DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 27, 2026

The Honorable Gavin Newsom
Governor of California
Office of the Governor
1021 O Street, Suite 9000
Sacramento, CA 95814

Dear Governor Newsom:

Pursuant to the Centers for Medicare & Medicaid Services' (CMS) statutory and regulatory oversight authorities under Title XIX of the Social Security Act, I am formally requesting detailed information regarding program integrity, eligibility verification, and provider oversight within California's Medi-Cal program.

California's Medi-Cal program is one of the nation's largest and most complex Medicaid systems, spanning fee-for-service (FFS), managed care, and the In-Home Supportive Services (IHSS) programs. Because of this structure, program integrity is not a single function but a set of controls and accountability mechanisms that must work across multiple delivery and administrative models.

Medi-Cal is federally overseen by CMS and administered by California's Department of Health Care Services (DHCS), which manages federal claiming, managed care oversight, and program integrity efforts. The California Department of Social Services (CDSS) oversees IHSS, while California's 58 counties conduct Medi-Cal eligibility determinations, IHSS assessments, and service authorizations. This locally administered system supports community-level operations but makes statewide consistency, data alignment, and oversight more difficult.

IHSS program expenditures total approximately $29 billion annually, with the federal government matching roughly 50% of the state's costs through federal financial participation (FFP)[i]. The state contributes approximately $10.6 billion, and counties fund the remaining share through their Maintenance of Effort structure. **IHSS expenditures in California have grown by approximately *348%*** from 2015-16 to 2025-26.[ii] [iii]

In addition to this exceptional growth in spending, several recent developments have raised concerns about California's oversight of these funds.

As you know, California operates a state-only health care program for adults who are not eligible for full Medicaid benefits due to immigration status. As part of an increased oversight plan established last year, CMS began conducting focused financial reviews to ensure that California and other states that operate these programs do not receive FFP for non-emergency or full benefit Medicaid services for individuals with an unsatisfactory immigration status (UIS).

In total through this work, CMS has identified over $1.6 billion in federal funds that the agency is recouping from California through voluntary recoveries and deferrals of future Medicaid payments to California. It is particularly concerning that California accounts for over $1.6 billion of the $1.8 billion, or more than 88%, of the funds that CMS is recouping from the seven states and Washington DC that operate these programs.

In 2024 alone, spending for home health care in CA increased by more than 21% -- representing the largest growth rate of any major health category nationwide. The number of home health agencies in California almost doubled between 2019 and 2024. LA County alone accounted for $1.4 billion, representing almost 9% of total FFS home health spending for the entire country, though comprising just 2% of national FFS enrollment[iv]. That's 5 times more than expected LA home health is taking money from other agencies nationwide, so fewer Americans can get access to these vital services. During a recent CMS visit to California, I met with several provider groups that raised numerous concerns that while the state has increased fraud enforcement activity, the state's efforts have been inadequate to stifle its explosive growth.

Given these concerns, CMS requests that the State of California provide us with a comprehensive program integrity action plan that incorporates written responses and supporting documentation addressing the following areas:

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

- Does DHCS establish threshold dollar targets for managed care plan fraud recoveries? If so, on what basis are the thresholds determined, do the dollar thresholds vary by plan size or other characteristics, and what targets has DHCS established for plan recoveries?

- Does DHCS receive cases referred to the state by 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 DHCS refer instances of suspected fraud to the state's Medicaid Fraud Control Unit (MFCU), and if so, how many matters were referred to the MFCU by the state, by year, for the past 5 years? How many such referrals did the MFCU accept, and how many did it reject? What were the resolutions of those matters

- What is the per capita rate of recovery by Medicaid managed care plans?

- What are the primary areas (topical, going to service type, and, as relevant, to geographical considerations) where fraud has been identified?

- For any areas where fraud has been identified, have these led to monetary recoveries?

- Does DHCS evaluate and monitor whether Medicaid managed care plans have any internal controls to identify and recover fraud?

- Does DHCS undertake any fraud, waste, and abuse (FWA) activities related to the below list of 14 high-risk services that have been the focus in MN, and if so, what activities has the state undertaken?
    - Adult Companion Services
    - Adult Day Services
    - Adult Rehabilitative Mental Health Services
    - Assertive Community Treatment
    - Early Intensive Developmental and Behavioral Intervention
    - Housing Stabilization Services
    - Individual Home Supports
    - Integrated Community Supports
    - Intensive Residential Treatment Services
    - Night Supervision
    - Nonemergency Medical Transportation
    - Peer Recovery Services
    - Personal Care Assistance / Community First Services and Supports
    - Recuperative Care

- Does DHCS validate encounter data to ensure it accurately reflects services delivered and supports program integrity monitoring?

- All immigration enumerators, if applicable, for every Medicaid beneficiary including:
    - Citizenship / immigration information from Medi-Cal health insurance application
    - USCIS/Alien Registration number (A-Number)
    - Form I-94, Arrival/Departure Record number
    - Student and Exchange Visitor Information System (SEVIS) ID number
    - Card Number/I-797 Receipt number

- All currently enrolled Medicaid Providers, irrespective of investigation status.

- All Medi-Cal provider enrollment forms from the past 5 years.

- Does DHCS and the Medicaid managed care plans with which it is contracted implement payment suspensions due to credible allegations of fraud, and if so, how many payment suspensions were implemented over the last 5 years? How many, if any, good cause exceptions to payment suspensions has the state permitted?

- Does DHCS test managed care plan compliance with fraud, waste, and abuse obligations under federal managed care regulations, and if so, how and what findings/results has DHCS obtained?

Eligibility Determination and Immigration Status Controls

- What controls are in place to ensure county eligibility determinations are accurate at initial enrollment and renewal?

- Does DHCS audit county eligibility determinations, and if so, how, and what error rates are observed?

- What DHCS processes exist to prevent or detect misclassification errors related to immigration status that may impact the eligibility for and availability of federal matching funds, and how does DHCS correct any such errors?

- Given known data limitations, what steps is DHCS taking to improve its ability to track Medi-Cal utilization and costs by eligibility category, including populations with unsatisfactory or unverified immigration status?

Provider Screening, Enrollment, and Validation

- What criteria does DHCS use to determine the risk level (limited, moderate, high) that applies to Medi-Cal providers?

- Does DHCS conduct off-cycle revalidations, and if so, in what circumstances?

- What criteria does DHCS use to determine whether and when to impose a payment suspension?

- In what circumstances does DHCS terminate a provider's enrollment?

- Does DHCS identify and monitor related entities, common ownership, or shared management across multiple enrolled providers, and if so, how?

- What tools, including reviews, audits, and other mechanisms, are used to ensure proper provider screening, enrollment, and revalidation (and to detect improper provider screening, enrollment, and revalidation) across locations or programs?

- Does DHCS verify that managed care plans conduct required provider credentialing, screening, and ongoing monitoring, and if so, how?

Program Integrity Infrastructure and Accountability

- Are program integrity responsibilities divided among DHCS, counties, managed care plans, and other state agencies, and if so, how?
- What metrics does DHCS use to assess the effectiveness over time of its program integrity initiatives?
- Are trends in error rates, recoveries, and enforcement outcomes evaluated and reported to CMS and the public, and if so, how?
- How does DHCS prioritize its program integrity objectives and determine personnel/resource tasking?

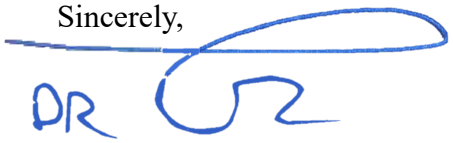
In-Home Supportive Services (IHSS) — Program-Specific Oversight

- Over the past decade, IHSS spending has grown dramatically from approximately $8.2 billion in 2015–2016 to approximately $28.5 billion in 2025–2026. What factors are driving this significant increase in program costs?
- Do CDSS and DHCS coordinate oversight of IHSS, including eligibility, provider enrollment, payment, and federal claiming, and if so, how?
- Does the state determine whether IHSS participants with cognitive impairment are capable of self-directing their own care, and if so, how? Specifically, what criteria or assessment tools are used to evaluate such individuals' ability to make decisions, manage caregivers, and ensure their own safety when cognitive impairment is present?
- What screening level (limited, moderate, high) applies to IHSS providers, and how often are such providers revalidated?
- Are IHSS providers enrolled at the agency level or at the individual service-provider level?
- Does CDSS or DHCS identify providers billing across multiple recipients, counties, or programs, and if so, how?
- Does the state monitor variability in county functional-need assessments and authorized service hours, and if so, how?
- Are assessments periodically audited for accuracy and consistency, and what corrective actions occur when discrepancies are identified?
- What controls exist to prevent payment for services rendered during periods of ineligibility or incorrect scope assignment?

- What are the most common sources of IHSS improper payments identified through audits or reviews?
- Does the state track recoveries, referrals, and corrective actions specific to IHSS, and if so, how?
- What enhancements are planned to strengthen program integrity across Medi-Cal delivery systems, particularly in high-volume, process-driven programs such as IHSS?

CMS requests that the state submit its initial response, along with any relevant supporting documentation, within 21 days of receipt of this letter. We look forward to your timely response.

Sincerely,



Dr. Mehmet Oz

cc: Tyler Sadwith
California Medicaid Director

Dan Brillman
Director, Center for Medicaid & CHIP Services, Centers for Medicare & Medicaid Services

Kimberly Brandt
Acting Director, Center for Program Integrity, Centers for Medicare & Medicaid Services

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[i] The 2025-26 California Spending Plan: Human Services
[ii] CA LAO 2015-16 Budget Analysis of the Human Services Budget
[iii] CA LAO 2025-26 Human Services Spending Analysis
[iv] 2021-123.pdf