CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

June 5, 2026

THIS LETTER SENT VIA EMAIL

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, DC 20201

CALIFORNIA RESPONSE TO CENTERS FOR MEDICARE & MEDICAID SERVICES' PROVIDER REVALIDATION STRATEGY REQUEST

Dear Dr. Oz,

The California Department of Health Care Services (DHCS) acknowledges the Centers for Medicare & Medicaid Services' (CMS) April 23, 2026, correspondence requesting a two-year plan to revalidate high-risk providers. As indicated in previous communications to you, California shares CMS' commitment to swiftly reviewing high-risk providers and ensuring that Medicaid provider enrollment data remains accurate, current, and limited to only qualified providers participating in the program. California values our partnership with CMS in ensuring Medicaid programs operate with accountability, transparency, in compliance with federal requirements, and consistent with federal approvals. We share a strong commitment to protecting taxpayer resources and maintaining public confidence in Medi-Cal.

DHCS prioritizes the integrity of the Medi-Cal program through strong protocols to prevent and vigorously combat fraud, waste, and abuse. To protect Medi-Cal, DHCS uses strong oversight, audits, fraud detection, investigations, payment suspensions, cost recovery, provider terminations, and strong partnerships with law enforcement to support civil and criminal prosecution of bad actors, holding those who violate program rules fully accountable. Rigorous provider screening, enrollment, and revalidation processes are in place today – including safeguards and reviews that go above and beyond minimum federal screening requirements – to ensure that only legitimate, qualified providers participate in Medi-Cal. A very detailed description of these efforts was also transmitted to you earlier this year.

California administers Medi-Cal under a comprehensive statutory and regulatory framework that complies with and exceeds federal provider screening and enrollment requirements, including 42 C.F.R. §§ 455.410, 455.414, and 455.450. Within this framework, the State applies a continuous, risk-based approach to provider enrollment, screening, and revalidation, supported by ongoing data validation, monitoring, and

enforcement activities. California exceeds minimum federal provider screening requirements in several ways, including by reviewing all enrolled locations and applying state-specific standards, including verification of Established Place of Business requirements[1]. California also requires providers to report changes in ownership, service location, or practice sites within 35 days – events that automatically trigger off-cycle revalidation to ensure provider information remains accurate, current, and fully aligned with Medi-Cal program integrity expectations. *These heightened requirements for off-cycle revalidation have been in place at state discretion for over a decade. The following provider revalidation strategy builds on this comprehensive foundation by expanding and operationalizing off-cycle revalidation activities over a two-year horizon, with particular focus on providers presenting elevated program integrity risks.*

DHCS prides itself on being recognized by CMS as a program integrity leader that has consistently implemented program integrity best practices. For example, DHCS has collaborated extensively with CMS' Center for Program Integrity (CPI) and has served as faculty for both CMS' Medicaid Integrity Institute (MII) and CMS-convened program integrity training courses, reflecting the State's role as a national leader in Medicaid oversight. DHCS has served on various MII workgroups such as CPI's annual MII education curriculum development and national performance metric and Return on Investment methodology development. DHCS has presented on its comprehensive investigative strategies to identify fraud networks involving collusion among multiple provider types to exploit targeted members at the MII and National Association of Medicaid Program Integrity conferences. DHCS' designated Program Integrity Unit served two terms on the executive board of the Health Care Fraud Prevention Partnership, a CMS-convened public-private partnership that helps detect and prevent health care fraud through data and information sharing across federal government, state government, law enforcement, private health insurance plans, and health care anti-fraud associations. And DHCS has worked side-by-side with CMS CPI contractors to support CPI's long-standing program integrity efforts and initiatives. In particular, hospice audits and investigations have been jointly conducted by DHCS and the Universal Program Integrity Contractor in a collaborative manner for over 15 years. This long-standing collaborative relationship between DHCS and CMS CPI demonstrates our shared objectives and commitment to combat fraud, waste, and abuse in the Medi-Cal program.

California remains committed to working with CMS to advance a revalidation strategy that strengthens oversight, safeguards program integrity, and ensures that only legitimate, qualified providers participate in Medi-Cal.

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[1] *Cal. Code Regs. Tit. 22, § 51000, Provider Enrollment Regulations,* Provider Enrollment Regulations - California Code of Regulations, Title 22, Division 3 Effective August 17, 2015, August 2015

OFF-CYCLE PROVIDER REVALIDATION METHODOLOGY AND TIMELINE

California's proposed off-cycle provider revalidation strategy is grounded in a risk-based methodology that prioritizes high-risk providers for targeted, off-cycle revalidation, consistent with CMS guidance to enhance oversight of providers designated at elevated risk levels. This approach supplements the federal five-year revalidation requirement and reflects the State's ongoing use of program integrity indicators, data analytics, and monitoring activities to identify providers warranting additional reviews.

Since August 2015, DHCS' Medi-Cal provider screening and enrollment requirements have exceeded federal minimum standards by requiring providers to report changes in ownership, service location, or practice sites within 35 days—events that automatically trigger targeted off-cycle revalidation activities. This ensures provider information remains accurate and prevents gaps that may expose the program to potential fraud, waste, or abuse.

These same principles underpin the State's expanded revalidation plan, which uses structured risk stratification, data analytics, and program-integrity indicators to identify providers requiring earlier or more intensive review. This includes integration of off-cycle revalidation for provider types not screened within the past 12 months and those identified through program-integrity surveillance as potentially higher risk.

Risk Stratification Framework

California will apply a structured risk stratification approach to inform revalidation prioritization. To operationalize this risk stratification framework, DHCS will incorporate insights from both federal oversight and state-level fraud detection. Our February 17, 2026 letter to CMS[2] highlights the importance of enhanced oversight for provider categories with elevated risk profiles, including clinical laboratories, hospice providers, transportation entities, pharmacies, and home health agencies. DHCS' risk stratification aligns with these federal priorities by using trend analysis, fraud pattern identification, and cross-agency referrals to focus resources where vulnerabilities are greatest.

High-risk providers subject to off-cycle revalidation per CMS's request will be identified based on a combination of:

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[2] DHCS, *California's Response to CMS' Request for Program Integrity Action Plan*, https://www.dhcs.ca.gov/wp-content/uploads/2026/04/California27s-Response-to-CMS27-Program-Integrity-Request.pdf, February 2026.

- **Federal screening risk categories** as defined in 42 C.F.R. § 455.450[3] and the Medicaid Provider Enrollment Compendium[4]

- **State-defined risk indicators**, including but not limited to:

    - Medi-Cal enrolled providers without National Provider Identifier (NPI) numbers

    - Providers not revalidated or screened within a defined timeframe

    - Providers associated with program integrity flags or anomalies

- **Provider types associated with credible allegation of fraud (CAF) referrals** to California's Medicaid Fraud Control Unit (MFCU) and DHCS' open investigations log, which includes complaints and tips from all sources (e.g., internal data analytics results, fraud referrals from Medi-Cal managed care plans (MCP), public complaints received)

This risk-based framework will ensure off-cycle revalidation resources are focused on providers with the highest potential program integrity impact.

PROCESS FOR CONTINUED ENROLLMENT & REVALIDATION ACTIVITIES

California's revalidation strategy is grounded in the continued enrollment framework established in state law[5], which provides enforceable, time-bound processes for off-cycle revalidation. DHCS will operationalize the following five steps to effectuate the off-cycle revalidation of high-risk providers, consistent with the standard processes adhered to for revalidation pursuant to federal and state requirements. Details regarding the high-risk providers targeted for off-cycle revalidation within the next two years are described below.

1. **Provider Notification and Response**
   DHCS will issue written notices to providers identified for continued enrollment. Providers must respond within 35 days indicating whether they will revalidate or voluntarily withdraw. Failure to respond results in automatic termination and deactivation.

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[3] *Code of Federal Regulations, Tit. 42, § 455.450,* https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.450
[4] CMS, *Medicaid Provider Enrollment Compendium (MPEC),* https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf, November 2025.
[5] *Cal. Code Regs. Tit. 22, § 51000.55,* https://www.law.cornell.edu/regulations/california/22-CCR-51000.55

2. **Revalidation Instructions**
   For providers that elect to continue enrollment, DHCS will issue application instructions. While state regulation allows up to 180 days for DHCS to issue application instructions, DHCS will voluntarily accelerate that timeline as part of DHCS' off-cycle revalidation strategy and instead issue instructions within 30 days.

3. **Application Submission**
   Providers will be required to submit a complete revalidation application within 70 days of receiving instructions. Failure to submit a complete application within this timeframe results in automatic termination and deactivation.

4. **DHCS Review**
   After submission, DHCS will follow statutory processing timelines, including:

   - Up to 180 days for review of submitted materials, and
   - 60 days for providers to correct identified deficiencies

5. **Withdrawals and Appeals (as applicable)**
   Providers choosing to withdraw will be disenrolled immediately, and all associated service locations will be deactivated. Any termination or deactivation under Title 22, Cal. Code Regs. § 51000.55 is subject to appeal under California Welfare & Institutions Code (Cal. Welf. & Inst. Code) § 14043.65.

California plans to conduct off-cycle revalidation of high-risk providers over the next two years pursuant to this process, in a structured, enforceable manner consistent with federal expectations and the State's broader program integrity framework.

As broader context, California has introduced statutory authority to expand the ability for DHCS and the California Department of Public Health (CDPH) to implement additional provider moratoria. DHCS is currently proposing to amend Welfare and Institutions Code section 14043.55 to enable it to implement moratoria on enrollment in the Medi-Cal program across all provider types. As part of this readiness work, DHCS will assess whether provider enrollment moratoria are warranted, incorporating existing fraud trends and anticipated statutory updates that authorize the imposition of provider enrollment moratoria. In addition, a new state statute is proposed to authorize CDPH to implement a licensing moratorium on home health agencies. This proposed home health agency licensing moratorium is intended to build upon the existing hospice licensing moratorium that has been in effect since 2022. The hospice licensing moratorium has effectively served as a moratorium for Medi-Cal provider enrollment, preventing newly licensed hospice providers from enrolling in the program. The home health agency licensing moratorium will have a similar effect on a broader range of providers.

Enforcement and Compliance

Providers will be required to respond to revalidation requests within defined timeframes (specified above) and maintain accurate enrollment information. Failure to respond to revalidation requests, submit required revalidation materials, or meet program eligibility requirements will result in provider deactivation or disenrollment in accordance with State and federal requirements.

These enforcement mechanisms will ensure that the State's phased revalidation strategy is both effective and actionable, and that only qualified providers remain enrolled in the Medi-Cal program.

Two-Year Phased Revalidation Approach

California will implement a disciplined, risk-based revalidation effort over the next two years, anchored in the State's continued-enrollment framework, structured risk stratification, and federal screening requirements. The approach emphasizes early initiation for higher-risk provider segments, sustained momentum across remaining categories, and an orderly transition to steady-state operations, while preserving statutory timeframes and the State's program-integrity controls.

Phase 1 - Continued Revalidation and Infrastructure Readiness (June 2026 – December 2026)

DHCS will continue ongoing risk-based revalidation efforts to maintain momentum for provider types due for revalidation, with a particular focus on provider types identified by the state as representing elevated program risk based on state-specific analysis and determinations, regardless of their federal categorical risk level designation. DHCS is revalidating these provider types at a level that exceeds federal minimum requirements by reviewing all enrolled locations and applying state-specific standards, including verification of Established Place of Business requirements. This includes Durable Medical Equipment (DME), Drug Medi-Cal (substance use disorder treatment providers), Clinical Labs, and Transportation (including non-emergency medical transportation) providers.

In parallel with these continued revalidation activities, DHCS will establish the operational and technical capacity required for high-volume, multi-program, off-cycle revalidations. Preparing for this targeted sprint is key, as the state is committing to off-cycle revalidations within a two-year time horizon, above and beyond federal requirements and state resources. Absorbing the additional proposed workload without additional federal support will require new operational efficiencies for successful execution. Infrastructure readiness work includes developing new targeted automation and batch workflows; surge staffing and training, including contractor support as appropriate; standardized notices, templates, and routing logic; near-term performance

monitoring, including cycle times, backlog, and risk indicators; and strengthened coordination protocols with state partner programs to ensure timely data sharing and consistent prioritization.

Taking into account current law and resource constraints, DHCS will ensure initiation occurs within this window, expediting downstream steps (e.g., fingerprinting or onsite reviews) as capacity comes online. To further support efficiency and reduce redundant administrative work, DHCS will rely on Medicare screening results where appropriate and permissible, consistent with federal screening alignment requirements contained in the Medicaid Provider Enrollment Compendium. Leveraging Medicare screening for applicable provider types allows the State to avoid duplicative activities, accelerate processing, and focuses resources on higher-risk areas. However, DHCS may require separate screening and reviews in lieu of solely relying on Medicare screenings on a targeted provider-by-provider basis based on identified risk factors, such as inconsistencies within the application, red flags identified during screening, the need to verify an established place of business, ownership or disclosure concerns, prior patient harm, criminal convictions, licensing actions, and similar issues. These actions are designed to accelerate throughput while maintaining quality and compliance.

Phase 2 - Acceleration of Higher-Risk Provider Categories (January 2027 – June 2028)

As emphasized in California's February 17, 2026 letter to CMS, high and moderate-risk provider categories represent areas where federal or State oversight bodies have identified program-integrity vulnerabilities, including risks related to billing for services not rendered, medically unnecessary services, or improper ownership arrangements. California's risk-based targeting is designed to accelerate identification of aberrant patterns and reduce vulnerabilities in high-risk sectors.

DHCS will extend revalidation activities for provider categories designated as high-risk or provider types that present higher fraud, waste, and abuse risk based on the risk stratification framework criteria described above. DHCS plans to implement Phase 2 by initiating off-cycle revalidation in three areas of focus:

1. **Elevated risk provider types that have not been screened within the past 12 months.**
   DHCS plans to revalidate the following provider types at each enrolled location, excluding chain pharmacies, and applying all state-specific requirements.

   - DME, Drug Medi-Cal, and Clinical Labs
   - Transportation providers (both NPI and non-NPI)

- Pharmacies and Diabetes Prevention Program

2. **Moderate- and high-risk provider types screened by the California Department of Public Health that have not been screened within the past 12 months.**
   California will initiate revalidations using federal revalidation requirements including screening and collection of disclosure statements and provider agreements.

   - Home Health Agencies and Certified Hospices
   - Skilled Nursing Facilities that were not previously subject to high-risk screening protocols

3. **Provider types without an NPI.**
   As noted, DHCS plans to revalidate transportation providers without an NPI that have not been screened within the past 12 months. California will assess additional opportunities to initiate revalidations of provider types not identified as elevated risk or designated as moderate- or high-risk that are not required to obtain an NPI using a data-informed approach for risk evaluation and prioritization. Absent any additional federal support, available administrative resources will be reprioritized and allocated to implement this voluntary, off-cycle provider revalidation strategy pursuant to a risk stratification framework tailored to California's specific circumstances.

Phase 3 - Stabilization (February 2028 – Ongoing)

The State will conduct off-cycle revalidation activities through the end of the two-year window and will maintain an ongoing, systematic process to ensure that all billing and non-billing providers are revalidated as they reach their respective applicable federal or State legal timelines.

METRICS AND PERFORMANCE MONITORING

California's off-cycle revalidation strategy includes a defined set of metrics to monitor the progress of revalidation activities, including off-cycle efforts. Monitoring will occur on a routine basis and support data-driven oversight of provider enrollment integrity. DHCS maintains the following core data elements, segmented by provider type:

- Total number of providers subject to revalidation
- Number and percentage in progress
- Number and percentage deactivated due to lack of notification response

- Number and percentage deactivated due to request to withdraw from the program
- Number and percentage deactivated due failure to submit revalidation application
- Number and percentage deactivated due to application denial
- Number and percentage approved
- Number and percentage of completed revalidations (final decision has been rendered by the state and the provider is either approved or deactivated)

These metrics enable clear insight into provider responsiveness, the proportion of providers completing required actions, and the extent of deactivation due to non-response or ineligibility. Collectively, these indicators provide a comprehensive view of outreach effectiveness, provider responsiveness, and revalidation progress across risk-stratified provider groups.

DHCS provides several public transparency mechanisms related to enrollment functions. These include the publicly accessible Provider Application and Validation for Enrollment (PAVE) portal[6], provider enrollment guidance and policy resources, stakeholder bulletins and regulatory notices, and provider directory[7] initiatives. In addition, the California Health and Human Services Agency Open Data Portal[8] publishes static datasets that support transparency into the provider ecosystem and downstream enrollment outcomes, including the "Profile of Enrolled Medi-Cal Fee-for-Service (FFS) Providers" dataset, which includes provider identifiers, taxonomy/specialty, geographic attributes, and enrollment status. These datasets function as an outcome-level reflection of enrollment and revalidation activity, and when combined with provider screening and eligibility validation data elements (e.g., sanctions, exclusions, and licensure status indicators used in screening and enrollment eligibility checks), they support external visibility into provider participation and ongoing eligibility maintenance. Collectively, these resources provide transactional, operational, and policy transparency for Medi-Cal providers and stakeholders.

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[6] DHCS, *PAVE Portal,* https://pave.dhcs.ca.gov
[7] DHCS, *Provider Directory*, https://www.healthcareoptions.dhcs.ca.gov/en/find-provider
[8] California Health and Human Services Agency, *California Health and Human Services Open Data Portal,* https://data.chhs.ca.gov/

CONSISTENCY AND ACCURACY OF PROVIDER DIRECTORIES

Provider directory accuracy is essential to DHCS since it supports network adequacy oversight and allows members to receive reliable information about available providers. By maintaining accurate provider directory data, DHCS also strengthens its safeguards for program integrity by confirming that only verified providers participate in Medi-Cal. To support the accuracy of provider directories, California maintains mechanisms to review and update directories based in FFS as well as managed care delivery systems. These verification and directory-accuracy activities support DHCS' broader fraud-detection efforts by identifying discrepancies in reported provider characteristics, practice locations, and accessibility attributes.

There are three types of managed care entities that deliver care to Medi-Cal members:

1. MCPs for physical health

2. Dental Managed Care (DMC) plans for dental care

3. Behavioral health plans (BHPs) for specialty mental health and substance use disorder care

All three types of managed care entities are required to maintain accurate and up-to-date electronic provider directories in accordance with 42 C.F.R. § 438.10, subdivision (h)(3), California Health and Safety Code § 1367.27, and applicable contract requirements.

Under the MCP contracts, MCPs must update their paper provider directories every month and their electronic directories every quarter; additionally, MCPs must update their directories within one week of receiving updated provider information. The requirement to update within one week of receiving updated provider information is more stringent than 42 C.F.R. § 438.10, subdivision (h)(3) requires. MCPs are required to provide links to the Provider directory website in their provider directories so that Members can locate Medi-Cal enrolled Providers, including Pharmacies and Behavioral Health providers.

Under the DMC contracts, information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than thirty (30) calendar days after Contractor receives updated provider information.

Under the BHP contracts, BHPs must update their paper provider directory at least monthly and electronic provider directories are required to be updated no later than thirty (30) calendar days after the BHP receives updated provider information. The BHP must ensure that it has processes in place to allow providers to promptly verify or

submit changes to the information required to be in the directory pursuant to 42 C.F.R. § 438.10(h)(3).

DHCS employs a two-pronged approach to routinely verify the accuracy of provider directory information, leveraging both the External Quality Review Organization's (EQRO) external validation activities and internal provider directory review process.

EQRO External Validation Activities

To illustrate the first component of the approach, the EQRO conducts external validation activities across MCPs, DMC, and BHPs.

For **MCPs**, DHCS leverages its EQRO to conduct revealed shopper calls to assess MCP compliance with contractual obligations with appointment wait time requirements. As part of the methodology and call scripts, the EQRO validates key data elements reported by MCPs in their 274-provider network file submission[9] that correspond to the provider characteristics presented in provider directories, including provider name, address, phone number; specialty, if applicable, accepting new patients' status, and population served. The MCP provider directories are checked for correspondence against the providers included in the 274-file submission. DHCS reviews the revealed shopper results and produces a report for each MCP on a quarterly basis. DHCS requires MCPs to review the report and respond with a plan to remediate any deficiencies, including correcting provider data inaccuracies. Through this comprehensive verification process, DHCS independently confirms provider directory accuracy, identifies discrepancies, and strengthens the reliability of network information available to Medi-Cal members.

For **DMC**, DHCS plans to follow the MCP methodology described above for the EQRO technical report that covers activities conducted July 1, 2026, through June 30, 2027.

For **BHPs**, DHCS leveraged the EQRO to pilot test secret shopper calls (in contrast to the revealed shopper calls used for MCPs and DMC plans) in 2025 among providers contracted with a select group of BHPs to gather data on the accuracy of provider information available to Medi-Cal members in BHP provider directories and to assess appointment availability. As part of the methodology and call scripts, the EQRO validates key data elements reported by BHPs in their 274-provider network file submission that correspond to the provider characteristics presented in provider directories, including provider name, address, phone number; specialty, if applicable, accepting new patients' status, and population served. The goal of the survey is to

[9] DHCS requires MCPs to submit information pertaining to their provider networks using the Health Insurance Portability and Accountability Act 274 transaction. In managed care, this means the plans must submit standardized, structured information about their networks including names, specialties, locations, affiliations and other details, in a machine-readable format.

evaluate the accuracy of outpatient BHP directory information and assess appointment availability. Findings from this pilot will be used to support BHPs in making targeted corrections to their data, and to strengthen ongoing compliance with timely access and provider directory requirements. DHCS has also planned to utilize lessons learned from the initial secret shopper pilot to expand the pilot to include more BHPs over the next few years, eventually expanding the secret shopper methodology into the EQRO's regular validation activities for all BHPs. Based on implementation experience, DHCS may also expand the secret shopper methodology into the EQRO's validation activities for all MCPs and DMC plans.

Internal Provider Directory Review Process

In addition to the EQRO's independent validation activities, DHCS staff conduct additional oversight, monitoring, and enforcement activities to strengthen the accuracy of provider directory data and ensure consistency across managed care and FFS delivery systems. These internal processes reinforce the accuracy of provider directory data and complement the EQRO's external validation activities.

For **MCPs,** DHCS conducts its own semi-annual quality assurance process to verify the accuracy of MCP-submitted provider data. DHCS conducts these verification checks by targeted outbound phone calls and supplemental online searches of a random sample. Staff confirm core directory elements such as the provider's name, location, phone number, office accessibility, patient acceptance status, languages, and specialty; document whether each data element can be verified; and identify discrepancies or unverifiable information. DHCS then provides this information to the MCP and requires the MCP to make the necessary revisions to its provider directory.

For **DMC**, DHCS directly performs secret shopper calls for DMC plans. During the secret shopper survey, DHCS staff confirm core directory elements such as the provider's name, location, phone number, office accessibility, patient acceptance status, languages, and specialty; document whether each data element can be verified; and identify discrepancies or unverifiable information. DHCS then provides this information to the DMC plan and requires the DMC plan to make the necessary revisions to its provider directory. For the EQRO technical report that covers activities conducted July 1, 2026, through June 30, 2027, DHCS plans to follow the MCP methodology described above in the EQRO External Validation Activities subsection. Thereafter, DHCS plans to review the provider directory for compliance with contract, state, and federal requirements. When issues are identified, DHCS will provide this information to the DMC plan and require the DMC plan to make the necessary revisions to its provider directory.

For **BHPs**, DHCS conducts ongoing monitoring and monthly outreach to BHPs to ensure timely updates are made to provider directories whenever there are provider network changes. DHCS staff review the provider directories to confirm they are publicly posted online and include all required data elements, including provider name, address,

phone number, specialty, languages spoken, office accessibility, and patient acceptance status. When issues are identified, DHCS provides this information to the BHP and requires the BHP to make the necessary revisions to its provider directory.

As part of previously identified improvements to further strengthen data consistency across all managed care and FFS delivery systems, DHCS is implementing targeted enhancements to the FFS provider directory that improve the completeness, accuracy, and reliability of provider information collected at enrollment and revalidation. These enhancements include new system controls that require providers to complete all mandatory directory fields before they are permitted to advance within the FFS Provider Portal, supported by clearer field indicators, error messaging, and guidance to ensure accurate reporting. DHCS is also updating its FFS provider directory[10] attestation so providers can specify whether they are accepting new Medi-Cal FFS members, Medi-Cal managed care members, or both, with these responses stored in structured formats for downstream publication. By standardizing these data elements and ensuring they are consistently and fully captured, the State strengthens the provider information within the FFS delivery system, supporting more oversight for directory data.

COORDINATION WITH LAW ENFORCEMENT

DHCS, through its Audits & Investigations (A&I) Program, the State's designated Medicaid Program Integrity Unit, maintains regular collaboration with state, local, and federal law-enforcement partners. Embedded with A&I are sworn officers that support California's program integrity work. California is one of the only states whose Medicaid agency employs armed sworn peace officers with the authority to execute search warrants, conduct field operations, and support criminal investigations, which significantly strengthens the State's ability to detect, investigate, and prevent Medicaid fraud.

DHCS coordinates regularly with California's MFCU, the California Department of Justice's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), CMS's CPI, CMS's Unified Program Integrity Contractor, the U.S. Department of Justice (DOJ), the Federal Bureau of Investigation, and the Health and Human Services of Office of Inspector General (HHS-OIG).[11] When DHCS identifies a CAF, it prepares and transmits a complete CAF referral to DMFEA and, consistent with 42 C.F.R. § 455.23 and state law, imposes a payment suspension unless a good-cause exception applies.

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[10] DHCS, *Provider Directory Requirements for Medi-Cal Fee-for-Service Providers*, *https://www.dhcs.ca.gov/providers-partners/provider-directory-requirements-for-medi-cal-fee-for-service-providers/*, 2026

[11] Office of Governor Gavin Newsom, *Hospice Provider Ban Update*, https://www.gov.ca.gov/2026/01/27/in-the-four-years-since-governor-newsoms-new-hospice-provider-ban-took-effect-california-has-revoked-more-than-280-licenses/, 2026

DHCS also participates in and contributes to multi-agency law-enforcement efforts. This includes the statewide Hospice Fraud Task Force, led by California Department of Public Health with participation from DHCS, California Department of Social Services, Department of Consumer Affairs, counties, and DMFEA. The task force supports cross-agency information sharing, coordinated investigations, field inspections, and enforcement actions. These collaborations have resulted in joint operations, targeted site visits, license revocations, Medi-Cal payment suspensions, and criminal prosecutions.

DHCS' investigative strategies have been nationally recognized for uncovering fraud networks spanning multiple provider types. DHCS has presented its methodologies at MII and national program-integrity conferences and collaborates closely with federal partners—including the Federal Bureau of Investigation, DOJ, and OIG—on high-priority cases such as opioid misuse, clinical laboratory fraud, and hospice investigations. In addition, findings from the U.S. Department of HHS-OIG 2024 MFCU Annual Report[12] highlight California's role in advancing national program-integrity outcomes. According to the report, California accounted for the largest share of Medicaid fraud recoveries nationwide in 2024, reflecting both the scale of the Medi-Cal program and the effectiveness of the State's investigative, enforcement, and oversight infrastructure. DHCS' collaboration with federal and state law-enforcement partners, combined with DHCS' data-driven investigative model, directly contributes to these nationally leading program-integrity results. These enforcement mechanisms ensure that revalidation is not merely an administrative process, but a proactive safeguard that rapidly identifies and resolves high-risk provider behavior to protect Medi-Cal program integrity.

DHCS strengthens oversight further through provider enrollment onsite visits, fingerprint-based criminal background checks, and screening of high-risk providers under 42 C.F.R. §§ 455.450, 455.432, and 455.434, with the exception of provider types for which screening functions are performed by CDPH. Findings from these activities inform provider enrollment and revalidation decisions. DHCS also coordinates closely with Medi-Cal MCPs Special Investigation Units (SIU), sharing intelligence, best practices, and ensuring alignment between provider investigations, plan compliance activities, and broader program integrity goals. To support alignment between DHCS and managed care program-integrity efforts, DHCS established structured coordination meetings with all MCP SIUs. These recurring meetings provide a forum for information-sharing, case-triage discussions, and monitoring emerging fraud trends.

Collectively, these partnerships with local, state, and federal law enforcement and investigative agencies, combined with DHCS' law enforcement authority and data-analytics capabilities, form the foundation of California's coordinated approach to preventing, identifying, investigating, and stopping fraud, and pursuing civil and criminal

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[12] OIG, *Medicaid Fraud Control Units Annual Report: Fiscal Year 2024,* https://oig.hhs.gov/documents/evaluation/10227/OEI-09-25-00090.pdf, 2025

prosecution of bad actors, holding those who violate program rules fully accountable. Integrating robust provider screening, enrollment, and revalidation into early detection and enforcement activities continues to be a key strategy to uphold the integrity of Medi-Cal and ensure that only legitimate, qualified providers participate in the program.

CLOSING

California appreciates CMS' continued partnership in strengthening Medicaid program integrity and looks forward to ongoing collaboration to support accurate provider enrollment and effective oversight. California values CMS' partnership and remains committed to advancing national best practices in Medicaid program integrity, including collaborative data sharing, investigative alignment, and continuous improvement across delivery systems.

Sincerely,

Tyler Sadwith

Tyler Sadwith
State Medicaid Director

cc: Michelle Baass
Director
California Department of Health Care Services
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