National
MLTSS
Health Plan Association

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

National MLTSS Health Plan Association Recommendations to Support Program Integrity in Medicaid Home and Community-Based Services (HCBS)

The National MLTSS Health Plan Association (MLTSS Association) is pleased to submit recommendations to the Centers for Medicare & Medicaid Services (CMS) on preventing fraud, strengthening program integrity, and safeguarding the nation's most vulnerable populations.

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and assume risk for long-term services and supports (LTSS) provided under Medicaid.[1] Our member plans assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Many MLTSS Association member plans are also leaders in integrated care for dually eligible individuals, offering Dual Eligible Special Needs Plans (D-SNPs) across the full spectrum of integration.

The MLTSS Association appreciates CMS's continued commitment to program integrity and the protection of Americans served by MLTSS plans. We also support and share in CMS's broader goal of rooting out fraud in the health care system and ensuring that members get the services they need.

The Value of HCBS

HCBS are services and supports that assist individuals with functional limitations or chronic conditions in performing activities of daily living (ADL) 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 being placed in a nursing facility or other institutional setting.

While people with disabilities represent a significant percentage 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

[1] Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, Lakeland Care, LA Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices.

years of age and over want to age at home.[2] This demand is only expected to grow: all baby boomers will be 65 or older by 2030, and by 2040, more than 82.3 million Americans will be over the age of 65.[3]

In addition to facilitating beneficiary choice, the evidence supporting both the value and cost-effectiveness of HCBS is well-established. Research shows that expansion of HCBS for older adults is associated with more individuals receiving services at lower cost.[4] 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.[5] Additionally, on average, states deliver HCBS at $17,298 per user, compared to $54,462 per person for institutional care.[6] These cost advantages reflect long-standing federal and state policy prioritizing community-based care, and preserving them requires robust program integrity frameworks that protect HCBS resources for those who need them most.

The Role of MLTSS Plans in Program Integrity Oversight and Current Policy Gaps

MLTSS plans invest substantially in fraud, waste, and abuse (FWA) detection and prevention through both upstream controls and layered detection models. Upstream controls include credentialing and provider enrollment validation, person-centered planning processes, and authorization guardrails, which work to prevent FWA before it occurs. These efforts are further reinforced by layered FWA detection models that incorporate real-time monitoring, pre-payment review, and post-payment analytics, including Electronic Visit Verification (EVV). However, structural barriers, including inconsistent state policies, limited data sharing authority, and gaps in federal guidance and regulation, constrain what plans can accomplish independently.

The recommendations below reflect the collective experience of MLTSS Association member plans and are intended to strengthen the federal-state-plan partnership in addressing FWA across all delivery settings while preserving access to critical services for our members. These recommendations also build on the MLTSS Association's prior input to CMS, including our response to the Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH).[7] Altogether, the Association's recommendations underscore areas of concern for plans related to FWA, barriers health plans face enforcing protections against FWA, the need to highlight state best practices, and areas for improvement at the plan, state and federal level.

[2] 2024 Home and Community Preferences and Future Possibilities | AARP
[3] Medicaid HCBS: Support at Home, Life in Community for nearly 5 million Americans | ADvancing States
[4] Medicaid home and community-based services spending for older adults: Is there a "woodwork" effect? | Journal of the American Geriatrics Society
[5] How Could Cuts to Medi-Cal Home and Community-Based Services Impact California? | CHCF
[6] Medicaid HCBS: Support at Home, Life in Community for nearly 5 million Americans | ADvancing States
[7] CRUSH RFI Response | MLTSS Association

Challenges and Recommendations

1. **Challenge: Limited cross-plan and inter-state data sharing capabilities, combined with fragmented LTSS delivery systems, can create gaps in program integrity oversight.**
    - A significant limitation in the current landscape is the lack of cross-payer visibility. Most states do not aggregate HCBS integrity data across MCOs, meaning fraudulent actors can engage in questionable billing practices across multiple plans without triggering any single plan's detection thresholds. Access to this information would allow health plans to utilize their data analysis infrastructure to identify potential duplicative or unnecessary services.
    - MLTSS Association member plans serve a high proportion of dually eligible individuals, giving plans direct line of sight into care and billing patterns that span both Medicare and Medicaid. Over 13 million Americans are dually enrolled in Medicare and Medicaid, yet MCOs managing these populations frequently lack routine access to Medicare claims data necessary to act on that perspective.[8] Federal guidance enabling Medicare-Medicaid data integration for program integrity purposes would allow MLTSS plans to leverage their dual-eligible visibility in ways the current FWA frameworks do not permit.
    - In some states, Medicaid LTSS benefits are administered across multiple delivery systems and funding streams, rather than through one centralized managed care plan.
        i. Example: In California, In-Home Supportive Services (IHSS) operate outside of managed care plan oversight.
    - When some services are carved out of managed care, MCOs lose visibility into the potentially duplicative or overlapping services a member may be receiving. s

    Recommendations: Data sharing across programs, supported by Federal guidance, can increase visibility into duplicative services; managed care offers the most opportunities for oversight.
    - CMS should issue guidance requiring states to take ownership of consolidating and sharing HCBS program integrity data across all Medicaid delivery systems, including managed care and fee-for-service, and establish interoperability and data standards for EVV, care management, and claims data.
    - We recommend that CMS encourage states with LTSS service carve-outs to establish standard data-sharing requirements between MCOs, states agencies, other state programs providing services, and other stakeholders.
    - Ultimately, comprehensive managed care, without service carveouts, provides the highest level of coordination, improves oversight, and reduces duplicative or undetected spending.

[8] Understanding Medicare-Medicaid Integration for Dually Eligible Individuals | CHCS

2. **Challenge: Current Electronic Visit Verification (EVV) requirements are limited and enforcement is inconsistent.**
    - EVV is one of the most significant HCBS-specific advancements in FWA prevention to date. However, current federal reporting requirements limit EVV data to the time, date, location, and type of service performed, as well as the individual providing and receiving the service.
    - While the 21st Century Cures Act established federal minimum standards for EVV, enforcement of EVV compliance remains uneven across states, as they may choose to enforce state-specific requirements for EVV verification. Differences across states and programs can include standards for handling exceptions, manual edits, live-in caregiver exemptions, and soft-launch enforcement periods.
        i. This inconsistent implementation and enforcement of EVV requirements can complicate and delay health plan investigations into improper payments, as well as reduce health plans' ability to build scalable interfaces and best practices across markets.
        ii. When plans are required to pay claims that do not meet EVV requirements during prolonged soft "go-live" periods, provider accountability suffers and program integrity protections are weakened.
    - Visit-level EVV data is not always transmitted to health plans in real-time, limiting plans' ability to conduct pre-payment validation, identify outliers or other utilization patterns that require additional review, and prevent improper payments before claims are adjudicated.
    - CMS training materials emphasize that EVV requirements confirm where and if a visit occurred but do not validate whether services were delivered in accordance with the authorized plan of care or whether services were appropriate for the member's needs.

    Recommendation: Build on EVV Minimum Standards to Further Prevent Improper Payments
    - EVV revolutionized Medicaid program integrity protections for HCBS. However, now that these requirements have been in place for over 5 years, there is an opportunity to build upon this platform to embed additional program integrity protections into the program.
    - We recommend that CMS consider how to utilize EVV to determine not only when and where services are delivered, but to validate that authorized services were appropriately delivered. We believe there are opportunities for CMS to issue additional guidance about service documentation to strengthen existing program integrity protections, while also ensuring that EVV models do not overcomplicate service delivery or create a barrier to access.
    - EVV is most powerful when it is tightly integrated with authorizations, claims processing, provider enrollment, Financial Management Services (FMS), and care management, and used to prevent improper payment before claims are paid.
        - We recommend that federal standards should require timely transmission of visit-level data to payers for validation and the ability to match EVV records to claims prior to

payment. **This integration would enable pre-payment validation of services and reduce reliance on post-payment recovery processes.**

- More robust Federal standards would establish a consistent baseline, accelerate provider adoption, and ensure EVV fulfills its intended program integrity

3. **Challenge: Ongoing State and Federal investigations, and Fair Hearings backlogs, can limit health plans' ability to prevent improper payments.**
   - Historically, program integrity efforts focused on the recovery of misspent funds. More recent initiatives have sought to move beyond "pay and chase" models to focus more heavily on prevention and early detection of fraud and improper payments.
     i. Pre-payment reviews can help to prevent improper payments from being made, but structural challenges, such as prompt payment requirements, can limit health plans' ability to meaningfully perform these activities. When issues are identified after a payment has been made, provider engagement and recovery efforts become more challenging.
   - However, many states continue to restrict MCO authority to act on suspected fraud prior to payment. In practice, this creates significant financial exposure for plans.
     i. For example, when state or federal law enforcement investigations are initiated, plans may be required to "stand down" and continue paying claims to providers under active Office of Inspector General (OIG) or Attorney General investigations, often for extended periods and at a cost of millions of dollars.
   - Granting plans the authority to deny or hold claims based on the full scope of information available to them, while preserving member access and due process protections would enable earlier FWA intervention and reduce overall program costs.
   - In some states, fair hearings backlogs extend to multiple years or thousands of cases, during which plans are required to maintain existing service levels regardless of changes in clinical condition and functional status. Systemic process failures, including unchecked authorization continuation during prolonged hearings backlogs, represent a structural source of waste that existing FWA frameworks do not adequately address.

Recommendation: Authorize MCOs to Deny or Hold Claims That Do Not Meet Program Integrity Requirements

- CMS should issue guidance authorizing states to allow MCOs to deny or hold claims when plans have identified credible evidence of non-compliance or suspected fraud and expressly permit simultaneous plan and state investigations.
- CMS should work with states to reduce fair hearings backlogs and establish guardrails to prevent the continuation of existing service levels when a member's condition has materially changed pending resolution of a hearing.

4. **Challenge: Limited provider ownership disclosure requirements may enable fraudulent providers to continue to operate.**
   - CMS has identified provider ownership disclosure as the area where state Medicaid programs fall short most frequently, making it the leading source of regulatory noncompliance across states.[9] Plans have also encountered situations where providers terminated for cause simply open new entities and continue operating without restriction.
   - Comprehensive ownership disclosure would close these loopholes and strengthen provider vetting by allowing changes in ownership to be caught during the initial Medicaid provider enrollment process. This would ensure that fraudulent providers operating under new ownership are identified and prohibited from re-enrolling.

   Recommendation: Require Full Ownership Transparency for HCBS Providers
   - CMS should require complete chain-of-ownership disclosure for all HCBS providers enrolled in Medicaid, including disclosure of ownership transfers at all levels of interest. This requirement should be coupled with stronger oversight of state licensing entities, including a mechanism for communicating verified provider terminations for FWA across all Medicaid plans operating within the state.

5. **Challenge: Traditional provider credentialing and enrollment frameworks may not adequately validate HCBS provider capabilities and service-level qualifications.**
   - Traditional credentialing and provider enrollment frameworks were primarily designed for licensed clinicians and facility-based providers and may not fully account for the operational structure of HCBS delivery systems.
   - HCBS networks include provider types such as personal care agencies, waiver providers, self-directed support entities, homemaker providers, supported employment organizations, adult day providers, and community integration providers.
   - A provider's enrollment category or specialty designation alone may not sufficiently validate whether the provider is qualified, authorized, or appropriately structured to deliver specific HCBS waiver services. Inconsistent HCBS provider taxonomies, limited service-level validation standards, and fragmented provider data structures can create gaps in oversight, authorization accuracy, claims adjudication, EVV validation, provider directory accuracy, network adequacy monitoring, and fraud detection efforts.

[9] Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

Recommendation: Establish HCBS-Specific Provider Validation and Service-Level Oversight Standards

- CMS should encourage states and MCOs to establish standardized HCBS provider taxonomies, service-level qualification requirements, and provider data structures that support validation of provider capabilities at a granular waiver-service level. CMS should also recognize the need for flexibility within HCBS credentialing and oversight frameworks to account for the operational realities of HCBS delivery systems while maintaining strong program integrity safeguards.
- Enhanced HCBS-specific provider validation frameworks would strengthen alignment between enrolled provider capabilities, authorized services, EVV monitoring, and billed HCBS services, improving program integrity, provider directory accuracy, network adequacy oversight, and member access to appropriate care.

6. **Challenge: Inconsistent HCBS provider identification and fragmented provider data governance limit program integrity oversight.**
   - Accurate, standardized, and well-governed provider data is foundational to effective Medicaid HCBS program integrity efforts. However, significant variation exists across states regarding HCBS provider classification, enrollment standards, and use of provider identifiers.
   - Current federal regulations do not require the use of a unique personal identifier for individuals who provide personal care services, and in most states, EVV systems do not require an individual's full Social Security Number (SSN). The lack of a unique identifier for EVV records can lead to conflicts that are difficult for health plans to identify.
   - Assigning unique identifiers to personal care attendants is recognized as an efficient way to identify a caregiver's identity on claims and to facilitate tracking attendants' transitions across locations and/or agencies. Without a national standard, overlapping shifts, duplicate billing, and cross-plan fraud patterns remain difficult to detect. A national program identifier would also help to identify whether a caregiver resides in the same home as the individual receiving care.
   - States may also apply "atypical provider" classifications inconsistently, including in situations where HCBS providers possess valid National Provider Identifiers (NPIs), and are nevertheless instructed to bill using state-assigned atypical identifiers rather than standardized national identifiers.
   - These inconsistencies create operational fragmentation across Medicaid programs and reduce the effectiveness of interoperability, provider screening, encounter data validation, provider directory accuracy, network adequacy oversight, and fraud detection analytics.
   - Lack of standardized provider data governance also creates downstream challenges for claims adjudication, EVV integration, ownership transparency, cross-plan monitoring, and oversight of multi-state HCBS providers.
   - Because HCBS delivery systems often rely on multiple disconnected provider, EVV, claims, and care management platforms, provider data discrepancies can persist across systems without clear accountability for remediation.

Recommendation: Establish a Standardized National Caregiver Identifier

- CMS should require a standardized national unique identifier for all HCBS caregivers participating in Medicaid, along with disclosure of whether the caregiver resides in the same household as the member they serve.
- CMS should recognize provider data integrity as a core component of Medicaid HCBS program integrity infrastructure and encourage states and managed care organizations to adopt standardized LTSS provider data governance frameworks.
- Federal guidance could promote:
    - Consistent HCBS provider classification standards,
    - Clearer criteria regarding when providers may appropriately be classified as "atypical,"
    - Broader use of NPIs where appropriate,
    - Standardized provider lifecycle governance processes,
    - Interoperable provider system requirements, and
    - Clearly defined operational accountability for provider data management across Medicaid delivery systems.
- Standardized provider data frameworks would strengthen claims accuracy, provider directory integrity, network adequacy oversight, encounter data quality, compliance monitoring, and cross-system fraud detection capabilities.
- CMS should also consider guidance supporting greater consistency in HCBS provider identification standards across Medicaid programs to reduce state-by-state variation that currently limits effective program integrity oversight.

7. Challenge: Fraud-prevention costs are barred from inclusion in the Medicaid MLR calculation.

- Within the Medicaid program, MCOs are generally barred from including prepayment fraud-prevention costs in the numerator of their medical loss ratio (MLR) calculation.
- This policy treats fraud prevention differently than quality-improvement initiatives or post-payment fraud-reduction programs.

Recommendation: Include Fraud Prevention Expenses in the MLR Numerator

- CMS should encourage Medicaid MCOs to invest in effective preventive anti-fraud measures by broadly allowing these expenses to be included in the numerator of the MLR.

Conclusion

MLTSS plans are committed partners in CMS's efforts to protect program integrity and ensure that HCBS services reach the individuals who need them. The recommendations outlined above reflect practical, plan-level experience with the structural barriers that currently limit effective FWA prevention in HCBS. We welcome the opportunity to engage further with CMS on any of these issues or recommendations and look forward to continued collaboration in support of high-quality, accountable HCBS delivery. If CMS has any questions, please contact me at mkaschak@mltss.org.

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Sincerely,

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