How Geotagged EVV Check-In Data Ca Get Wired Into Medicaid and Medicar Managed Care Claim Edits to Reject Home Health Fraud at Submission an Break the Decade-Long Federal Moratorium Loop

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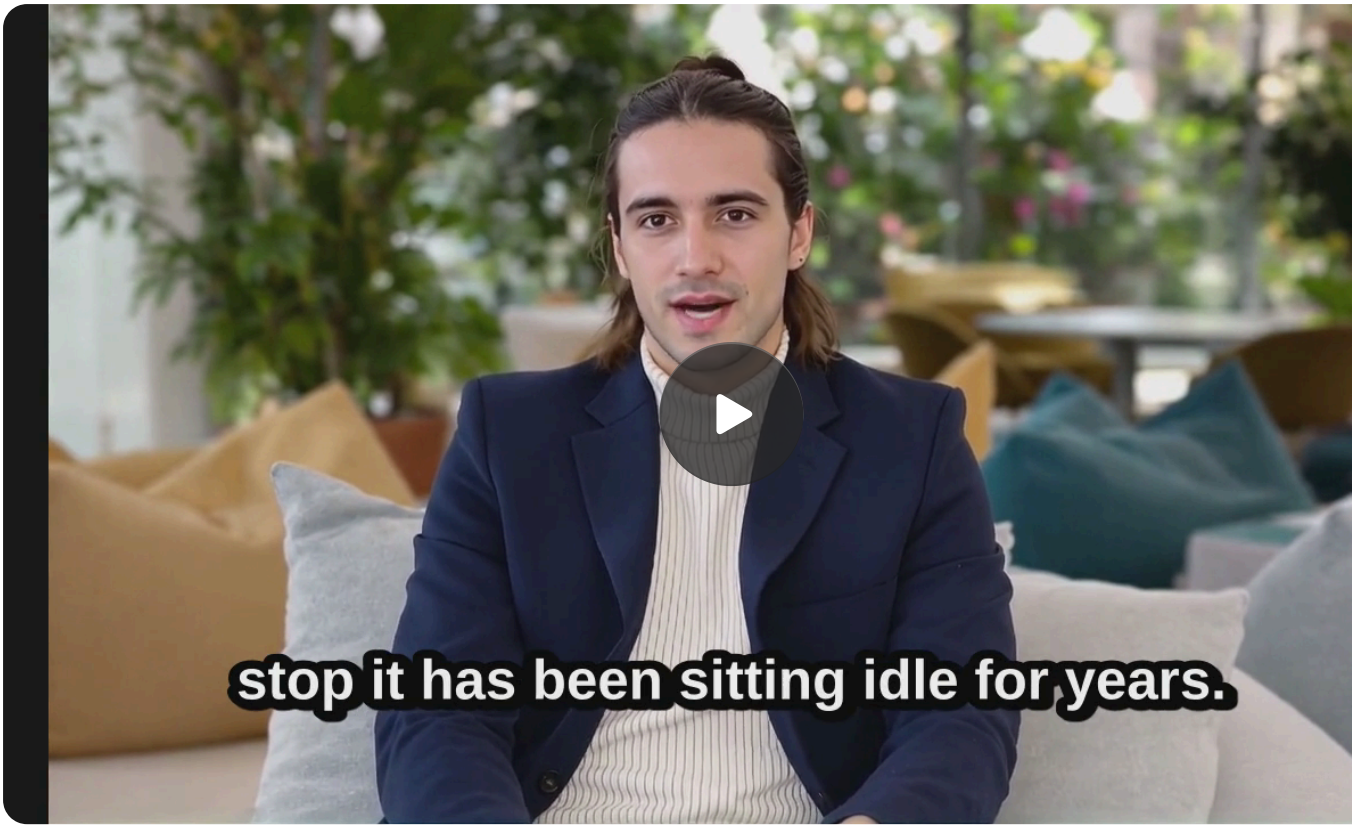

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Part I: How Geotagged EVV Check-In Data Can Get Wired Into Medicaid and Medicare Managed Care Claim Edits to Reject Home Health Fraud at Submission and Break the Decade-Long Federal Moratorium Loop

CMS just reimposed a nationwide home health agency moratorium. LA County has 12-15% of all HHAs while holding 3% of Medicare beneficiaries. Ohio found 18 agencies at one address. The pay-and-chase loop is running again...

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Part II: How Geotagged EVV Check-In Data Can Get Wired Into Medicaid and Medicare Managed Care Claim Edits to Reject Home Health Fraud at Submission and Break the Decade-Long Federal Moratorium Loop

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Abstract

- CMS just dropped a nationwide HHA enrollment moratorium effective May 2026, citing LA County explosion (1,000+ new HHAs since 2019, 12-15% of national total), Ohio cluster schemes (18 HHAs at one address), and a parade criminal cases
- Pattern is familiar: moratorium 2013-2019, expire, fraud explodes again, rep
- 21st Century Cures Act mandated EVV for Medicaid PCS by 2021 (with FM penalty) and HHCS by 2023, covering six data elements including GPS-verif location
- EVV data largely sits in aggregator databases (Sandata, HHAeXchange, AuthentiCare, CareBridge) and gets used post-pay
- Thesis: wire EVV verification IDs into the 837P claim transaction as a REF segment, run pre-pay API match against aggregator on six elements, hard re on no-match for high-risk providers
- Managed care is the wedge because MA plans (42 CFR 422) and Medicaid M (42 CFR 438) can require this contractually without new statute
- Spoofing objection is solved by device attestation (Apple App Attest, Google Integrity) plus biometrics plus cell tower triangulation

- Dead zone objection is solved by store-and-forward with statistical fraud monitoring
- Vendor consolidation (HHAeXchange acquiring Sandata in 2022, Elevance acquiring CareBridge for $2.7B in 2024) makes federation feasible
- Investment opportunity in middleware between EVV aggregators and claim adjudication, plus payment integrity vendors selling per-dollar-recovered

Why CMS just dropped the moratorium and why this loop never closes

CMS published the notice on May 13, walking through how HHA fraud remains stubbornly bad even after a decade of bolting on safeguards. The agency catalog LA County situation (well over 1,000 new HHAs since 2019, the county now hol 12 to 15 percent of all HHAs nationwide while accounting for roughly 3 percent total Medicare beneficiaries), the Ohio cluster phenomenon (nine known cases o plus HHAs at one address, one location stacking 18 agencies on top of each othe a roll call of criminal cases stretching from Massachusetts to Texas to Michigan ending in serious federal prison time. The pattern is depressingly familiar to an who has been watching home health for a decade. CMS imposed localized morat starting in 2013 in Miami-Dade, Cook County, and Harris County, expanded the statewide across Florida, Illinois, Michigan, and Texas in 2016, kept extending t then let them quietly expire on January 30, 2019. Three years later the LA Count numbers detonated. Now the moratoria are back, this time nationwide for six m with the extension button basically pre-pressed.

The honest read here is that enrollment moratoria are a goalie save, not a defens They prevent the next batch of bad actors from getting through the door but do absolutely nothing about the 11,500 HHAs already inside the building, and they cannot run forever without becoming a de facto industry ban. The notice itself u the phrase “pay-and-chase” in scare quotes and then proceeds to describe in det exactly the dynamic that produces it. Claims get paid. Years pass. An investigati opens. By the time a sentence comes down (75 months federal in the Texas signa

forgery case, 12 years for the Massachusetts $100M restitution case, 42 months i Ohio case where the owner lived in California and billed for dead patients) the c offshore, the shell companies are dissolved, and the Trust Funds are out the mor The Michigan $2.8M wire fraud case cited in the notice ended exactly this way, v funds moving through shell accounts and ultimately out of the country. Restitut orders look impressive in press releases. Recovery rates do not.

What no anti-fraud measure in current production actually does is stop the bill getting paid in the first place. Capitalization requirements at 42 CFR 489.28 pre shell HHAs with no money. The high-screening designation forces fingerprintin site visits. The 36-month change-in-majority-ownership rule at 42 CFR 424.550 broker resale schemes. The 2019-2020 PPEO killed the upfront-payment vulnera around RAPs. All useful, none of them addressed the actual mechanism by whic fraudulent home health claims convert to cash, which is the submission of an 83 transaction for a visit that did not happen or did not match what was billed. Tha submission is where the dollars are decided.

EVV in one paragraph for readers who haven't been paying attention

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