DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 3, 2026

The Honorable Kathy Hochul
Governor of New York
NYS State Capitol Building
Albany, NY 12224

James V. McDonald, MD, MPH
Commissioner
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Amir Bassiri
New York State Medicaid Director
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Frank T. Walsh, Jr.,
Acting Medicaid Inspector General
Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

Dear Governor Hochul, Commissioner McDonald, Director Bassiri, and Acting Inspector General Walsh:

Pursuant to sections 1902(a)(4), 1902(a)(6), 1902(a)(27), 1902(a)(42), 1902(a)(64), 1902(a)(75), 1902 (a)(77), 1903(i)(2), and 1936 of the Social Security Act and implementing regulations at 42 CFR Parts 430.32, 431.16, 433.32, 455.12 and 456, which establish program integrity responsibilities for Centers for Medicare & Medicaid Services (CMS) and states' Medicaid programs, I am formally requesting detailed information regarding program integrity and provider screening and enrollment oversight within New York's Medicaid program. This request is necessary to ensure public confidence and protect beneficiaries in your state's Medicaid program.

CMS values the federal–state partnership that underpins Medicaid. As partners, CMS and state Medicaid agencies share mutual obligations and accountability to maintain the integrity of the Medicaid program. These obligations include reviewing claims payments and state policies or practices to ensure that Medicaid funds are used appropriately; confirming claims submitted for

Federal Financial Participation (FFP) comply with federal requirements; and ensuring effective safeguards exist to prevent and detect fraud, waste, and abuse (FWA).

Recent public reporting, federal prosecutions, and CMS analyses raise serious concerns about New York's oversight of personal care, home health, adult day care programming, non-emergency medical transportation (NEMT), and behavioral health services. This evidence, combined with New York's elevated per capita Medicaid spending and workforce utilization patterns that significantly exceed national norms, underscore the need for immediate investigation, corrective action, and enhanced transparency.

CMS Data and Recent Public Reporting on Fraud, Waste, and Abuse in New York

The data is clear, New York far outspends other states on its Medicaid program on a statewide and per beneficiary basis.

New York's Medicaid program costs over $90B a year—the second highest in the nation.[1] New York's average spending on each beneficiary is $12,528—36% higher than the national average.[2] New York's average Medicaid spending per resident was the highest in the country—nearly 80% higher than the national average.[3] These elevated costs reflect a combination of more New Yorkers enrolled in Medicaid relative to the state's population, potential fraud, expansive benefit structures, and excessive provider payment levels within New York's program compared with most other states.[4][5]

In addition to overall Medicaid enrollment size, one of the leading drivers of this high expenditure appears to be related to the workforce delivering long-term care, particularly home-based personal care services. Between 2023 and 2024, the home health and personal care aide job category represented 38 percent of all job growth in New York.[6] While CMS recognizes that changing demographic factors and legitimate care needs, such as keeping individuals in the home and out of institutional settings, may lead to proportional workforce increases, the numbers observed in New York remain disproportionate to what would reasonably be expected.

New York's significant Medicaid spending has resulted in a large long-term care workforce that, when combined with the vulnerabilities inherent in community-based services,[7] create a high-risk environment for FWA. Recent federal law enforcement actions by the Department of Justice underscore these concerns. In one case, two individuals pled guilty to a $68 million scheme

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[1] https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes

[2] https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-state-and-eligibility-group/

[3] Based on CMS-64 total Medicaid expenditure data (federal and state funds combined) divided by 2024 Census population estimates

[4] CMS-64 Medicaid expenditure data (compiled by KFF State Health Facts): https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/

[5] U.S. Census Bureau, 2024 State Population Estimates: https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html

[6] https://www.empirecenter.org/publications/health-workforce-jumps-by-another-10-percent/

[7] https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services

involving fraudulent claims for services not provided at Brooklyn-based adult day care centers and illegal kickbacks and bribes as a fiscal intermediary for the New York Medicaid Consumer Directed Personal Assistance Program (CDPAP).[8] In another case, 10 defendants were arrested in a home health aide fraud scheme, where Medicaid was billed for home health services that were never rendered.[9] These cases expose ongoing program integrity vulnerabilities within the New York State Medicaid program and home and community-based service delivery system that warrant structural program-integrity measures given the scale of such services. CMS seeks New York's assessment of, and proactive measures to address such risks.

CMS's Review of New York State Medicaid Claims for Federal Financial Participation

CMS has analyzed recent claims for FFP submitted by New York State Medicaid to CMS to better understand the scale of potential FWA in New York's Medicaid program. Analysis of personal care, home health, adult day care, NEMT, and behavioral health services reveal alarming spending patterns, rapid growth in high-risk service categories, and significant provider concentration that warrant immediate state attention and corrective action.

Personal care services represent an extraordinary concentration of Medicaid spending in New York. HCPCS code T1019 (personal care services, per 15 minutes) accounted for $44.6 billion in total payments from 2023 through 2025 (partial), with over 152 million claims spanning 14.5 million beneficiaries. The total payments for T1019 services were more than 20 times greater than the next highest paid code, T1020 (personal care services, per diem), which accounted for $2.06 billion over the same period. New York State Department of Health (DoH) data show approximately 6.8 million Medicaid beneficiaries as of July 2025.[10] CMS analyses show approximately 5.1 million beneficiaries received T1019 services in partial 2025 data, meaning nearly three out of every four Medicaid beneficiaries received personal care services during that time. CMS recognizes that the volume of claims and large number of beneficiaries served may represent claims payments for well-known and long-term Medicaid services. However, the time-unit structure of T1019, combined with provider concentration, extremely high claim volume, and exceptionally high proportion of beneficiaries receiving services, presents inherent risk for overbilling, documentation inadequacies, and additional claims billing spikes.

CMS analyses of home health aide services (G0156) claims demonstrate accelerating expenditure growth vastly outpacing population growth. In both 2023 and 2024, home health aide services' total payments increased a remarkable 65% from each prior year, amounting to $147 million and $242 million in respective total payments, while 2023 and 2024 beneficiary counts grew less than 45% from each prior year. Partial 2025 data show $293 million in payments, suggesting total yearly spending could exceed $350 million. While it is possible that increased home health aide services spending represents legitimate growth in access, the rapid growth and time-unit structure of these services may be indicative of FWA, similar to the trends in personal care services.

[8] https://www.justice.gov/usao-edny/pr/two-individuals-plead-guilty-68-million-fraud-scheme-brooklyn-based-adult-day-cares
[9] https://www.justice.gov/usao-sdny/pr/10-defendants-arrested-home-health-aide-fraud-scheme
[10] https://www.health.ny.gov/health_care/medicaid/enrollment/historical/all_months.htm

Adult day care services represent another area of major concern. Combined adult day care code (S5100–S5105) claims totaled approximately $571 million in 2023, $650 million in 2024, and $597 million in partial 2025 data. Center-based adult day care (S5105) alone accounted for $1.21 billion across this same period. CMS' analyses flagged S5105 as spiking (at least $100,000 billed in the most recent three months of data with a minimum of 50% increase in average monthly billing), with payments of $52.7 million in the most recent three-month analysis period, representing a 106% increase. This growth is occurring despite recent federal criminal prosecution of Brooklyn-based adult day care centers for $68 million in fraudulent billing.[11] CMS' analyses show the number of beneficiaries receiving combined adult day care services increased by 11% in 2023 and 14% in 2024 compared to the prior year. Significant year-over-year beneficiary growth in combined adult day care services underscores the need to verify documented attendance, confirm compliance, and identify duplicate billing to strengthen internal controls and reduce the likelihood of improper payments.

CMS analyses shows that NEMT represents $2.82 billion in combined spending across HCPCS codes S0215, A0100, and A0130 from 2023 through 2025 (partial). Non-emergency medical transportation; encounter/trip (T2003) was also flagged as spiking in the most recent three months of data, with $14.6 million in recent payments, representing a 121% increase from the prior three months. CMS found that eight of the top 20 highest-paid adult day care service (S5105) providers are also among the top 20 highest-paid NEMT providers for T2003. CMS recognizes the same provider billing for adult day care and NEMT services may reflect increased care coordination and reduced administrative burden for beneficiaries. However, this overlap could also suggest potential coordination between adult day care facilities and transportation services that may involve beneficiary recruitment schemes, inflated mileage claims, phantom rides, or billing for transportation to adult day care sessions that never occurred. That the same providers bill both services would seem to foster an environment ripe for coordinated fraud that current state controls may not detect or prevent.

Behavioral health psychotherapy codes 90832 (30-minute sessions) and 90834 (45-minute sessions) together accounted for more than $2.4 billion in total statewide payments from 2023 through 2025 (partial). The magnitude of utilization for these services warrants additional scrutiny of documentation, medical necessity determinations, and encounter validation, similar to other time-based billing codes utilized in New York.

CMS requests that New York provide written responses and supporting documentation addressing the following areas:

Fraud, Waste, Abuse, and Improper Payments — Program-Level Oversight

- How many full-time equivalent staff are employed by DOH whose primary job duty is related to fraud, waste, and abuse? Beyond full time staff, what contractors has DOH procured to address fraud, waste, and abuse? Please describe the scope of work, timeframe, total dollars for these contracts, and outcomes or results from these contracts.

[11] https://www.justice.gov/opa/pr/two-individuals-plead-guilty-68m-adult-day-care-fraud-scheme

- Does DOH establish targets for managed care plan fraud recoveries, and if so, on what basis are these targets determined and what targets has DOH established for plan recoveries?
- Does DOH receive cases referred to the state by managed care plans, and, if so, how many cases were referred to the state by plans, by year, over the past 5 years? What were the resolutions of those cases?
- Does DOH refer cases to the state's Medicaid Fraud Control Unit (MFCU) and Office of the Medicaid Inspector General (OMIG), and if so, how many cases were referred to the MFCU and OMIG by the state, by year, for the past 5 years? What were the resolutions of those cases?
- What are the primary areas where FWA has been identified and expenditures recovered in the past 5 years? Please specify the amount of expenditures recovered in each area.
- Does DOH have internal controls, in addition to those required by CMS, to identify and recover potential FWA expenditures? If so, what are those controls?
- Does DOH evaluate and monitor whether managed care plans have any internal controls to identify FWA and recover associated overpayments? If so, please explain.
- Does DOH validate encounter data from managed care plans to ensure it accurately reflects services delivered, pursuant to 42 CFR 438.818?
- How many payment suspensions did DOH implement due to credible allegations of fraud over the last 5 years, pursuant to 42 CFR 455.23?
- Please provide all guidance, policies, or training materials related to state staff responsibilities for fraud detection, prevention, and reporting.
- Please provide all guidance, policies, or training materials related to FWA that have been shared with New York State Medicaid providers.
- Please provide all reports from Quality Improvement Organizations (QIOs), External Quality Review Organizations (EQROs), or other independent review bodies from the past 5 years that identify or describe overpayments, instances of upcoding, or fraud.
- Please provide all records or logs documenting allegations of FWA referred to the state from providers, managed care organizations, or other stakeholders over the past 5 years, including how these cases were investigated and resolved.

Provider Screening, Enrollment, and Revalidation

- Please provide a list of all currently enrolled New York State Medicaid providers, regardless of investigation status.
- What criteria does DOH use to determine the risk level (limited, moderate, high) that applies to New York State Medicaid providers pursuant to 42 CFR 455.450?
- Does DOH conduct off-cycle revalidations pursuant to 42 CFR 455.414, and if so, in what circumstances and what is the scope of such revalidations?
- Does DOH allow for exceptions that prevent provider termination, such as for sole community providers or rural providers, and if so, what are these exceptions?
- How many providers have been suspended and/or terminated, including through off-cycle revalidation, in the past 5 years?
- In what circumstances does DOH suspend or terminate a New York State Medicaid provider's enrollment beyond federal reasons outlined in 42 CFR 455.416?

- Does DOH identify and monitor related entities, common ownership, or shared management across multiple enrolled providers, and if so, how?
- What tools are used to detect improper provider screening, enrollment, and revalidation, across locations?

Program Integrity Infrastructure and Accountability

- Are program integrity responsibilities divided among DOH, MFCU, other state agencies, managed care plans, contractors, or providers, and if so, how?
- What metrics does DOH use to assess the effectiveness of its program integrity initiatives over time? How are these metrics publicly displayed?
- Are trends in error rates, recoveries, and enforcement outcomes evaluated and reported to the public, and if so, how?
- How, including by what metrics, does DOH measure potential FWA risks, and use that information to prioritize prevention, detection, and remediation activity and staffing?

Targeted Oversight Questions to Address High-Risk Billing Patterns and Systemic Vulnerabilities in New York State Medicaid

- Does DOH undertake any fraud investigation or oversight specifically related to the below list of five high-risk services, and if so, what activities has the state undertaken?
    - Adult day care services
    - Personal care services, including those covered in Sections 1905, 1915, and 1115 of the Social Security Act
    - Behavioral health services
    - NEMT services
    - Home Health Aide services
- What steps is DOH taking to investigate the overlap between top providers of the high-risk service categories identified above, to ensure there are no improper kickback or steering arrangements?
- How frequently does the state conduct post-payment reviews or audits for the five high-risk service categories identified above?
- What are DOH's total annual overpayment recoveries for the past 5 years, and what proportion relates to each high-risk service category identified in this letter?
- What data analytics tools or dashboards are currently deployed to flag coding intensity and utilization anomalies across the five high-risk service categories identified above?
- What documentation can the state provide as evidence that Electronic Visit Verification has been implemented and is being used in compliance with the 21st Century Cares Act?
- What processes are in place to monitor high-volume providers of personal care, home health, adult day care program, NEMT, and behavioral health services?
- How does New York State Medicaid identify and investigate outlier providers with unusually high claim volumes or concentrations of payments in narrow service categories?
- What controls exist to detect upcoding or overuse in behavioral health or personal care services, especially for services with time-bound delivery codes (e.g., 90832, 90834, and T1019)?

- How does DOH use predictive models or algorithms to detect patterns of FWA in community-based services?
- What corrective actions are applied when documentation deficiencies or improper billing are identified?
- How does the state coordinate with law enforcement to address systemic vulnerabilities and pursue recovery of improper payments? What are the recent results of such coordination?
- For personal care services, how does DOH ensure that individuals meet the needs criteria and level of care for the different authorities?
- How does DOH use its Electronic Visit Verification (EVV) data to identify suspected fraud, waste and abuse for agency and individual Personal Care Aides (PCAs)?
- What safeguards and thresholds does DOH have in its personal care services, such as location when clocking in on EVV, manual entry of services as opposed to using EVV, radius in miles of where PCA clocked in from where they deliver services, etc.?
- How does DOH use EVV data to monitor self-directed care and paid family caregivers?
- For 1905 personal care services, how does DOH monitor for fraud and how does DOH monitor for waste?
- How many individuals in the DOH 1915k program utilize personal care services and how does DOH monitor for fraud?
- For self-directed care and paid family caregivers, what internal controls does DOH have to mitigate or address FWA?
- How many fraud, waste, and abuse allegations have been identified for personal care services by agency, individual independent provider, self, and family caregiver in the past 5 years? What are the resolutions of those allegations?
- Given that NY Medicaid has one of the highest rates of spending on personal care services per capita among all states, can you measure how high-need the beneficiaries are in terms of activities of daily living (ADL) and instrumental activities of daily living (IADL), and what evidence does DOH have that these services are preventing institutionalization?
- How many CDPAP recipients have qualified at each level of need — 1IADl, 2IADL, 1 ADL, 2 ADL, etc.
- What training do personal care attendants have to undergo? What screening do they have to undertake (i.e., fingerprints, interviews of associates)?
- What is the average number of hours a personal care attendant provides in a week, what is the maximum number of hours a personal care attendant provides, and how many personal care attendants are providing the maximum number of hours?
- What organization credentials and oversees personal care attendants in NY Medicaid?

CMS respectfully requests that the state submit its response, along with any relevant supporting documentation, within 30 days of receipt of this letter. If additional time is required, please notify CMS promptly with a proposed timeline.

We look forward to your timely response.

Sincerely,

Dr. Mehmet Oz

NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.