



**Texas Association for
Home Care & Hospice**
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Rachel Hammon

Executive Director, Texas Association for Home Care & Hospice (TAHC&H)

House Energy and Commerce, Oversight and Investigations Subcommittee Hearing

“Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid”

On behalf of The Texas Association for Home Care & Hospice (TAHC&H), I would like to thank the Committee for holding this important hearing on fraud in Medicare and Medicaid, particularly with respect to the impact on the home-based care sector. TAHCH represents more than 1,150 licensed home health and hospice agencies across Texas and is committed to helping Congress and the Centers for Medicare and Medicaid Services (CMS) strengthen program integrity while safeguarding access to care for seniors and people with disabilities.

Fraud in the Medicare skilled home health space is not evenly distributed across the United States, and counties with extreme fraud patterns are significantly skewing national utilization numbers, negatively impacting CMS payment modeling. For example, Los Angeles County accounts for over \$1.7 billion annually in Medicare FFS home health spending—more than the total Medicare FFS home health spending in the entire state of Texas. Since 2020, over 1,500 newly Medicare-certified home health agencies have enrolled in Los Angeles County, while much of the rest of the country has experienced sustained declines in the number of providers. In Texas alone, there has been a 36% decline in Medicare beneficiaries receiving home health since 2018. Nationally, one in four home health agencies has closed and more than two million fewer beneficiaries are receiving home health services compared to pre-PDGM levels. CMS’s payment methodology, particularly under PDGM and associated behavioral adjustments, has contributed to shrinking access to the home health benefit, not because of declining need, but because payment policy is distorted by fraudulent behavior concentrated in certain markets.

Because PDGM relies on national claims data and cost reports to recalibrate case-mix weights and behavioral assumptions, incorporating fraudulent claims into the national dataset negatively impacts rate setting. Distorted utilization patterns influence behavioral adjustments and national payment assumptions, leading to unjustified nationwide payment reductions. This contributes to the destabilization of legitimate agencies, exacerbates “health care deserts,” and reduces access for beneficiaries who rely on home health services. Continuing to include fraudulent billing patterns in national payment calculations penalizes high-quality home health agencies who represent the vast majority of home health agencies while allowing concentrated fraud in isolated markets to drive national policy consequences.

Fraud not only enriches criminals, it causes seniors to lose access to care. Earlier this year, CMS released the *Calendar Year (CY) 2026 Home Health Prospective Payment System Final Rule*, which proposed cutting payments to Medicare Home Health Agencies (HHAs) by more than \$1 billion nationwide and would have had devastating consequences for access to care in Texas. Although the finalized cuts were less than those proposed,

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continued cuts to home health payment rates create challenges in recruiting and retaining clinicians, and cause agencies to close, especially in rural areas. Most importantly, it causes patients to lose access to preferred in-home care and forces them toward higher-cost institutional settings.

CMS must take decisive action against fraud, but doing so should not penalize compliant, trusted home health agencies or limit access to hospice and home care. Protecting patients requires both eliminating fraudulent actors and ensuring that legitimate providers remain adequately funded. TAHC&H supports robust and targeted anti-fraud measures to protect the integrity of the hospice and home care industry.

To protect beneficiary access and program integrity, CMS should recalculate the CY 2026 rate to reverse payment reductions made since 2020 that were based on compromised, fraud-tainted claims data. CMS should implement enrollment moratoria and suspend payments in high fraud regions like Los Angeles County, as well as expand oversight tools like the Review Choice Demonstration (RCD) and deploy advanced fraud prevention tools, including AI and real-time anomaly detection. We should also work to ensure that anti-fraud measures do not limit access to legitimate care from trusted providers.

TAHC&H is committed to combating fraud, waste, and abuse in the Medicare and Medicaid programs. Fraud harms our patients, honest providers, and the long-term health of the Medicare Trust Fund. Effective antifraud policy must be targeted, data-driven, and precise, without harming the entire industry that provides essential care to families across the country.

Thank you,

Rachel Hammon, RN, BSN

A handwritten signature in black ink that reads "Rachel Hammon RN". The signature is written in a cursive style with a large initial "R" and "H".

Executive Director