Medicaid HCBS Program Integrity

State Best Practices & Emerging Strategies to Preserve Program Access While Reducing Fraud, Waste, and Abuse

Home and Community-Based Services (HCBS) represent vital components of Medicaid, enabling millions of people with disabilities and those who are aging to live and thrive in their communities. Effective oversight must balance robust strategies to detect, deter, and pursue instances of fraud, waste, and abuse with sophisticated strategies that reflect the nature of the services provided, including instances where providers may provide 24/7 support for people with significant disabilities.

This brief, developed by ADvancing States, the National Association of Medicaid Directors (NAMD), and the National Association of State Directors of Developmental Disabilities Services (NASDDDS), highlights strong program integrity tools that states may consider deploying to prevent, detect, and act upon instances of fraud, waste, and abuse within Medicaid HCBS. We acknowledge that some of the strategies suggested may require additional staff or technical resources. Additionally, implementing these recommendations will likely require capacity building and cross-agency collaboration. ADvancing States, NAMD, and NASDDDS stand ready to support states in assessing their system capacity and identifying the highest-impact, most feasible interventions for their systems.

PART I. PROGRAM DESIGN BEST PRACTICES FOR HCBS INTEGRITY

KEY PROGRAM DESIGN PILLARS
• **Independent eligibility assessments:** Validated, separated from provider financial interests
• **Tiered provider enrollment:** Enhanced screening for high-risk provider types
• **Utilization management:** Benchmarked to similar care plans
• **Case management/care coordination oversight:** An independent check on service delivery
• **Robust incident management systems:** Tied to billing and claims data
• **MCO accountability:** Contractual integrity obligations, where appropriate and applicable

Effective program design establishes the necessary structures to prevent fraud, waste, and abuse in HCBS. The following state best practices represent structural safeguards that reduce risk while preserving access and quality.

A. Eligibility and Level-of-Care Determination, Independent Assessments of Need and Person-Centered Service Planning

- **Standardized, validated assessment tools**: Use validated instruments (e.g., Supports Intensity Scale, interRAI, ICAP) consistently across the state to avoid inconsistencies and prevent inflated or under-identification of care levels.
- **Independent functional needs assessments:** Conduct assessments through entities separate from providers to eliminate financial incentives that could distort the accuracy of assessed service needs.
- **Case management design:** Design and support case management functions that use independent needs assessments to directly inform the person-centered service planning process. Consider contracting with case management agencies or designing programmatic specifications for state or county case management to expand performance management activities.

- **Clinically triggered reassessments:** Require reassessments tied to clinical events (e.g., hospitalization, change in condition) and requests for service increases, including exceptions to caps, to ensure timely needs assessments and appropriate service authorizations.
- **Annual assessments:** Conduct objective annual reassessments that reflect an objective assessment for continued levels of service need, rather than a presumed upward trend in utilization and/or need.
- **Person-centered service planning:** Develop service plans grounded in formal needs assessments, consideration of natural (unpaid) supports, risk assessment and mitigation strategies, and the appropriate service milieu to address identified need areas. Establish clear referral processes for high-utilization provider types, supported by objective assessments and person-centered planning.

B. Provider Enrollment and Credentialing

- **Risk-tiered screening:** Apply tiered provider screening by risk level (limited, moderate, high), including fingerprinting, site visits, and background checks with regular periodicity to detect any status change.
- **Reorganization prohibitions for sanctioned providers:** Prohibit the reorganization and re-enrollment of individuals and immediate family members of providers under active state investigation or sanctions.
- **Application red flags:** Identify flag-worthy indicators on provider application and enrollment documents, such as multiple providers sharing the same address or the same owners/operators, etc.
- **Provisional enrollment periods:** Require enhanced monitoring for newly enrolled providers before granting full billing rights for certain services.
- **Time-limited provider agreements:** Use time-limited agreements/contracts, allowing states to pursue non-renewal rather than formal disenrollment for providers unable to maintain standards.
- **Financial transparency requirements:** Require full financial disclosure with clear and recurring timelines for pending mergers, acquisitions, or other financial affiliations. Specific required disclosures could include:
  - Management agreements or administrative services agreements, including any providers/practices under common management;
  - Restrictions on equity transfers, including any continuity planning agreements;
  - Transactions involving substantially all assets or equity of the practice within the last [X] years, with an ongoing obligation to update the disclosures;
  - Provider investments or ownership interests in management services organizations (MSOs) or other entities; and restrictive covenants, executive compensation, and owner revenue derived from Medicaid.
- **Cross-state sanction disclosure:** Require timely disclosure of active sanctions in other states, with specified reporting timelines.
- **Real-time database checks:** Screen providers against OIG exclusion lists, death master files, and state licensure systems at enrollment and on an ongoing basis.

C. Service Authorization and Utilization Management

- **Prior authorization**: Require prior authorization and apply needs-based criteria for high-cost or high-volume services, with clinical review by qualified professionals for services above certain thresholds or durations.
- **Conflict-free systems:** Establish policies ensuring that assessment, authorization, case management, and service provision are separated and conflict-free.
- **Resource allocation limits:** Use assessment-based budget allocation or reasonable limitations on authorizations for certain waiver services to ensure comparable service access for individuals with similar support needs.
- **Isolation risk safeguards:** Apply enhanced monitoring or audits on provider arrangements that may isolate an individual from regular community engagement, such as situations where all providers are family caregivers, or where service plans involve one-person living arrangements with limited external engagement in the service plan.

- **Authorization benchmarks:** Use comparative benchmarks to flag authorizations significantly exceeding the average for comparable beneficiary profiles.
- **Regular face-to-face case manager contact:** Mandate face-to-face contact between case managers and beneficiaries, without providers present, to verify services are being received. Clearly communicate to individuals and families the importance of these contacts for both health and welfare and program integrity.
- **Waiver cap exception rules:** For states leveraging budget limits by levels of support or through other caps on waiver budgets (sometimes known as soft waiver caps), require additional assessment for any requests to exceed the caps. Ensure that all exceptions are based on actual assessed need and include a fading back to normal service levels, as appropriate.
- **Fiscal management entity oversight:** Limit the number of fiscal management entities in self-directed programs and establish stringent record keeping, fiscal solvency, data reporting, and related requirements to ensure full transparency and accountability of resources, service utilization, and providers.

D. Quality Assurance and Ongoing Oversight

- **Incident management systems:** Maintain mandatory incident reporting systems for abuse, neglect, exploitation, and unexplained injuries, cross-referenced to billing records and other data sources related to provider performance. Include flags for over- or under-reporting of incidents.
- **Experience of care surveys and ombudsman programs:** Administer individual experience of care surveys (such as the National Core Indicators™) and support independent ombudsman programs providing a direct channel for beneficiaries to report concerns without fear of service loss (including strategic use of the grievance process as required in the Access regulation).
- **Stratified quality reviews:** Conduct intensive reviews for new or flagged providers and standard reviews for established providers with clean records.
- **Managed care accountability:** Include contract requirements holding MCOs accountable for provider network integrity, with financial penalties for failure to report or act on fraud indicators, emphasizing the need for expedient encounter data to ensure timeliness of detection capabilities.
- **Human rights committees:** Utilize human rights committees or similar advisory groups to review relevant issues, including unexplained/unanticipated deaths, overly restrictive procedures not related to diagnostic indications, mortality/fatality review, and others.
- **System partner oversight:** Develop oversight strategies for system partners and contractors with roles in service authorization or utilization management (e.g., county partners, administrative entities, utilization management contractors, etc.).

PART II. FRAUD, WASTE, AND ABUSE: DETECTION AND DETERRENCE STRATEGIES

HIGH-IMPACT FRAUD ENFORCEMENT ACTIONS
• **24-hour billing rule edits**: Prevent payment when claimed hours exceed what is physically possible
• **Social network analysis:** Detect patient brokering and kickback networks
• **Unannounced site visits:** Conducted with independent beneficiary interviews
• **Beneficiary contact programs:** Verify service delivery directly with individuals and families
• **Pre-payment review:** Targeted at programs for high-risk flagged providers
• **MFCU coordination**: Criminal prosecution of major fraud schemes

While program design sets the structure, fraud, waste, and abuse detection and deterrence efforts are essential for ongoing program management. The most effective state programs combine data-driven detection with targeted onsite reviews and robust administrative remedies tailored to the HCBS provider network and the services they deliver.

A. Data Analytics and Predictive Modeling

- **Claims outlier detection:** Deploy claims analysis platforms that flag statistical outliers, including: case management agencies with questionable referral patterns; providers billing for more hours than physically possible in a day; overlapping services or service periods not permissible within the authorized person-centered plan; services billed for the same person in different settings; and billing for deceased beneficiaries or individuals who have moved out of state.
- **Social network analysis:** Identify relationships between providers, referral sources, and beneficiaries that suggest patient brokering or kickback arrangements.
- **Peer comparison algorithms:** Compare each provider's billing patterns against a cohort of similar providers in the same region and service type serving individuals with similar support needs (as identified in the assessment).
- **Longitudinal trend monitoring:** Detect gradual billing creep not tied to an identified or sustained level of need. Periodically review and, where appropriate, scale back "exceptional" rates with periodic reviews to determine ongoing need.
- **Workforce data integration:** Use available data sets, such as NCI State of the Workforce, to detect instances where providers may be diverting resources from direct services (not paying direct support professionals sufficiently).
- **Rate development analytics**: Incorporate data analytics and predictive modeling into rate development, including comparison of audited cost reports and rate studies with claims data.

B. Pre-Payment Review and Claims Edits

- **Automated claims edits:** Prevent payment for services that: exceed authorized hours; occur outside the authorization period; are billed by providers with active sanctions; exceed authorized hours or limits; are disallowed to be concurrently provided (e.g., residential habilitation and in-home habilitation for private homes).
- **Targeted pre-payment review:** Require additional documentation before paying claims from providers exhibiting risk indicators.
- **Benefit coordination checks:** Prevent duplicate billing across Medicaid, Medicare, and other payers for the same service episode.

C. Onsite Investigations and Unannounced Site Visits

- **Unannounced compliance visits:** Conduct unannounced visits to targeted provider types, including direct interviews of beneficiaries conducted without providers present.
- **Beneficiary and family contact strategies:** Independently verify service provisions through direct outreach to beneficiaries and families**.**

D. Provider Training and Education

- **Mandatory compliance training:** Require compliance training as a condition of enrollment renewal, covering documentation requirements, service standards, and reporting obligations, to be applicable to paid family caregivers and other non-traditional provider types.
- **Plain-language billing guidance:** Provide accessible billing instructions to minimize administrative errors leading to improper payments.
- **New rule outreach and training:** Offer targeted outreach when new billing codes or program rules are implemented, with a grace period before penalties are assessed.

- **Targeted technical assistance:** Provide direct technical assistance to providers when billing patterns indicate a misunderstanding of necessary billing documentation and submission requirements.

E. Individual and Family Training — Enlisting Beneficiaries as Partners in Prevention

- **Beneficiary and family training:** Train individuals receiving HCBS and their representatives to identify and respond when they are impacted by fraud, waste, and abuse. Provide accessible reporting tools and resources for family use, including pathways for questions or reports that are accessible to people with cognitive, sensory, and communication disabilities.
- **Explanation of benefits access:** Give beneficiaries access to service authorization and utilization reports (similar to an easy-to-read explanation of benefits) to enable beneficiaries to see amounts/units/volume billed by the provider.

F. Administrative Remedies and Sanctions

- **Progressive corrective action**: Apply a graduated response, from compliance plans, admission moratoria, and potential repayment to payment suspension and termination of services for serious ongoing violations, based on both types of infractions and level of risk.
- **Phase-down plans:** Require sanctioned providers to implement supervised phase-down plans to ensure continuity of care.
- **Provisional termination authority:** Allow states to immediately suspend providers with credible fraud allegations without waiting for full adjudication.
- **Cross-agency and cross-state exclusion:** Automatically cross-reference terminated providers with other state programs, licensing boards, and federal exclusion databases.

PART III. ELECTRONIC VISIT VERIFICATION (EVV): BALANCING OVERSIGHT AND TRUST

EVV: BALANCING OVERSIGHT AND BENEFICIARY RIGHTS
• **Multiple technology options:** Telephony, mobile, fixed-point; not one-size-fits-all
• **Self-direction exceptions:** Honor beneficiary autonomy while maintaining accountability
• **Strict data governance:** Limit access, define retention
• **Claims Integration**: Integrate EVV with claims for real-time fraud detection before payment
• **Worker identity verification:** Prevent proxy check-in schemes
• **Cross-program wage matching**: Detect multi-payer billing fraud
• **Co-design**: Developed with people with lived experience and their families

The 21st Century Cures Act required states to implement EVV for personal care (and similar services where personal care was incidental to the provision of the service, such as habilitation) and home health services. EVV captures six data elements per visit: type of service, individual receiving service, individual providing service, date, location, and start/end time. While a powerful verification tool, EVV implementation has raised civil rights, privacy, and access concerns from beneficiaries, advocates, and providers alike. Balancing these concerns while leveraging EVV to enhance program integrity will be essential.

How EVV Can Be Improved to Fight Fraud More Effectively

- **Real-time anomaly detection:** Integrate EVV data streams with claims analytics so visits flagged as suspicious (e.g., impossible travel times, locations inconsistent with expected patterns, abnormal duration) are automatically held for pre-payment review.
- **Worker-beneficiary identity matching:** EVV systems should confirm the worker checking in is the authorized worker on record using biometric check-in, worker ID confirmation, or challenge questions.
- **Service plan alignment:** Automatically compare EVV-captured service hours to the authorized service plan, with persistent anomalies triggering case management or other party review rather than auto-payment.
- **Cross-program wage data validation:** Cross-reference EVV data with payroll records, unemployment insurance wage data, and other Medicaid billing from the same worker on the same date to detect multi-payer billing for overlapping periods.
- **Retrospective pattern audits:** Use EVV data longitudinally to identify providers or workers who consistently check in and out at exact authorization limits, a pattern that may indicate time falsification. Set high standards and use enforcement capabilities related to tolerance for manual edits (e.g., flags for edits over a certain number trigger review).
- **Interoperability standards:** Require EVV systems to use interoperable data standards to facilitate cross-state data sharing and federal oversight.

EMERGING TOOLS: AI AND ADVANCED ANALYTICS FOR HCBS INTEGRITY

Artificial intelligence (AI), machine learning, and advanced data analytics offer powerful new capabilities to detect and prevent fraud, waste, and abuse in HCBS. However, people with I/DD and their families, and the provider networks active in most states, present unique considerations that CMS and states must consider when deploying these tools.

A concerted state/federal partnership should identify both opportunities and necessary protections related to the use of AI in the delivery and oversight of HCBS, including human-in-the-loop (HITL) requirements and careful consideration for the unique nature of HCBS delivery systems and the populations of individuals who rely upon them.

CONCLUSION

Preserving the integrity of HCBS programs is imperative, as HCBS is a lifeline for many people with disabilities and older adults. While state agencies that oversee HCBS are committed to ensuring that Medicaid funds are spent appropriately and in ways that benefit HCBS recipients, infrastructure, program design, and resources vary from state to state for a variety of reasons. Maximizing the impact of these strategies may require time, planning, and thoughtful sequencing. The strategies described in this brief are most effective when implemented in combination and devised in partnership with the federal government, states, providers, and people receiving HCBS and their families.