From Policy to Practice:
Medicaid MCOs are Taking Action to Safeguard Home and Community-Based Services (HCBS)

Home and community-based services (HCBS) are the cornerstone of Medicaid's long-term services and supports (LTSS) system, enabling approximately 8.4 million[i] Americans with disabilities, chronic conditions, and age-related frailty to live safely and independently in their homes and communities rather than in institutional settings. As the nation's largest payer for LTSS, Medicaid finances a range of HCBS including personal care and homemaker services, adult day programs, and supported employment.

As Medicaid's predominant delivery model, Medicaid managed care organizations (MCOs) are at the forefront of efforts to address fraud, waste, and abuse (FWA) in the delivery of HCBS, and should be leveraged as a key resource for program integrity efforts by state and federal partners. Working with their state and federal partners, Medicaid MCOs take a comprehensive approach to ensuring that HCBS are delivered appropriately, to the right people, in the right settings, and at the right time.

What Are Home and Community-Based Services?

HCBS are services and supports that assist individuals with functional limitations or chronic conditions in performing activities of daily living while remaining in their homes and communities.

For Americans with disabilities, HCBS are often the difference between living independently in their own home and community and unnecessarily placed in a nursing facility or other institutional setting. Yet, the demand for HCBS services among people with disabilities far exceeds current capacity. In 2024, individuals with intellectual and developmental disabilities comprised the majority of the 711,000 Americans on waiting lists for HCBS.[ii]

While people with disabilities represent a critical segment of HCBS users, the demand for these services is set to expand even further as the nation's population ages. 75% of Americans who are 50 years of age and over want to age at home.[iii] In addition to facilitating beneficiary choice, the evidence supporting both the value and cost-effectiveness of HCBS is well-established. Research has found that expansion of HCBS for older adults is associated with more individuals receiving services at lower cost.[iv] A recent economic analysis found that if 3% of current HCBS beneficiaries in California transitioned to nursing home care, it would generate a net spending increase of $57 million in the first year alone and $1.17 billion over five years.[v]

Services frequently covered under Medicaid HCBS programs include:

- Personal care and attendant services
- Home health aide services
- Adult day health services
- Resources and respite care for family caregivers
- Supported employment and day habilitation
- Environmental modifications and assistive technology.

The Role of Medicaid MCOs & HCBS Delivery

Medicaid MCOs coordinate and manage the full continuum of HCBS, bringing private sector innovation and accountability to the care and support of Medicaid beneficiaries. Unlike fee-for-service (FFS) systems, Medicaid MCOs maintain an ongoing, holistic relationship with each member, creating the foundation for improved engagement and quality care.

Key Medicaid MCO roles in HCBS delivery include:

- **Care Assessment & Person-Centered Planning:** Care managers conduct comprehensive assessments of each member's functional needs, preferences, and goals, and develop individualized service plans designed to support maximum independence and wellbeing.

- **Provider Network Management:** Medicaid MCOs build and maintain networks of qualified HCBS providers, verify licensure and credentials, and monitor provider performance. Provider network management is especially crucial as HCBS workforce shortages persist, and the existing workforce continues to experience high rates of caregiver turnover. Medicaid MCOs must ensure that robust program integrity efforts do not further impede members' access to care, especially for those in rural or high-acuity areas.

- **Collaborative Partnerships:** Medicaid MCOs build collaborative relationships with Community Based Organizations (CBOs) that augment services and add essential support for social connectiveness, access to nutrition, transportation, and other services. These partnerships support capacity building across the HCBS ecosystem.

- **Utilization Management:** Medicaid MCOs review HCBS service requests against clinical criteria and individual need assessments, ensuring that only appropriate, medically necessary services are approved and that service plans reflect each member's specific needs.

- **Ongoing Care Coordination:** Care managers maintain regular contact with members, caregivers, and providers to monitor whether services are being delivered as planned and identify changing needs.

- **Transitions & Rebalancing:** Medicaid MCOs actively support members transitioning from institutional settings back to the community, coordinating the HCBS needed to make those transitions safe, sustainable, and person-centered.

Partnering with Medicaid MCOs allows states to better manage costs and state budgets with predictability. In 2023, FFS delivery accounted for 48% of LTSS users, yet consumed more than 60% of total LTSS costs. Medicaid managed care served nearly 60% of all LTSS beneficiaries while accounting for only 38% of total expenditures.[vi]

Medicaid MCOs Target Fraud, Waste, and Abuse in HCBS

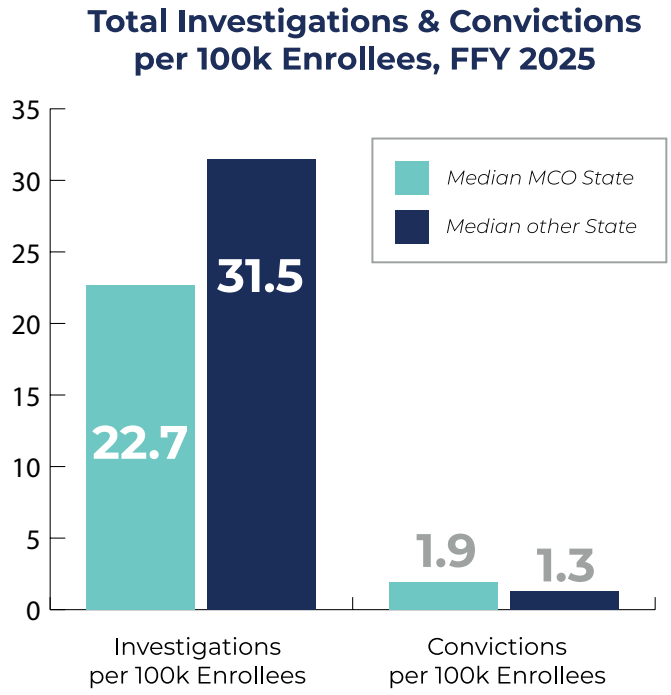
In the delivery of HCBS, Medicaid MCOs work closely with state and federal partners to maintain the integrity of the Medicaid program by supplementing federal and state oversight with a front-line layer of prevention, detection, and enforcement. Health plans hold contracts with states that often include requirements for program integrity responsibilities and must also work within the bounds of existing state policies and regulations.

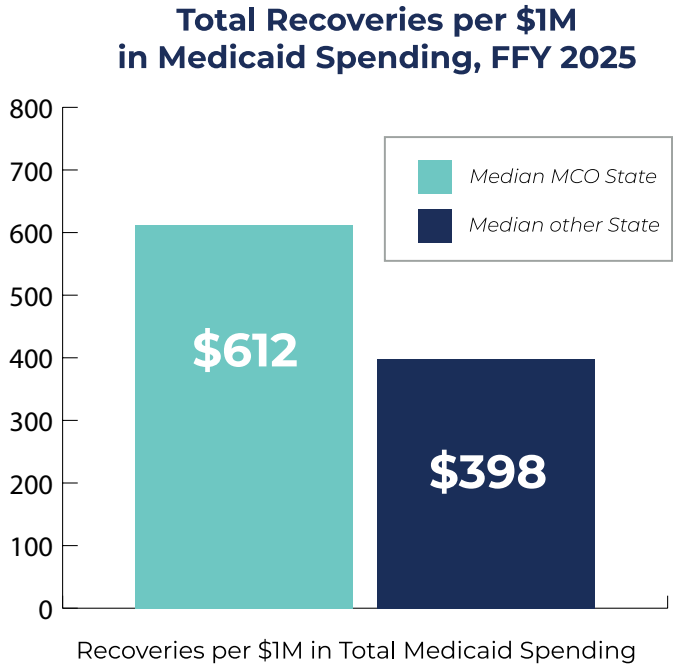
A critical component of the partnership between health plans and state and federal partners is the referral of suspected fraud to Medicaid Fraud Control Units (MFCUs), state-level law enforcement agencies that investigate and prosecute Medicaid fraud. Medicaid

MCOs have doubled the number of fraud referrals to MFCUs from just under 3,000 in 2021 to nearly 6,000 in 2025.[vii] Strengthening front-end prevention strategies, such as prepayment review, provider education, and real-time monitoring, is critical to reducing improper overpayments before they occur, rather than relying primarily on post-payment recovery.

In states where managed care is the predominant delivery system, the MFCU reporting data reflect the meaningful impact of Medicaid MCO program integrity strategies in protecting HCBS and other Medicaid services over other states.[viii] For example, the latest MFCU data for 2025 show that the median MCO state recovered $612 for every $1 million of a state's total Medicaid budget through MCFU investigations, exceeding the median of other states which recovered $398 per $1 million in total Medicaid spending.

Figure 1. MFCU Investigations, Convictions, and Recoveries in States with Managed Care As the Predominant Delivery System vs. Other States, FFY 2025





Note: MFCU = Medicaid Fraud Control Unit. FFY = Federal Fiscal Year. M = Million. k = Thousands. "Other states" include 13 states where less than half of all enrollees are in MCOs based on 2024 CMS MCO Enrollment Reports (AL, AK, AR, CO, CT, ID, MA, ME, MT, ND, SD, VT, WY).
Source: MHPA analysis of Statistical Chart data from Medicaid Fraud Control Unit Annual Report: Fiscal Year 2025.

Moreover, the median MCO state opened fewer investigations per enrollee compared to other states, yet yielded more convictions and higher recoveries, meaning fraud dollars are recouped more efficiently. See Figure 1 for additional details on the impact of Medicaid MCO program integrity efforts for FFY 2025.

Medicaid MCO program integrity efforts go well beyond what is required by law. Medicaid MCOs are essential partners in protecting HCBS from FWA and ensuring Medicaid resources are preserved for individuals who truly need care. Examples of MCO FWA prevention activities that are especially relevant to HCBS include:

Care Management and Service Plan Oversight: Because HCBS are delivered in homes and community settings, Medicaid MCO care managers play a critical front-line integrity role by comparing assessed need, authorized hours, and actual service delivery. Routine member outreach, reassessments, and reviews of person-centered service plans can help identify red flags such as services that do not match functional need, duplicate supports, or claims for care that members or caregivers report did not occur. This real-time visibility also enables earlier intervention to prevent inappropriate billing before claims are submitted or paid.

Provider Screening, Enrollment, & Credentialing: Medicaid MCOs strengthen HCBS oversight through provider screening and ongoing credentialing of agencies and, where applicable, direct care workers delivering personal care and other in-home supports. These activities can include licensure checks, background reviews, exclusion screening, and validation that provider information is current and consistent across enrollment, claims, and service authorization records.

Electronic Visit Verification (EVV) Monitoring: The 21st Century Cures Act requires states to implement EVV systems for personal care and home health services. EVV captures and verifies that HCBS are delivered at the time and location for which they are billed. This creates digital records that enable state Medicaid agencies and Medicaid MCOs with access to this data the ability to audit and detect discrepancies. For HCBS services subject to EVV, Medicaid MCOs can use visit data to confirm that services were delivered on the date, at the time, and in the location billed.

Advanced Data Analytics & Investigations: Medicaid MCOs use data analytics as well as investigation capabilities in dedicated Special Investigation Units to detect HCBS billing patterns that may warrant review, such as unusually high volumes of personal care hours, identical billing across multiple members, concurrent claims that are not operationally plausible, or services billed during inpatient stays or other incompatible settings. This approach helps health plans prioritize provider audits, documentation requests, and referrals for suspected fraud, waste, or abuse.

Overpayment Identification, Payment Integrity, &Referrals: When HCBS claims appear improper, Medicaid MCOs may recover overpayments, conduct prepayment or post-payment review, and coordinate with state Medicaid agencies on corrective action. Health plans also support enforcement by referring suspected provider fraud to states and MFCUs for further investigation. Complementing post-payment recovery efforts with enhanced prepayment controls, such as targeted prior authorization validation and prepayment review for high-risk providers, reduce the volume of improper payments entering the system.

The Future Stakes

The demand for HCBS services among the disabled population far exceeds current capacity. Moreover, the population of older Americans with significant disabilities is projected to double by 2065[ix] and aging in place remains the overwhelming preference of those who need long-term care. Certainly, the importance of a well-functioning, well-protected HCBS system has never been greater. When FWA drains HCBS funding, it wastes taxpayer dollars and directly threatens access to care and services for Medicaid beneficiaries in need of HCBS.

Medicaid MCOs stand ready to work with federal and state partners to meet that challenge to support and promote a sustainable and accountable HCBS system for the continued delivery of high-quality, person-centered care.

[i] Centers for Medicare & Medicaid Services / Mathematica, Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2023 (2024). Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2023.pdf

[ii] KFF, A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024 (October 2024). Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2024/

[iii] AARP Report, 2024. Available at: https://www.aarp.org/pri/topics/livable-communities/housing/2024-home-community-preferences/

[iv] McGarry, B. E., & Grabowski, D. C. (2023). Medicaid Home and Community-Based Services spending for older adults: Is there a "woodwork" effect? Journal of the American Geriatrics Society, 71(10), 3143–3151. https://doi.org/10.1111/jgs.18478

[v] ATI Advisory, How Could Cuts to Medi-Cal Home and Community-Based Services Impact California? (2025). California Health Care Foundation. Available at: https://www.chcf.org/wp-content/uploads/2025/10/HowCutsMediCalHomeCommunityBasedServicesImpactCA.pdf

[vi] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2023.pdf

[vii] Medicaid Fraud Control Units Annual Report: Fiscal Year 2025 (March 2026). Available at: https://oig.hhs.gov/documents/evaluation/11553/OEI-09-26-00140.pdf. More information available at: https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/

[viii] NOTE: "All other states" include states where less than half of all enrollees are in MCOs (AL, AK, AR, CO, CT, ID, MA, ME, MT, ND, SD, VT, WY) and includes AR, CO, ID, MA, and ND, which have some MCO enrollees but less than half of their total population. In 2023, MS also had <50% of enrollees in MCOs and is counted as "All other" for 2023 and "MCO" for 2024 and 2025.

[ix] https://aspe.hhs.gov/reports/long-term-care-services-supports-older-americans-risks-financing-2022-research-brief