National Alliance for Care at Home

2/4/2026

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

Re: Recommendations to Strengthen Medicaid HCBS Program Integrity

Dear Administrator Oz:

The National Alliance for Care at Home (the Alliance) is writing to provide recommendations to support the Centers for Medicare & Medicaid Services' (CMS) ongoing work on program integrity in the Medicaid program.

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, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients 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.

On December 22, the Alliance and LeadingAge sent you a letter discussing opportunities to strengthen fraud, waste, and abuse protections in home health and hospice, with a strong focus on Medicare-led initiatives. This letter serves as a companion document from the Alliance with additional recommendations to strengthen Medicaid-funded program integrity. As we emphasized in our December 22 letter, the Alliance and our members strongly support efforts to strengthen program integrity and believe that fraud, waste, and abuse are unacceptable. We do not tolerate bad actors in this space. We further agree with the concerns you raised, as discussed in your January 27 online video, that money inappropriately diverted to fraudsters results in less care provided to those who truly need it.

The Medicaid program's core statutory and regulatory underpinnings 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, rather than an adversarial one, 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 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 actions right now around the country have caused damage to legitimate providers and are further weakening an already overtaxed and under-resourced service system. As CMS and the states continue to refine their oversight strategies, we encourage the agency to adopt measures that are analytically rigorous, operationally feasible, and take a targeted risk-based approach, consistent with CMS's statutory authorities.

Our detailed recommendations below are consistent with this approach, and we hope you find them helpful.

Convene State and Local Fraud Workgroups
Providers, case managers, social service agencies, beneficiaries, and their advocates have ground-level knowledge of the service dynamics associated with different parts of the country. CMS should work with state and local governments to convene workgroups of these entities and individuals to help identify hotspots, areas of concern, and issues for further inquiry. Proactively engaging the community to help identify fraud can improve the ability of regulators to focus on areas of highest concern and greatest impact.

Establish Risk-Based Approach to Prioritization
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, tracking the patients that each agency serves can identify fraudulent providers that are recycling beneficiary ID numbers to defraud the Medicaid agency.

Increase Federal and State Funding for Licensure and Survey Staff
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. Further, in some states there are HCBS providers without current licensure requirements. Improving

program integrity in those jurisdictions will necessarily require increased surveying resources. Further, staffing increases should 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.

Require Provider Licensure for HCBS Delivery

Depending on the state and provider type, some agencies are not subject to state licensure requirements in order to serve as a qualified Medicaid provider. According to preliminary review, approximately 35 states require some form of licensure for personal care services, though the scope and breadth of those requirements varies substantially. CMS should work with states to establish a minimum threshold of provider licensure requirements that entities must meet in order to meet Medicaid provider qualifications which, at a minimum, should include an on-site review by state surveyors.

Implement Additional Provider Enrollment Criteria

Require agencies to provide additional documentation 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:

1) Proof that the provider has a comprehensive liability insurance policy
2) A copy of lease/deed for provider's office location.
3) A legitimate business email address that is HIPAA compliant, a public-facing website, and an active phone number.
4) Copies of tax returns and/or audited financial statements (for changes of ownership/revalidation/reactivation).
5) Credit reports (for changes of ownership/ revalidation/reactivation)
6) Proof that the provider employs staff, especially any required clinical and DCW staff (e.g., payroll tax records).
7) Disclosure of any managing employees (e.g., Medical Director, Administrator) that are employed or contracted with another Medicaid-enrolled and/or Medicare-certified entity.

Increase Medicaid Case Management Capacity

Medicaid home care services, and particularly 1915(c) waivers that underpin the vast majority of HCBS across the country, are predicated on strong case management that monitors the health of and services provided to beneficiaries. Case managers can provide early warning of fraudulent providers as they are responsible for finding providers for their clients and can identify instances where illegitimate businesses are enrolled as Medicaid providers but may not actually be serving enrollees. Similarly, case managers who maintain

close contact with their clients can identify concerns when billed services are not being delivered.

Unfortunately, Medicaid case managers are overstrained and are often unable to perform functions beyond the bare minimum requirements. Research has indicated that optimal case management caseloads are 35-45 clients, yet some case managers have client loads in the hundreds. We recommend that CMS establish standards for case management caseloads and provide guidance regarding expectations for their oversight, monitoring, and reporting of suspected fraud in the system.

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. Though we believe that there should be a minimum set of necessary skills to qualify as a direct care worker, we also recognize that 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 participants needs.

Direct States and Providers to Collaborate on Direct Care Worker Monitoring
In some instances, fraud may exist at the DCW level unbeknownst to the provider. For example, direct care workers (DCWs) may move from one provider to another in order to avoid scrutiny for bad actions. As more states mandate direct enrollment of DCWs into data-systems, such as electronic visit verification (EVV) aggregators, states should allow providers to verify a DCWs prior employment and any issues that may have arisen.

Revisit EVV Requirements
The 21st Century Cures Act mandated that states implement EVV for personal care services and home health services in Medicaid. Unfortunately, a wide range of deficiencies have occurred with EVV implementation, limiting its effectiveness and creating more burden and costs than benefit or savings. For example, many of the services at the core of fraud concerns in Minnesota were subject to EVV yet the technology was inadequate to address

the underlying concerns. Specific deficiencies leading to this inadequacy include lack of proper interoperability between various EVV solutions and state aggregators; inability to properly and automatically link claims to EVV records; ability to 'spoof' locations via applications and/or burner phones; and various other limitations that undercut the promise of the technology. In summary, the current EVV system places burdens on legitimate providers who try to comply without properly preventing those bad actors who seek to circumvent the system and commit fraud.

Providers remain committed to ensuring that services are delivered appropriately, but we believe that the current EVV system has failed in its goals. We believe that EVV technology is no replacement for proper government oversight of agencies and recommend that CMS and GAO evaluate whether state, Federal, and provider resources currently spent on EVV technology would be better allocated towards staff for auditing, surveys, and other program integrity oversight.

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 Comparable Requirements for Agency, Individual, and Self-Direction Providers

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 participants and their families. We also have concerns about differentiated oversight and regulatory requirements for agency providers compared to individuals and those employed under self-directed arrangements. While we recognize that some standards – such as suggested requirements for business locations, websites, and payroll records – are not applicable 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.

The Alliance recommends that CMS provide direction to states regarding minimum standards that all providers must meet regardless of if 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.

Establish 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 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.

Conclusion
We appreciate the efforts that you have made to raise attention and awareness to program integrity concerns in the Medicaid program. We look forward to collaborating with you and all of CMS to strengthen policies and programs that protect these crucial resources and that effectively identify those who perpetuate fraudulent activities. If you and your staff have any questions about this letter or the recommendations we proposed, please contact the National Alliance's Regulatory team at: regulatory@allianceforcareathome.org.

Thank you for your consideration of these recommendations.

Sincerely,

Steven Landers, MD, MPH
Chief Executive Officer
National Alliance for Care at Home