December 22, 2025

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

Re: Recommendations to Strengthen Home Health and Hospice Program Integrity

Dear Administrator Oz:

The National Alliance for Care at Home and LeadingAge appreciate the opportunity to provide recommendations to support the Centers for Medicare & Medicaid Services' (CMS) ongoing work to modernize and strengthen program integrity across the Medicare and Medicaid programs. We strongly support CMS's ongoing efforts to strengthen program integrity and believe that fraud, waste, and abuse can be effectively prevented and addressed while reducing burden on legitimate providers furnishing critical services 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 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.

Program Integrity in Medicare Home Health and Hospice

Medicare home health and hospice fraud, waste, and abuse has historically been tied to geographic hot spots, often in regions with the highest numbers of Medicare beneficiaries.[1] In the mid-1990s, the Health Care Financing Administration (HCFA), the predecessor agency to CMS, launched Operation Restore Trust to address home health and hospice fraud.[2] This initiative initially focused on California, Florida, Illinois, New York, and Texas, and was subsequently expanded to other states. In September 1997, HCFA also implemented a six-month nationwide moratorium on the certification of new home health care agencies and stepped up its cost audits and medical reviews of claims.[3] More than a decade later, CMS revived and expanded this approach to combat fraud, waste, and abuse. In 2013, CMS began imposing health agency enrollment moratoria in certain areas of the country. These moratoria were extended in 6-month increments and ultimately expanded to apply statewide in Florida, Illinois, Michigan, and Texas until 2019. CMS also implemented the Home Health Pre-Claim Review Demonstration in 2016,[4] that later became the Home Health Review Choice Demonstration (RCD) launched in 2019 with the sunset of the enrollment moratoria. Today, RCD operates in Florida, Illinois, North Carolina, Ohio, Oklahoma, and Texas.

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[1] https://www.kff.org/state-category/medicare/medicare-enrollment/
[2] https://www.legistorm.com/stormfeed/view_rss/143022/organization/69541/title/secretary-shalala-launches-new-quotoperation-restore-trustquot.html
[3] https://pmc.ncbi.nlm.nih.gov/articles/PMC2690212/
[4] https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/pre-claim-review-initiatives/downloads/pcrd_hh_operational_guide.pdf

While CMS can expand RCD to all states in Jurisdiction M,[5,6] this expansion would not address areas outside of that jurisdiction that exhibit outlier patterns, such as increases in agency enrollments, high total number of agencies relative to beneficiaries, and high home health spending per fee-for-service (FFS) beneficiary, which have long been associated with increased risk of fraud, waste, and abuse.[7] In our respective comment letters in response to the Calendar Year (CY) 2026 Home Health proposed rule,[8] both the Alliance and LeadingAge highlighted that rapid increases in home health agency enrollments and associated aberrant billing patterns in Los Angeles County, California are impacting CMS's rate-setting calculations and are highly indicative of fraudulent activity.

Similarly, Arizona, California, Nevada, and Texas are now hot spots for Medicare hospice fraud, waste, and abuse with a recent surge of new hospices in those states. In California, the state implemented a moratorium on the licensure of new hospices effective January 1, 2022, which will remain effective until January 1, 2027, or one year after emergency regulations are issued.[9] CMS has responded by implementing a provisional period of enhanced oversight (PPEO) for newly enrolling hospices (including changes in ownership and reactivating after a period of deactivation) in Arizona, California, Nevada, and Texas, requiring pre-payment medical review.[10] Additionally, CMS conducted a nationwide hospice site visit project and subsequently expanded prepayment medical review to existing hospices in those four states.[11] CMS also implemented new regulations that require hospice certifying physicians to be enrolled or opted out of Medicare,[12] and subjecting hospices to the highest level of provider enrollment application screening.[13] While CMS has implemented several of the hospice program integrity recommendations previously put forth by the hospice industry,[14] we note that several recommendations remain outstanding.

Under your leadership, CMS has taken several meaningful steps towards its goal of "crushing fraud, waste, and abuse",[15] including the announcement of a recent CMS-State Tax Fraud Partnership,[16] a Chili Cook-off Competition aimed at leveraging Artificial Intelligence to detect anomalies and trends in

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[5] Jurisdiction M – Illinois, Ohio, Texas, North Carolina, Florida, Oklahoma, Tennessee, Louisiana, Georgia, Alabama, Indiana, Mississippi, Kentucky, South Carolina, Arkansas, and New Mexico.

[6] https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10599?DLPage=3&DLEntries=10&DLSort=1&DLSortDir=descending

[7] CMS's Market Saturation Tool provides this type of information and identifies "extreme values", available at: https://data.cms.gov/tools/market-saturation-utilization-state-county-mapping-tool

[8] https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf and https://leadingage.org/wp-content/uploads/2025/08/LeadingAge-CY2026HomeHealthProposedRuleCommentLetter-8.28.25.pdf

[9] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-53.aspx

[10] https://www.cms.gov/files/document/mln7867599-period-enhanced-oversight-new-hospices-arizona-california-nevada-texas.pdf

[11] https://www.cms.gov/files/document/cpi-hospice-fast-facts.pdf

[12] https://www.govinfo.gov/content/pkg/FR-2023-08-02/pdf/2023-16116.pdf

[13] https://www.govinfo.gov/content/pkg/FR-2023-11-13/pdf/2023-24455.pdf

[14] https://allianceforcareathome.org/wp-content/uploads/Hospice_Program_Integrity_Ideas_Hospice_Industry_Consensus.pdf

[15] https://www.cms.gov/fraud

[16] https://www.cms.gov/files/document/tax-fraud-letter-oz.pdf

Medicare claims data that can be translated into novel indicators of fraud,[17] the launch of a new prior authorization model (Wasteful and Inappropriate Service Reduction Model or WISeR) on January 1, 2026 aimed at reducing unnecessary or inappropriate services with little to no clinical benefit,[18] and major oversight changes for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) in the CY 2026 Home Health final rule.[19] We support and applaud CMS's ongoing efforts to strengthen program integrity and protect beneficiaries by more effectively identifying and removing fraudulent providers from the Medicare program. At the same time, we encourage the agency to further prioritize front-end safeguards that prevent ill-suited entities seeking to defraud the Medicare program from enrolling in the first place.

The recommendations below reflect our assessment of areas where CMS can leverage existing authorities, as well as implement regulatory or administrative refinements, in a risk-based targeted approach that would strengthen oversight and prevent bad actors from gaining access to the Medicare trust funds. We also suggest that CMS re-examine the 34 hospice program recommendations previously submitted to the agency and consider advancing those proposals not already implemented that would meaningfully strengthen oversight while preserving access to high-quality hospice care.[20] We stress that most home health agencies and hospices operate in good faith and are committed to delivering high-quality, compliant care to beneficiaries. In evaluating next steps, CMS should adopt a risk-based approach that exempts these providers from additional enrollment requirements and medical review activities to better focus agency resources on those providers at highest risk for fraud, waste, and abuse.

Strengthen Enrollment Controls to Mitigate Fraud and Integrity Risks

Strengthening oversight at the point of entry into the Medicare program is a critical component of effective program integrity. To advance this goal, CMS may need to consider targeted regulatory and operational changes to enhance identity verification and enrollment oversight, particularly in areas with elevated risk for fraud, waste, and abuse. CMS should also evaluate how existing authorities can be leveraged to support these efforts, including the regulatory framework finalized in the CY 2026 Home Health final rule at 42 CFR 424.510(d)(2)(iii)(C) that permits CMS to require the submission of any other documentation needed to validate the information on the enrollment application.

In light of these considerations, we offer the following recommendations that should be targeted towards areas at high-risk of fraud, waste, and abuse. We recommend that CMS:

- Require home health agencies and hospices to provide additional documentation at the time of enrollment, demonstrating that they are legitimate businesses. This information could include the furnishing of:
    - Proof that the provider has a comprehensive liability insurance policy, which is currently required for DMEPOS suppliers per 42 CFR 424.57(c)(10).
    - A copy of lease/deed for provider's office location.

[17] https://www.cms.gov/priorities/crushing-fraud-waste-abuse/overview/crushing-fraud-chili-cook-competition
[18] https://www.cms.gov/files/document/wiser-fact-sheet.pd
[19] https://www.govinfo.gov/content/pkg/FR-2025-12-02/pdf/2025-21767.pdf
[20] https://leadingage.org/national-hospice-leaders-urge-cms-and-congress-to-advance-program-integrity-in-hospice-care-through-effective-oversight/

  - 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 the required clinical staff (e.g., payroll tax records).
  - Disclosure of any managing employees (e.g., Medical Director, Administrator) that are employed or contracted with another Medicare-certified entity.

- Conduct enhanced site visits prior to approving a home health agency or hospice enrollment application. While CMS did undertake a nationwide site visit project for hospice in 2023,[21] more checks should be conducted during the course of the site visit, similar to the additional checks during DME supplier site visits.[22] The national site visit contractor should also be required to run a report prior to a visit to determine if other certified home health agencies or hospices are associated with the same address, as evidence shows fraudulent companies are linked to a shared address.

- Consider whether to require fingerprint-based background checks for managing employees listed on the provider's enrollment application. Currently, CMS requires fingerprint-based background checks for individuals with a 5 percent or greater ownership interest. As part of this effort, CMS should also clarify the "managing employee" definition with the MACs and State Survey Agencies for consistent application of this requirement.

- Revisit the current home health agency capitalization requirements at 42 CFR 489.28 that were originally established in 1998 and consider whether similar requirements should be put in place for hospices. Undercapitalization can be a major red flag for an intent to defraud. CMS should work with industry to identify ways to meaningfully update these requirements, while at the same time ensuring that any changes do not stifle competition. For example, CMS could establish more parameters around which banks and financial institutions can provide proof of operating funds (e.g., FDIC/NCUA insured) and also require the MACs to do more checks on the legitimacy of attestations provided by the identified bank/financial institution. CMS should also consider whether cost report information should be reviewed and audited in conjunction with a change in ownership when evaluating whether a home health agency has sufficient capitalization.

- 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.

[21] https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care
[22] https://www.cms.gov/files/document/provider-enrollment-site-visits-npec-aug-2024.pdf

With Industry Input, Develop a Risk-Based Approach to Guide Oversight Efforts

CMS has the tools to implement data-driven, risk-based oversight, including predictive analytics, targeted medical review, and focused payment oversight. Using a targeted, risk-based approach would prioritize oversight of home health agencies and hospices that exhibit billing patterns associated with elevated program integrity risk, ensuring that resources are focused where they can have the greatest impact.

For example, an HHA may be at higher risk for fraud, waste, and abuse in instances where a high percentage of certifications are completed by 1-2 physicians (potential for anti-kickback violations), a high percentage of patients are seen by 3+ agencies in a year (patient sharing), an agency has no low-utilization payment adjustment (LUPA) periods of home health care, an agency has no admissions from institutional referral sources (e.g., hospitals or skilled nursing facilities), and the agency is an outlier agencies with regards to patient lengths of stay. Other factors for both home health and hospices potentially associated with an elevated risk for fraud, waste, and abuse include clustering of agencies (co-location) and shared staff (e.g., Administrators, Medical Directors, etc.) across multiple locations. It is important to note that the presence of one or more of these characteristics or patterns does not necessarily mean a provider is engaging in fraud, unless proven through direct investigation. However, when a provider has several of these characteristics and are geographically clustered in certain areas of the country, they raise concerns about aberrant or fraudulent practices that warrant further review.

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 establish a comprehensive set of indicators that paint a more complete picture of program risk. This workgroup could also help to identify new and emerging risk factors earlier, identify operational barriers to oversight, and help to align program integrity modernization efforts with provider capabilities. A more sophisticated risk-stratified framework would focus oversight on providers with objectively elevated risk while reducing unnecessary administrative burdens for compliant agencies. Ensuring that program integrity efforts are targeted is critically important. We applaud this Administration for focusing on regulatory burden reduction. We want to support you in achieving both your goals of crushing fraud and reducing burden so that good actors can continue to provide high-quality care and bad actors are prevented from entering the Medicare program or quickly removed.

Better Leverage Regulatory and Enforcement Tools to Prevent Problematic Providers from Persisting in the Medicare Program

CMS has broad authority to regulate provider and supplier enrollment, revocation, and participation through regulations codified at 42 CFR Part 424 (provider enrollment), Parts 418, 484, and 489 (conditions of participation), and Section 1866(j) of the Social Security Act. As outlined above, Medicare home health and hospice fraud, waste, and abuse have historically been concentrated in areas exhibiting rapid provider growth, market saturation, and high spending per FFS beneficiary. While CMS has taken meaningful steps to strengthen program integrity, persistent and emerging hot spots highlight the need for sustained, risk-based post-enrollment oversight to address problematic providers. Targeted oversight efforts would allow CMS to intervene more swiftly against high-risk entities while minimizing disruption for compliant providers.

To strengthen the integrity of home health and hospice care in targeted areas at high risk for fraud, waste, and abuse, we recommend that CMS:

- 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.

- 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 and there would be no need for any additional or new forms.

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

- Use its 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) – "[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 process. CMS has leveraged this authority for hospice services in four states and could expand PPEO to home health and other areas of the country that are at high risk for fraud, waste, and abuse.

- In certain circumstances, CMS should still consider a targeted, strategic use of enrollment moratoria under Section 1866(j)(7), where data demonstrates concentrated fraud activity (e.g., home health agencies in Los Angeles, County). This should be coupled with PPEO in surrounding areas, and it should be clearly articulated when such moratoria will be lifted and what actions need to take place by that date (e.g., new regulations, working with states on licensure improvements).

- 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, CMS should require home health agencies and hospices in areas at high-risk for fraud, waste, and abuse:
    - To be surveyed once per year for the first three years.
    - To complete training from 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. This would not be a Targeted Probe and Educate program, but would require the participating providers to test their knowledge on a pass/fail basis.

- CMS revise the interpretive guidance and surveyor instruction in Appendix M to require AOs and state agency surveyors to implement new procedures to scrutinize whether the 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. Revisions should include surveyor contact with at least some of the contracted facilities for hospices not providing inpatient care directly. This contact should include questioning the contracted facility about education that the hospice has provided, how frequently the hospice and the contract facility communicate about bed availability, etc.

- Evaluate whether RCD has been successful in reducing fraud, waste, and abuse through a formal evaluation that is made public. 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.

Enhance Public Reporting to Improve Systemwide Accountability

CMS can significantly strengthen program integrity by more closely reviewing existing data and by expanding and modernizing the scope of publicly available data related to provider enrollment, survey outcomes, ownership, and comparative billing risk. The public availability of such information could allow providers – who work closely within their communities and often are the first to identify emerging issues – to flag concerning patterns or trends. This effectively multiplies CMS's oversight capacity and can provide earlier insight into potential problems.

We recommend that CMS:

- Develop Medicare Administrative Contractor (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 times the information is incomplete.

- Ensure the integrity of the CMS Market Saturation Dataset and work to update the data on a more timely basis (current tool only has data through 2024).[23] This data has the potential to be very useful and user friendly 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.

- Re-establish the Program for Evaluating Payment Patterns Electronic Report (PEPPER) (i.e., Comparative Billing Reports) and work with providers to revise and improve the target areas.[24] While these reports are meant to be used by providers to understand their billing patterns relative to their peers in CMS-identified areas of payment vulnerability, we also recommend that CMS review these reports and use them as part of a risk-based approach for targeted medical review activities. This includes identifying providers that do not access their PEPPER reports as part of an overall risk-based approach to oversight.

- Prioritize the transition of home health and hospice survey data from the Certification and Survey Provider Enhanced Reporting (CASPER) system to the Quality, Certification and Oversight Reports (QCOR) and correct current data errors and delays that risk misleading the public. This would include posting more current data on Home Health Agency Provider Reports which currently are only accurate and/or available through May 19, 2021. This nearly five-year delay in data allows bad actors to flourish. Ensuring the same functionality of home health and hospice provider data as skilled nursing facilities have on QCOR will improve insights of overall industry compliance and individual provider compliance.

- CMS should provide primers and tools that can aid the public interpretation of survey and deficiency reports. CMS should publish a user guide that explains how to read and evaluate survey data and Additionally, CMS should summarize and publicly report survey enforcement actions (e.g., how many surveys completed, deficiencies per survey, condition-level deficiencies, immediate jeopardy deficiencies, civil monetary penalties, accepted plans of correction) by state and by accrediting organization/State Survey Agency.

Increase Oversight and Standardization of CMS Contractor Activities and Reduce Burden for Compliant Providers

While CMS continues to strengthen oversight of home health and hospice providers, the agency should also expand its oversight of contractors, AOs, and State Survey Agencies to ensure consistent, effective, and high-quality operations across survey & certification, enrollment, claims review, and ongoing

[23] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county
[24] https://pepper.cbrpepper.org/index.html

monitoring. This expanded oversight will help safeguard program integrity while supporting compliant providers.

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.[25] Under the final rule, CMS is enhancing its supervision of AOs by requiring more frequent, specific, and detailed data submissions, expanding its ability to monitor AO operations, and strengthening its authority to respond when an AO is performing inadequately. These actions are intended to improve accountability, reduce program integrity risks, and protect beneficiaries and Medicare funds. 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 for Participation.

In addition, we recommend that CMS strengthen its oversight of all contractors that review and approve enrollment applications and conduct Medicare audits and reviews, including the MACs, Supplemental Medical Review Contractors (SMRCs), Recovery Audit Contractors (RACs), and Unified Program Integrity Contractors (UPICs). CMS should also undertake reviews, similar to the medical review accuracy checks currently conducted, to evaluate the MACs performance completing the required verifications at enrollment and revalidation to ensure accuracy and consistency in the provider enrollment process. For medical reviews and investigations, strengthened oversight should ensure that these contractors follow consistent, risk-based procedures and that staff conducting reviews and investigations have the appropriate experience and training to carry out their responsibilities effectively. Our members report that there is inconsistent and inaccurate application of the laws and regulations not only across contractors, but also within the same contractor when different staff are conducting reviews. Finally, CMS should publicly provide appeals data, especially information on denials overturned on appeal.

To further optimize oversight while reducing burden on compliant providers, we recommend that CMS evaluate whether it can leverage the RAC Data Warehouse and other data-sharing tools to coordinate contractor activity. By limiting multiple contractors from conducting audits simultaneously in the same geographic areas or on the same providers, CMS can reduce redundancy and administrative strain on home health agencies and hospices that demonstrate a history of compliance. Coordinated, standardized contractor activity, combined with targeted, risk-based oversight, will allow CMS to focus resources on high-risk areas while minimizing unnecessary disruption for providers operating in good standing. Additionally, CMS should implement ongoing monitoring and training requirements for contractors and review staff to ensure that audit and investigation practices remain consistent, accurate, and aligned with program integrity objectives.

Conclusion

The National Alliance for Care at Home and LeadingAge commend 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 public

[25] https://www.govinfo.gov/content/pkg/FR-2025-12-02/pdf/2025-21767.pdf

resources on providers and geographic areas at highest risk while minimizing unnecessary burdens and protecting patient access to high-quality home-based care. By enhancing enrollment controls, refining post-enrollment monitoring, standardizing contractor oversight, and improving transparency and 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 legitimate providers delivering high-quality care. It is important for CMS to also ensure that highly suspect and fraudulent billing activities do not impact home health payment rates or disrupt legitimate agency operations. 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.

Thank you for your consideration of these recommendations.

Sincerely,

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

Katie Smith Sloan
President & Chief Executive Officer
LeadingAge

Cc: Kim Brandt, Deputy Administrator, Chief Operating Officer, and Director of the Center for Program Integrity, Centers for Medicare & Medicaid Services

About the National Alliance for Care at Home (the Alliance): We are 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 include over 1,500 providers representing 10,000 offices and locations, serving over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. As an inclusive thought leader, advocate, educator, and convener, we serve as a voice for providers and recipients of home care, home health, hospice, palliative care, and Medicaid home and community-based services throughout all stages of life. Learn more at: www.AllianceForCareAtHome.org.

About LeadingAge: We represent more than 5,400 nonprofit aging services providers and other mission-driven organizations serving older adults that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information visit: leadingage.org.