individual lists but rarely find matches with direct care workers. The information should also be available to provider agencies so that they are aware of prior issues when a potential worker seeks employment with their agency. Home care agencies report that they are identifying and reporting issues with workers but struggle to find information and resources demonstrating how this data is collected and aggregated. Though we recognize challenges with making some of this information available publicly, CMS should require that states establish a process for enrolled and validated Medicaid providers to search nonpublic records to identify potential challenges with applicants.

CMS should also collect additional information about ownership of provider agencies that is made available at a national level. This resource would be crucial for states to reference when there are issues with multi-state providers with the same umbrella ownership but differences in NPIs, names, or other identifying information at the state level.

Case Management

Medicaid has a laudable statutory and regulatory framework for case management in many of its HCBS programs. High quality, independent case management, can be the key to

effective service delivery due to its focus on assessing need; developing plans of care and resulting authorizations; securing access to services; and monitoring delivery and participant wellbeing. Effective case managers can also be extremely helpful at identifying instances where fraud occurs. For example, if a case manager identifies enrolled providers that never accept referrals for HCBS participants, it could be an indication that the provider is not actually delivering care. Similarly, case managers should have monthly contact with participants to monitor their service provision and overall health and well-being. That contact could provide insight into providers who are billing for hours that aren't actually delivered.

However, despite a robust framework for case management, actual operations are hindered by under-resourced systems that overburden case managers with unreasonable client loads that prevent the service delivery from achieving their true potential for beneficiaries and anti-fraud activity. Similarly, case managers with excessive caseloads may be unable to effectively assess the level of need and develop appropriate individualized plans of care for participants. This can lead to authorizations for the maximum level of services regardless of individual participant characteristics, given the need to provide support but the inability to determine the appropriate levels. Additionally, the type of independent case management and person-centered planning is required for HCBS offered under 1915(c) waivers, but not for 1905(a) services such as private duty nursing, home health, and state-plan personal care services.[22]

We therefore recommend that CMS seek to implement caseload standards to allow case managers to appropriately serve individuals, allocate care effectively, and assist with identification of suspected fraud for additional investigation. We further recommend that CMS seek to align case management standards, and to require case management, for all HCBS. Standards should include specific case management qualifications and training requirements, to further support consistency, oversight, and informed decision-making. Such requirements will likely differ depending on the population supported by the case manager; however, a minimum level of requirements will likely improve overall service delivery. These recommendations will likely require statutory authorization from Congress.

Additionally, CMS and states can use data analytics to identify case managers that routinely authorize the maximum hours of service for all clients regardless of individual needs and characteristics. While we do not believe that these activities are fraudulent or due to poor intentions, they can be inappropriate and lead to waste in the system. Those case managers with routinely excessive authorizations can be flagged for additional training, remediation, and corrective action.

[22] States have the option to implement targeted case management under 42 CFR § 440.169 of the Social Security Act for specific populations, but no requirements exist.

Enhance Provider HCBS Quality Reporting
Although CMS has begun to establish mandatory HCBS quality reporting as part of the Medicaid Access Rule of 2024, it is not yet implemented nationwide. We recommend that this initiative be continued and strengthened to ensure that HCBS is included in broader efforts to improve quality of care. Further, we believe that quality reporting can also assist with fraud prevention and mitigation. Data collection protocols for HCBS quality generally enable the state to receive feedback from enrollees, which can be a direct conduit for identifying instances where the provider is billing for services that are not rendered to a specific beneficiary.

Establish Minimum Screening for Workers, Including Background Checks
While we recognize that there have been prior efforts to establish a national background check program, the implementation has been variable around the country. We recommend establishing minimum expectations for background checks, including fingerprinting; providing federal guidelines for the scope and breadth as well as timeliness of such investigations; and mandating that Medicaid payment rates cover the cost of those checks.

Require Minimum Training for DCWs
Minimum standards and mandatory training for DCWs can improve quality of care and reduce fraud by filtering out actors that are unwilling to complete those requirements. Therefore, CMS should require that all direct care workers have minimum training as part of service delivery. This training should include oversight and testing of competency to provide services, regardless of the service delivery model and should be provided by an independent organization acting on behalf of each state agency. Though we believe that there should be a minimum set of necessary skills to qualify as a direct care worker, we also recognize that there should options for the recipient of care to request a modification or exemption from certain skills or requirements if they are unnecessary or potentially harmful based on the participant's needs.

Agency Capitalization Requirements Similar to Those at 42 CFR § 489.28
Prior experience in homecare has demonstrated that undercapitalization can be a major red flag for an intent to defraud. We recognize that many small providers may not be able to meet onerous capitalization requirements and further recognize that there is value in small providers who can deliver culturally-competent services based on the unique needs and preferences of beneficiaries and communities. However, we also believe that HCBS delivery necessitates some level of organizational stability, particularly with increasing technology mandates and regulatory requirements. CMS and states should consider establishing a capitalization threshold for HCBS providers. In the absence of a 'hard' requirement that predicates Medicaid enrollment, failure could instead be used as an indicator for additional scrutiny to ensure business legitimacy prior to effectuating the

provider agreement and paying claims. These recommendations will likely require Congressional approval.

Individual Providers and Self-Direction

Self-direction has proliferated throughout HCBS over the past several decades as a confluence of policy decisions, beneficiary advocacy, and workforce shortages have promoted and necessitated the use of participant-selected providers. The Alliance affirms the value of self-direction and the benefits it provides to some participants and their families. We also note that some states, irrespective of self-direction, also allow for home care workers to enroll in Medicaid and provide services as individual providers rather than as employees of a provider agency. We do not believe that this is inappropriate nor do we recommend that CMS cease this practice.

However, we have concerns about differentiated oversight and regulatory requirements for agency providers compared to individuals and those employed under self-directed arrangements. Many Medicaid programs hold home health and personal care agencies to different (and higher) conditions and standards than those to which it holds independent and self-directed providers. While we recognize that some of our recommended standards – such as suggested requirements for business locations, websites, and payroll records – may not be applicable to individual workers, we believe that strengthening oversight of self-directed care is essential both from a health and safety perspective as well as to address issues of fraud and abuse. Generally speaking, unless there are specific reasons or exceptions – which should be allowable, but should also require justification and documentation on a case-by-case basis – all providers should be held to the same standards regardless of whether they are delivering services through agency, individual, or self-directed models of care.

The Alliance recommends that CMS provide direction to states regarding minimum standards that all providers must meet regardless of whether they are agency or individual entities. We further believe that CMS should require expanded oversight of self-directed arrangements, such as through enhanced case management monitoring. States that allow for self-direction generally have third party entities that support the provider enrollment, tax deduction, and claims processing for providers hired through self-directed models, frequently called Fiscal Intermediaries (FIs) or Financial Management Services (FMS). CMS should also provide guidance to states about enhanced requirements to place on FIs/FMS so that they are held accountable for monitoring the providers they support and ensuring that fraudulent activity is not occurring.

Recommendations for Collaborative State and Federal Actions

The Alliance encourages CMS to work in close partnership with states to develop program integrity standards that are consistent, enforceable, and informed by on-the-ground

experience. States and the Federal government should also engage home-based care providers as partners in developing program integrity strategies for HCBS and related services, while ensuring that any new requirements account for the operational realities of delivering care in community and home settings. There should also be recognition of increased costs to providers as they respond to these measures.

During Alliance listening sessions, members noted that fraud in home-based care settings is not solely a federal issue — it is also a state licensing and oversight issue — and that coordination between CMS and state authorities is essential to closing the gaps that bad actors exploit. California's moratorium[23] on new hospice licensure is a model of state-level action that, when paired with CMS's PPEO authority, can meaningfully slow the entry of fraudulent providers into the local market. States such as Texas and Colorado have also implemented useful databases and protocols for flagging suspicious patterns of co-location and shared addresses among providers — practices CMS should encourage broadly. In Medicaid, states have authority to pause provider enrollment and can similarly pair licensure moratorium, Medicaid provider enrollment freezes, and higher scrutiny on newly-enrolled entities to further buttress the Federal-State partnerships.

We recommend that CMS share best practices across states, strengthen federal-state data sharing, and work to identify incentives for states to proactively engage in program integrity efforts, with appropriate consequences for non-compliance with federal program integrity requirements. CMS should also publish and share the most up-to-date information on technology and data analytic tools available to help states identify and prevent fraud, waste, and abuse.

CONCLUSION

The Alliance commends CMS for its ongoing efforts to strengthen program integrity and protect beneficiaries, and we encourage the agency to continue advancing a targeted, risk-based oversight framework that leverages data analytics, AI, and other technology tools to detect and prevent fraud, waste, and abuse. Such an approach should focus resources on providers and geographic areas at highest risk while minimizing unnecessary burdens and protecting patient access to high-quality home-based care.

The roadmap for effective program integrity in home health, hospice, and HCBS is well-established. By enhancing enrollment controls through in-person site visits, validation surveys, stronger identity verification, while making better use of existing PPEO and RCD authorities, standardizing contractor and AO oversight, and improving transparency and

[23] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-25-04.aspx#:~:text=The%20California%20Department%20of%20Public%20Health%20(CDPH),date%20of%20adoption%20of%20the%20emergency%20regulations

public reporting, CMS can more effectively prevent bad actors from entering the program, respond swiftly to emerging risks, and preserve payment stability and access for the legitimate providers delivering high-quality care. It is equally important that CMS ensure that highly suspect and fraudulent billing activities do not impact home health and hospice payment rates or disrupt legitimate operations for compliant agencies.

We welcome the opportunity to answer any questions, provide further information, or participate in any future convenings related to the agency's program integrity work. If you have questions about our comments on home health and hospice, please contact me at HLoeffler@allianceforcareathome.org. If you have questions about our comments on Medicaid, please contact Damon Terzaghi, Vice President of Medicaid and Home Care Policy at dterzaghi@allianceforcareathome.org.

Sincerely,

/s/

Hillary A. Loeffler
Vice President, Policy & Regulatory Affairs
National Alliance for Care at Home