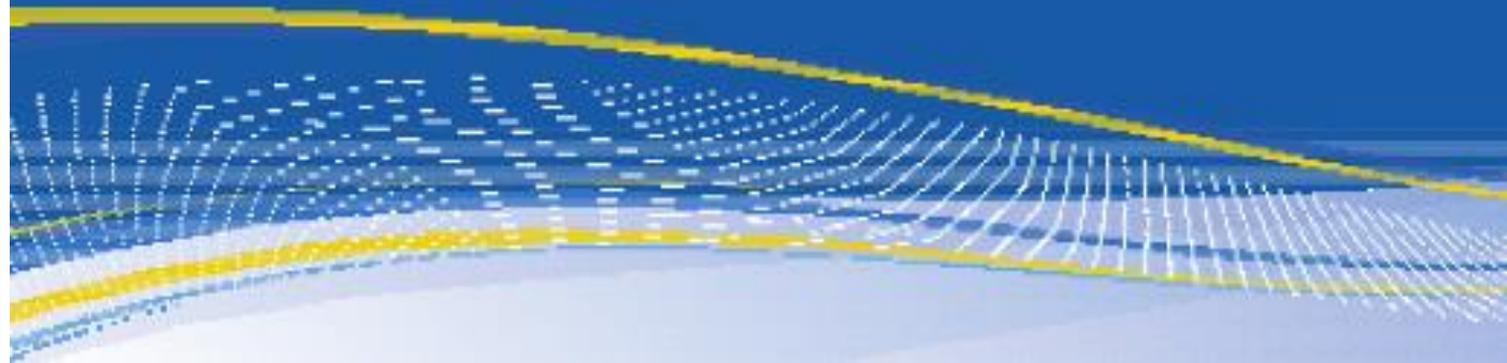




Financial Accountability



Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
August 2017



Training Objectives

- Provide an overview of common challenges observed while reviewing Appendices I and J of §1915(c) new waiver and renewal applications, which specifically address financial accountability measures.
- Discuss the importance of financial accountability in light of an October 2016 report from the Department of Health and Human Services (HHS), Office of Inspector General (OIG), “State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program.”
- Review promising practice suggestions to address common challenges in accordance with the §1915(c) Home and Community-Based Services (HCBS) Technical Guide and Review Criteria.

Data Analysis Background

Data Collected and Analyzed by CMS

- This training includes application trends related to Appendices I and J.
 - Based on data from two new waiver applications and 113 renewal applications submitted between March 2015 and March 2017.
 - Data was collected from initial submissions (i.e., before an informal request for additional information is issued)
 - Data was only included for applications with relevant information.
 - For example, only 100 renewal applications included sufficient rate setting methodology information in Appendix I-2-a.

Data Analysis Background

Importance of Financial Accountability in 1915(c) Waiver Programs

- In October 2016, HHS OIG issued a report that showed the results of eight audits performed on four states' 1915(c) waiver programs.
- In this report, HHS OIG found that State Medicaid agencies claimed unallowable and unsupported Medicaid reimbursements for HCBS services.
- Findings from the report are closely related to fiscal integrity oversight and monitoring, which is covered in Appendix I and J of the waiver application.

Data Analysis Background

Importance of Financial Accountability in 1915(c) Waiver Programs

- This table demonstrates a summary of HHS OIG's findings and which appendices from the 1915(c) waiver application would address them.
- States' detailed Appendix I and J descriptions demonstrate to CMS that the state has established clear processes to mitigate many of the HHS OIG's findings.

HHS OIG's Findings	Related 1915(c) Appendix
Claimed unallowable room and board costs.	Appendix I-2-a, I-5 and I-6
Reimbursed personal care services by unqualified personnel.	Appendix C-1/C-3, QIS C, and I-1
Provided services to individuals who did not meet level of care requirement outlined in the waiver.	Appendix B-6 and QIS B
Unable to ensure that all payment rates under HCBS waiver program were properly supported and documented.	Appendix I-2-a

Data Analysis Background

Why Look at Initial Submissions?

- CMS may ask questions or request modifications through a Request for Additional Information (RAI) to ensure waiver applications meet federal requirements as described in the 1915(c) Technical Guide.
- Including sufficient detail in the waiver application prior to submitting it to CMS:
 - Reduces the number of questions in the informal and/or formal RAI, reduces the amount of time required for approval and reduces the burden on the state.
 - Maximizes the information available for public comment.

Data Analysis Background

Top 3 Issues in Appendices I and J Leading to RAIs for New and Renewal Applications

- CMS reviewed the list of questions sent to the states during Appendix I and J reviews and noted the following three most common issues:
 - **Issue 1:** More documentation needed for the basis of Factor D, D', G and G' estimates in Appendix J-2-c.
 - **Issue 2:** More documentation needed for rate setting methods for waiver service(s) in Appendix I-2-a.
 - **Issue 3:** More documentation needed for post-payment financial audit program in Appendix I-1.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates (Appendix J-2-c)

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

- The factor derivations described in Appendix J-2-c demonstrate the cost neutrality of the waiver.
 - **Factor D:** Estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.
 - **Factor D':** Estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.
 - **Factor G:** Estimated annual average per capita Medicaid cost for hospital, NF, or ICF/IID care that would be incurred for individuals served in the waiver, were the waiver not granted.
 - **Factor G':** Estimated annual average per capita Medicaid costs for all services other than those included in factor G for individuals served in the waiver, were the waiver not granted.
 - **Cost Neutrality Formula:** $D+D' \leq G+G'$.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- States are expected to use 372 reports as the basis for estimating factors D, D', G and G'.
- Another basis can be used (e.g., Consumer Price Index), as long as the basis is **explained** and **justified** in the 1915(c) waiver application.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- Details of the documentation issues in factor estimates that CMS noted during data analysis include:
 - Not enough explanation for how estimates were trended.
 - Explanations that include growth percentages, but no explanation for how these percentages were established.
 - Discrepancies between 372 reports and factor estimates when the application indicates 372 reports were used.
 - Not enough detail regarding an alternate basis for CMS to validate the state's calculation.

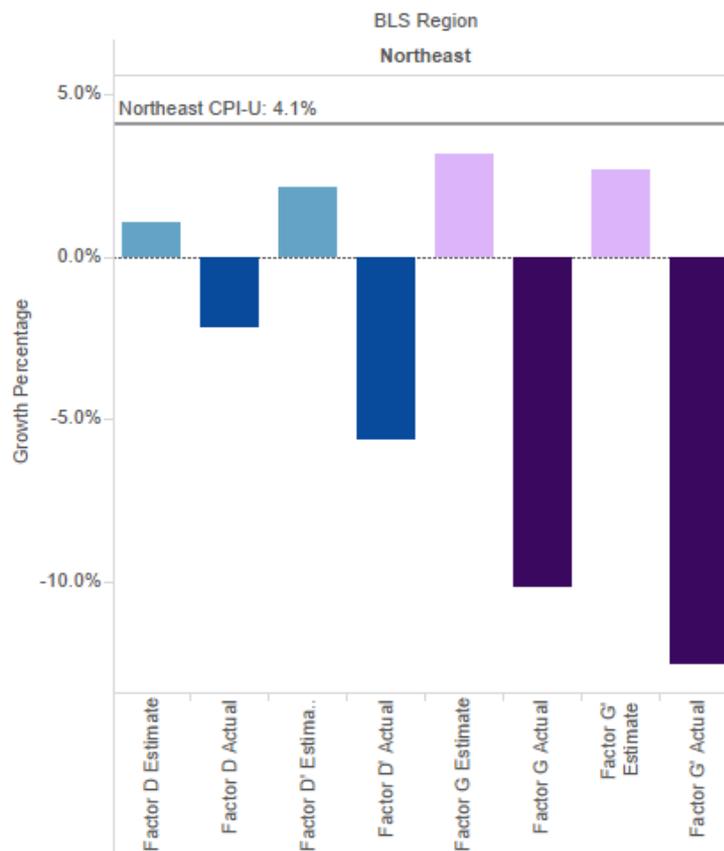
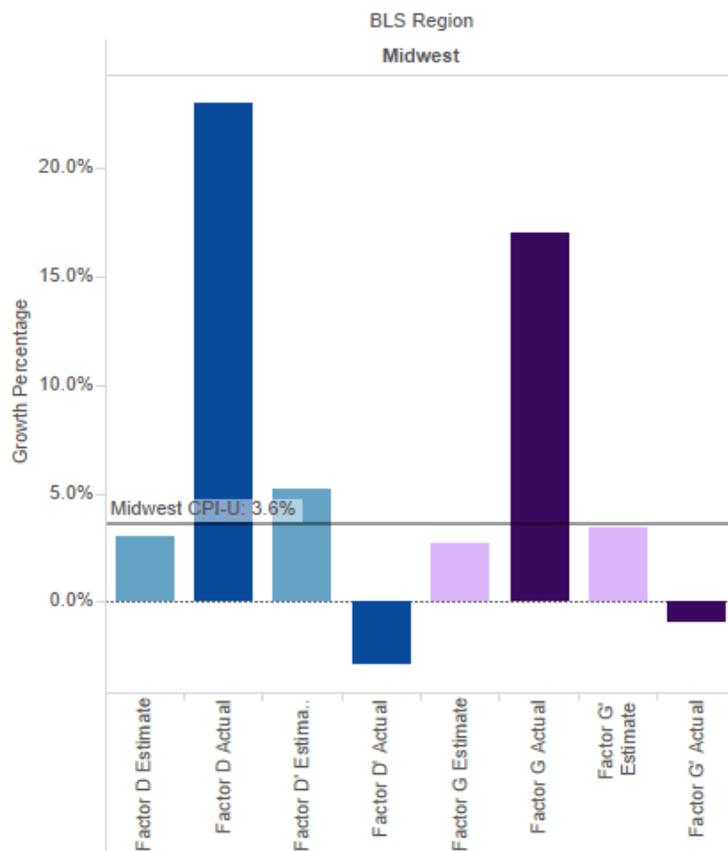
Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- To illustrate the importance of documenting deviations from 372 reports, estimated factor growth from applications were compared to:
 - Actual growth based on 372 reports.
 - Regional Consumer Price Indices for all Urban Consumers (CPI-U), an inflation/trending metric commonly used as an alternate basis for estimating factor growth.
- Comparisons were divided by Bureau of Labor Statistics (BLS) regions to account for regional cost differences.

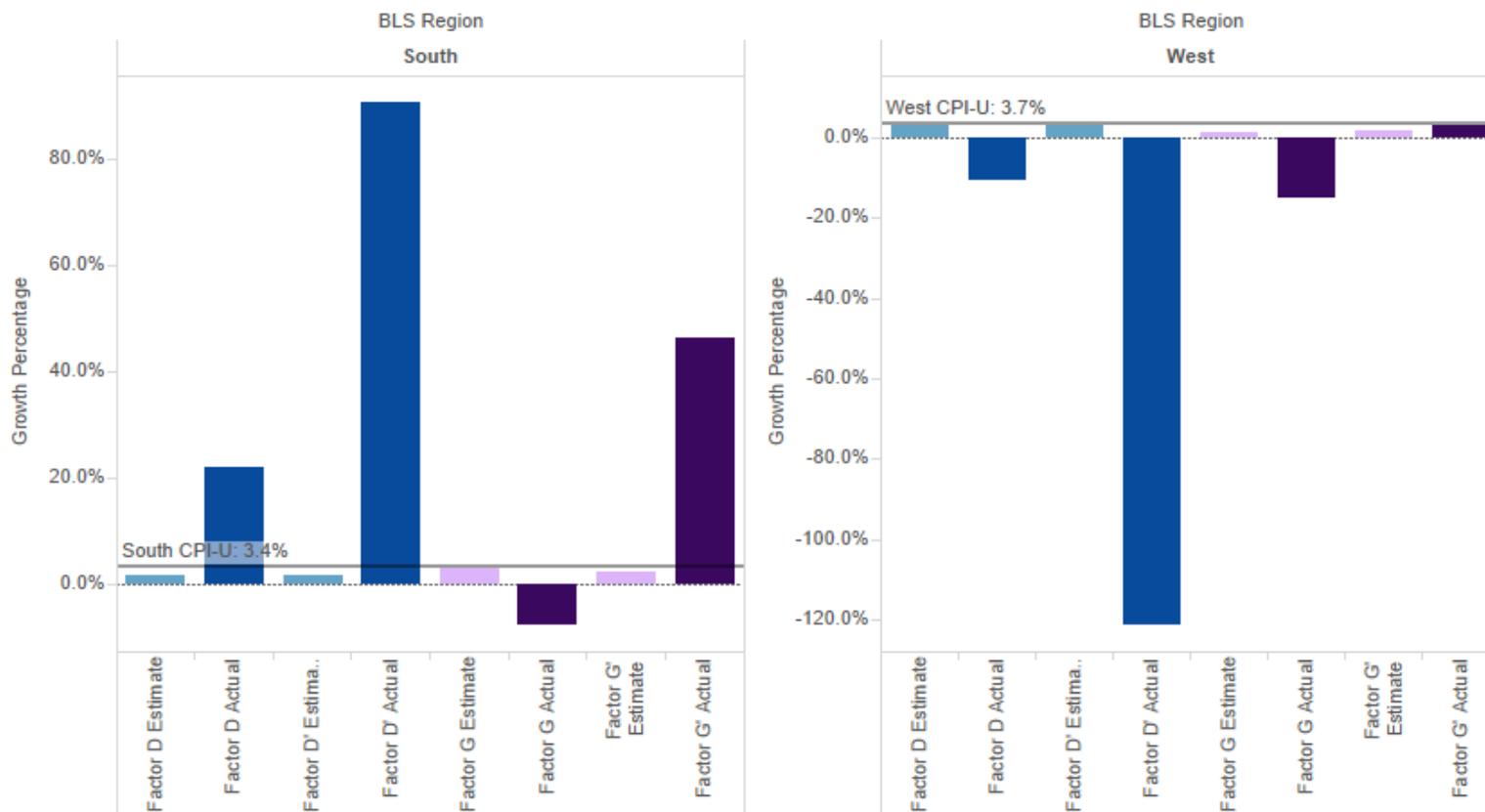
Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Comparison of Estimated Growth, Actual Growth and Regional CPI-U



Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Comparison of Estimated Growth, Actual Growth and Regional CPI-U



Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Identifying the Basis of Factor Estimates

- Overall, factor growth estimates more closely aligned with CPI-U than with historical 372 data.
- CMS hypothesizes this is because applications with major programmatic changes (e.g., addition or removal of services) skew 372 data.
- Without proper documentation for deviations from 372 data, CMS cannot ascertain why estimated factor trends differ significantly from 372 trends.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Additional Considerations for Factor Derivation

- It is important that calculations of estimates in Appendix J-2-d (Factor D Derivation) match the basis documented in Appendix J-2-c. Trends compound annually, so deviating from the proposed basis by even 0.2% can have a large impact on estimates.
- For example, the average cost of waiver services per year is \$153 million. If an application states estimates are based on a CPI-U of 3.4%, but calculations show 3.6% annual growth, there is a \$3.3 million difference in estimated costs after 5 years.

Year	Inflation: 3.4% (A)	Inflation: 3.6% (B)	Difference (B-A)
1	\$ 153,000,000.00	\$ 153,000,000.00	
2	\$ 158,202,000.00	\$ 158,508,000.00	\$ 306,000.00
3	\$ 163,580,868.00	\$ 164,214,288.00	\$ 633,420.00
4	\$ 169,142,617.51	\$ 170,126,002.37	\$ 983,384.86
5	\$ 174,893,466.51	\$ 176,250,538.45	\$ 1,357,071.95
Total Difference Over Five Years			\$ 3,279,876.81

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Promising Practice Checklist for Determining if an Alternate Basis is Appropriate

- Does your 372 data have outliers (e.g., abnormally large increases and decreases in participant counts, service utilization, service costs, etc.)?
- Are there new services that are not reflected in 372 data?
- Are there services that have been removed since the last 372?
- Has the waiver experienced changes in the scope or definition of services?
- Are there external reasons for service cost or utilization changes (e.g., the addition of a specific number of slots or legislative budgetary increase)?
- Document the reasons for deviating from 372 trends in Appendix J-2-c.
- Document the alternate basis used to estimate factors and explain why this approach was used.

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Promising Practice Checklist for Documenting Factor Estimates in Appendix J-2-c:

- Does the state document the source of the baseline for Factors D, D', G and G'?
If this is not the 372, does the state include the baseline in the application?
- Does the state include the percentages used to trend the baseline?
- Does the state explain and justify the percentages in Appendix J-2-c?
 - If the percentages are based on inflation, does the state indicate the population, area, series title and index base period for the inflation metric?

➤ **Special Considerations for Factor D**

- Does the state describe the basis for calculating the elements used in Factor D estimation (i.e., estimated number of users, units per user, average cost per unit, and overall average length of stay)?
- If the application includes a new service, has the state included the basis of estimates?
- Is the basis of factor estimates described in Appendix J-2-c consistent with the growth trends in Appendix J-2-d?

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Promising Practice Checklist for Documenting Factor Estimates in Appendix J-2-c:* (continued)

➤ **Special Consideration for Factor D'**

- If the state develops D' through sampling a comparable population, does the state provide information on the process used, including specific data sources?

➤ **Special Consideration for Factors G and G'**

- Does the state's data only include the level(s) of care indicated in the waiver request?
- If Factor G' is greater than Factor D', does the state explain why?

***Note:** For additional information on developing Factor estimates, see the CMS training “Cost Neutrality.” <https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-1e-cost-neutrality.pdf>

Issue 1: Documenting the Basis of Factor D, D', G and G' Estimates

Example for Documenting Factor Estimates in Appendix J-2-c:

➤ **Insufficient Response:**

“Factor D was trended forward five percent in Waiver Year 1 and then three percent annually each year after.”

➤ **Sufficient Response:**

“Factor D was trended forward five percent in Waiver Year 1 to account for enrollment increases due to changes in the Waiver. Factor D was then trended forward three percent annually in coordination with the average BLS West Census Region CPI-U for medical care services for the period January 2015-2016.”

Issue 2: Documenting Rate Setting Methods for Waiver Service (Appendix I-2-a)

Issue 2: Documenting Rate Setting Methods for Waiver Service

- CMS analyzed issues in Appendix I-2-a of 113 renewal applications with RAIs.
- Compared to 2016 data analysis, states continue to have similar issues in the initial waiver submissions.
- Four common issues identified during reviews were:
 1. No indication of when current rates were set for each service in the waiver application. **21 percent** of applications (24 of 113)
 2. Not enough documentation of the frequency of rate update methods. **37 percent** of applications (42 of 113)
 3. Not enough documentation of how acuity tiers were based (for waivers utilizing acuity tiers). **60 percent** of applications (18 of 30)*
 4. Not enough documentation of the basis of annual trends (i.e., COLA, CPI, and other inflationary measures). **29 percent** of applications (33 of 113)

*Only 30 applications reported acuity tiers.

Issue 2: Documenting Rate Setting Methods for Waiver Service

- States need to add detail regarding the rate setting methodologies used for waiver services.
 - The inputs and calculations used to develop final rates should be adequately documented.
 - This information should be included for every waiver service. The state's description may group services when the same method is employed.
- Lack of detail regarding the rate methodology can make it difficult to:
 - Monitor whether states are reviewing rate sufficiency in accordance with §1902(a)30(A) of the Act.
 - Demonstrate compliance with the sub-assurance “the state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.”
 - Ensure that rates do not include room and board.

Issue 2: Documenting Rate Setting Methods for Waiver Service

Promising Practice Checklist for Documenting Rate Setting Methods in Appendix I-2-a:

- Does the application provide sufficient detail for an independent party to understand how rates were developed?
 - What is the rate setting methodology (e.g., fee schedule, negotiated market price, cost reconciliation, etc.)?
 - What data sources are used to determine rates (e.g., provider cost survey, wage data, etc.)?
 - If applicable, what cost factors (i.e., base wage, employee expenses, administrative expenses, program expenses, productivity adjustments, and inflation) and cost assumptions does the state use to determine rates?
 - If a tiered rate setting methodology is used, what differences in cost assumptions produce the tiered rates?

Issue 2: Documenting Rate Setting Methods for Waiver Service

Promising Practice Checklist for Documenting Rate Setting Methods in Appendix I-2-a: (continued)

- Does the application list differences between agency-directed and self-directed service rate setting, if any?
- Does the application indicate when the rate methodology was set?
- Does the application indicate when the rate was last reviewed*?
- Does the application include rate setting information for each waiver service? Remember that the state may group services where the same method is employed.

***Note:** States should review rates every five years, consistent with the waiver renewal cycle.

Issue 2: Documenting Rate Setting Methods for Waiver Service

Promising Practice Checklist for Documenting Rate Setting Methods in Appendix I-2-a: (continued)

- Does the application list differences between agency-directed and self-directed service rate setting, if any?
- Does the application indicate when the rate methodology was set?
- Does the application indicate when the rate was last reviewed*?
- Does the application include rate setting information for each waiver service? Remember that the state may group services where the same method is employed.

***Note:** States should review rates every five years, consistent with the waiver renewal cycle.

Issue 2: Documenting Rate Setting Methods for Waiver Service

Example of Describing Rate Methodology

- **Overly General Response** : “Personal care rates were developed using the same methodology utilized in the Traumatic Brain Injury (TBI) Waiver.”
- **Framework for Sufficient Response***: “The state used the fee schedule model of rate setting for its Personal Care Services. The initial rate methodology was set in 2012 and was last rebased by the state’s Medicaid Agency in June 2017. The rate model begins with an examination of the most relevant state-specific information available from the Bureau of Labor Statistics (BLS) as a means to identify basic employee wages for personal care aides (PCA). The average BLS wage for PCAs surveyed in 2012 is \$20.00 per hour. A provider survey was used to determine benefits, annual paid time off and training, productivity, administrative, and program expense factors. These factors were applied to the \$20.00 per hour wage to come up with a final rate of \$31.00. Personal care rates are standard statewide and do not vary based on location.”

** This example provides a minimal framework for describing the state’s rate setting methodology. States should be as specific as possible in explaining the methods and factors used to develop rates.*

Issue 2: Documenting Rate Setting Methods for Waiver Service

Example of Describing Rate Methodology Review

- Per CMS Guidance, rates should be reviewed every five years to ensure compliance with efficiency, economy, quality of care, and to ensure rates are sufficient to enlist enough providers.
- If a state is unable to update rates, the application should provide a detailed explanation.
- **Example (Fee Schedule Methodology)*:** “The rate will remain the same for this renewal period. The state has compared its current rates to those of three border states who have similar TBI waiver programs. The state’s rates are all within 3% of rates for similar services, so we believe they are sufficient to enlist providers and ensure efficiency, economy, and quality of care. The state will submit an amendment application if rates change based on legislative appropriations.”

** This example provides a minimal framework for describing the state’s rate review method. States should be as specific as possible in explaining the methods and factors used to review or rebase rates.*

Issue 2: Documenting Rate Setting Methods for Waiver Service

Special Considerations: Federal Match Cannot be Claimed for Room and Board

- Per 1915(c) Technical Guide, page 6 and 266, room and board payment expenses of waiver participants **cannot** be claimed as part of Federal Financial Participation (FFP) under 1915(c) waiver.
 - *“42 CFR §441.310(a)(2) prohibits making Medicaid payments for room and board (i.e., housing, food, and utility costs)”*
- States need to be able to demonstrate that payment rates do not pay for room and board and report their methodology for excluding room and board payments for applicable residential settings in Appendix I-5 of the 1915(c) waiver application.
- This is an area of interest for the Department of Health and Human Services (HHS) Office of Inspector General (OIG).
- The HHS OIG Work Plan for FY 2017 includes a review of unallowable room-and-board costs in state claims for Federal reimbursement and three detailed reports have been issued based on their audit results.

Issue 2: Documenting Rate Setting Methods for Waiver Service

Special Considerations: Federal Match Cannot be Claimed for Room and Board – Technical Guide Requirements

- Does the waiver furnish services in residential settings other than the private residence of the individual?
 - If yes, does the methodology employed assure that the costs of room and board have been isolated and excluded from payments for services in applicable residential settings?
 - We generally see two methods of excluding the cost of room and board:
 - The state specifically outlines what constitutes “room and board costs” and labels these as “unallowable costs” in cost report / cost survey instructions to providers.
 - The state pays providers (either part or all of) room and board costs. The state agency then deducts the total room and board payments (including any money collected from beneficiaries) from its per diem rate before submitting its claim for Federal reimbursement.

Issue 2: Documenting Rate Setting Methods for Waiver Service

Special Considerations: Federal Match Cannot be Claimed for Room and Board – Technical Guide Requirements

- Exceptions:
 - Participant is receiving institutional respite or respite in a licensed or certified facility outside his or her private residence
 - Participant requires a live-in caregiver (who is not related); in such case the caregiver's room and board expense can be included
 - This is reported in Appendix I-6

Issue 3: Documenting Post-Payment Financial Audit Program (Appendix I-1)

Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

- Applications sometimes lack detail in describing post-payment activities, particularly the scope of reviews.
 - **Methods:** 19 of 113 applications (17 percent) did not detail the type of post-payment activity conducted.
 - **Scope:** 77 of 113 applications (70 percent) did not describe how providers, individuals, records or claims are selected for review.
 - Waiver applications continue to show need for improvement in this area. 2016 data collection analysis results showed that 58 percent of the applications did not include sufficient information about the scope of the post-payment activities.
 - **Frequency:** 31 of 113 applications (28 percent) did not describe how frequently reviews are conducted.
- Ensuring strong post-payment methods addresses HHS OIG's concerns, such as assuring that services are provided by qualified personnel.

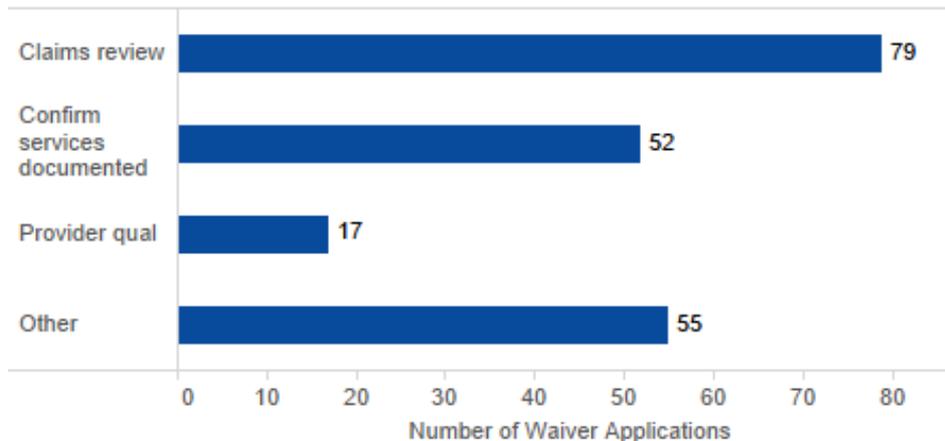
Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

- The following are trends for applications including sufficient detail.
- **Methods**
 - Many waiver applications indicate states use multiple methods for validating payments, including reviewing claims data, confirming services are documented, and verifying provider qualifications.

Top 3 Methods of Post-Payment Review

Based on 113 applications that provided this information



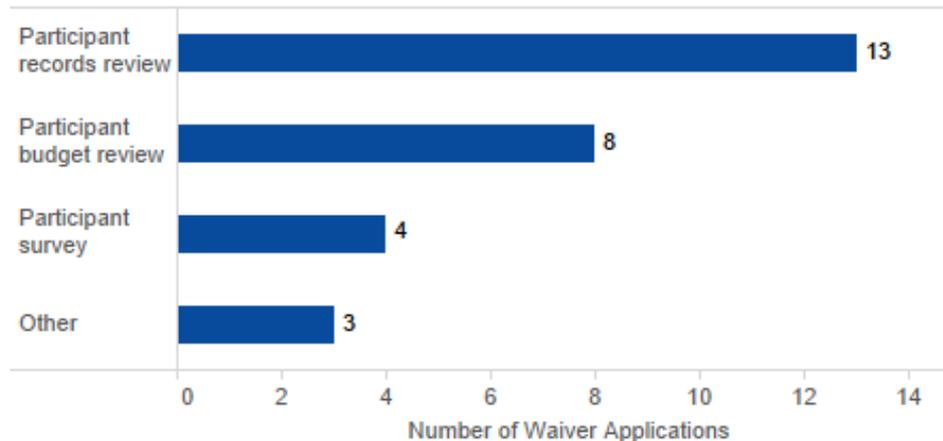
Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

➤ **Methods** (continued)

- **48 percent of applications** with self-direction opportunities (28 of 58) included methods for post-payment reviews of self-directed services in Appendix I-1.
- Records review is the most common method of validating payments in self-direction.

Top 3 Methods of Post-Payment Review in Self-Direction
Based on 58 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

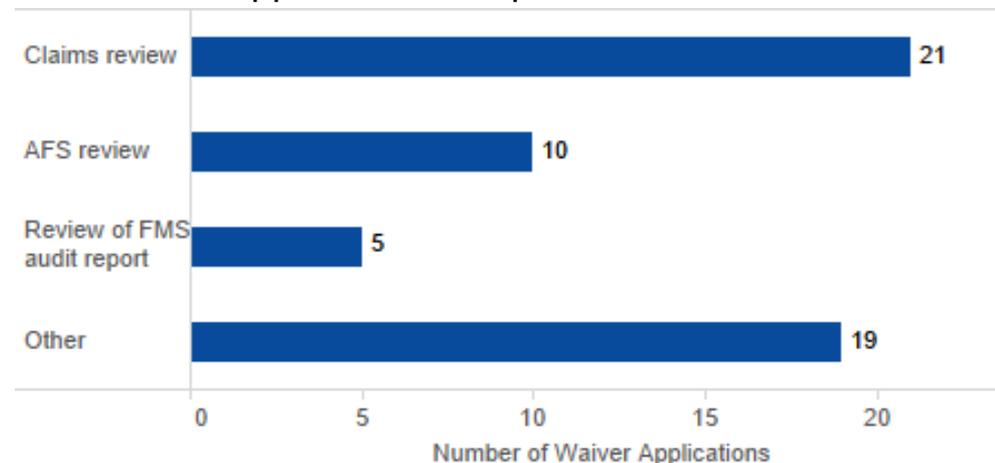
Trends in Appendix I-1

➤ **Methods** (continued)

- **70 percent** of applications with a Financial Management Services (FMS) entity (35 of 50) included information about how the state reviewed the FMS entity. This is an improvement from data collected in 2016, when only 55 percent of states reported this data.
- Notably, **three** applications included information regarding automated reporting systems used to verify contract compliance.

Top 3 Methods of Reviewing FMS Entities in Self-Direction

Based on 35 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

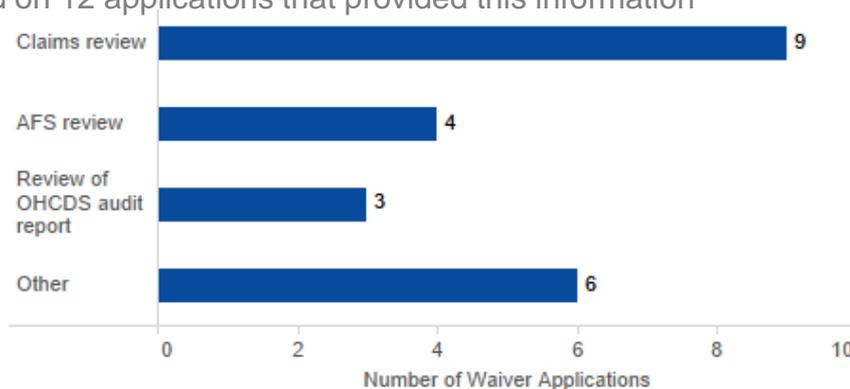
Trends in Appendix I-1

➤ **Methods** (continued)

- Among states that performed Organized Health Care Delivery System (OHCDS) oversight reviews, 12 applications included information about how the state reviewed OHCDS.
 - **Two** applications indicated the state reviewed all of the OHCDS' standard operating procedures.
 - **One** application specified the state reviewed all provider records to verify the OHCDS properly validated provider qualifications.

Top 3 Methods of Reviewing Organized Health Care Delivery Systems (OHCDS)

Based on 12 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

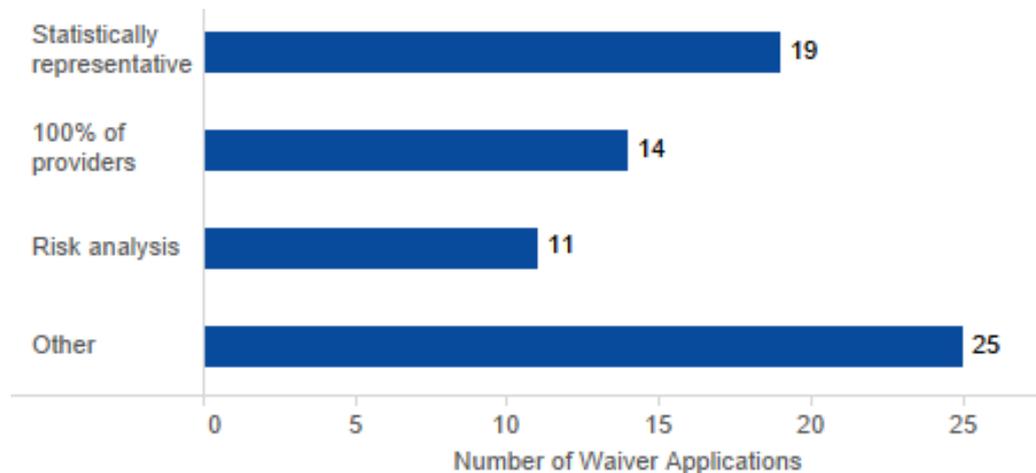
Trends in Appendix I-1

➤ Scope

- Although most applications indicate they select a statistically representative sample of providers for post-payment reviews, **11** (of 61) applications that reported scope indicated the state identifies providers with the highest risk of fraud, waste and abuse.

Top 3 Methods of Selecting Providers for Review

Based on 61 applications that provided this information



Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

➤ **Scope** (continued)

- Risk analyses include:
 - Prior findings.
 - Compliance with plans of correction.
 - Incident reports.
 - Fraud allegations.
 - Total dollar value of claims.
 - Number of individuals served.
 - Rank of provider claims compared to other providers of similar services.

Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

➤ **Scope** (continued)

- **14** (of 61) applications indicate the state reviews 100% of providers.
 - In three applications, these are all on-site reviews.
 - Larger waiver programs may review providers on a cycle (e.g., every two years) to manage resources.
 - One state reviews all providers each of the first three years after a provider begins furnishing billable services. The state then uses a risk analysis to determine whether to review providers annually or every two years.

Issue 3: Documenting Post-Payment Financial Audit Program

Trends in Appendix I-1

➤ Frequency

- Nine (of 113) applications listed the frequency of post-payment reviews as “ongoing.”
 - States should be more specific in defining how often post-payment activities are conducted (e.g., utilization reviews conducted monthly, or desk reviews conducted annually).

Issue 3: Documenting Post-Payment Financial Audit Program

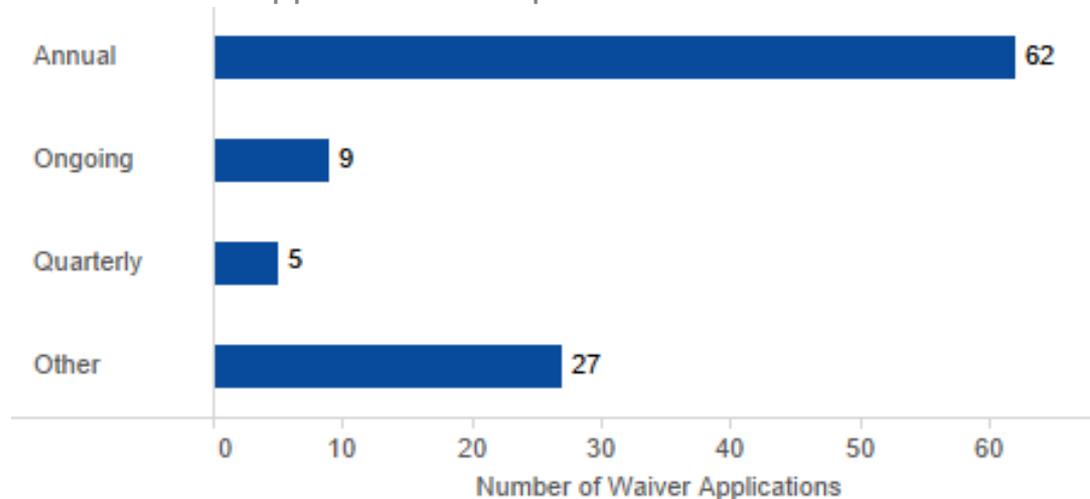
Trends in Appendix I-1

➤ Frequency

- It is most common for states to conduct post-payment reviews annually (62 of 88 applications).
- Some states indicated they review services with a higher risk of fraud, waste and abuse more frequently (e.g., monthly, twice a month, quarterly).

Top 3 Frequencies for Post-Payment Reviews

Based on 84 applications that provided this information

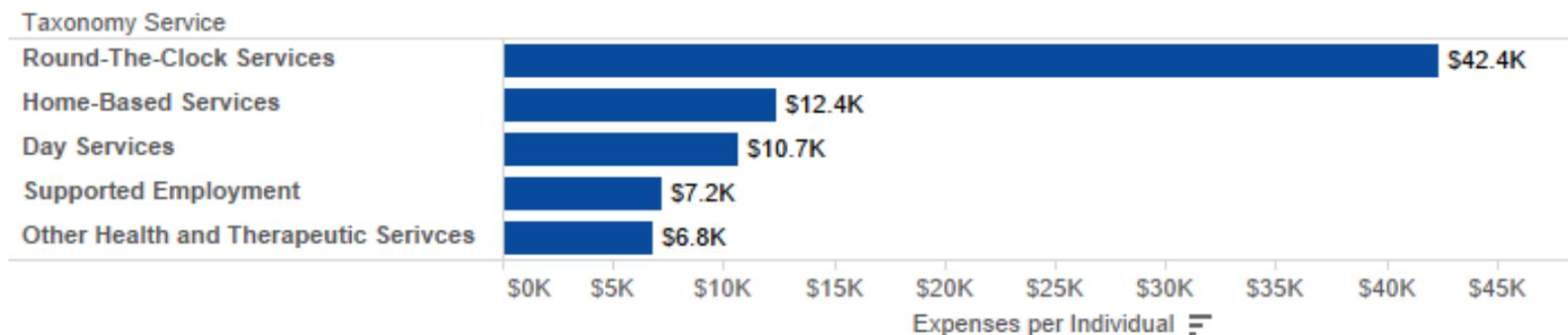


Issue 3: Documenting Post-Payment Financial Audit Program

Consideration for States

- 372 data from 2011-2016 shows that spending per individual is highest for five taxonomies:

Top 5 Taxonomies by Expenses per Individual



- States should consider additional post-payment review / financial accountability requirements for services in these taxonomies.*

* **Note:** For ideas specific to personal care services (home-based services taxonomy), see the CMS training “Increasing Fiscal Protections for Personal Care Services.” A link is available on slide 48.

Issue 3: Documenting Post-Payment Financial Audit Program

Promising Practice Checklist for Documenting Appendix I-1:

- Does the application describe how data is selected for review? Does this differ by service?
 - Data source (e.g., MMIS claims)?
 - Frequency (e.g., annually)?
 - Sampling methodology (e.g., 100% of providers, representative sample with a 95% confidence level and +/- 5% margin of error, etc.)?
 - Time period (e.g., one year of claims data)?
- Does the application indicate the method of the review (i.e., what the reviewer is validating)? Does this differ by service?
 - Are these desk or on-site reviews?

Issue 3: Documenting Post-Payment Financial Audit Program

Promising Practice Checklist for Documenting Appendix I-1 (continued):

- Does the application detail how the results of reviews are communicated to providers?
- Does the application indicate whether corrective action plans are required from providers?
 - If so, does the application describe how the state ensures corrective action plans are followed by providers?
- If applicable, does the application describe how the state performs billing / post-payment reviews of claims processed by a FMS or OHCDIS entity?

Issue 3: Documenting Post-Payment Financial Audit Program

Example of the state's post-payment financial audit program

- Document the three required elements of the post-payment review program:
 - Scope
 - **Example:** “Due to the nature of this waiver, all participating providers are selected for audit. The state selects a statistically valid (95 percent confidence level with a five percent margin of error) random sample from a 6-month period of claims for each provider.”
 - Frequency
 - **Example:** “Post-payment audits are performed annually.”
 - Methods
 - **Example:** “Paid claims are compared to service documentation to ensure services were rendered.”
- Specify who performs the audit.
 - **Example:** “Post-payment audits are performed by Mock Example Third-Party Contractor Name on an annual basis.”

Summary

- Based on our application reviews, the most challenging areas of Appendix I and J are Appendices I-1, I-2-a, and J-2-c. This is a continuing trend from 2016.
- In Appendix I-1, it is important to remember that there are three separate audit requirements and that the primary goal is to describe a post-payment system sufficient to assure fiscal integrity.
- In Appendix I-2-a, states should be sure to revisit their rate setting methodology once every five years and provide adequate detail for the rate setting methodology they have selected to use.
- For Appendix J-2-c, states should be sure to provide a justifiable basis for their estimates.
- Ensuring strong financial accountability processes will be one of the best methods to prevent improper payments related to rates and provider qualifications outlined in HHS OIG's October 2016 report.

Additional Resources

- Additional rate setting resources are available on the website below. Topics include:
 - [Rate Methodology in a FFS HCBS Structure](#)
 - [Fee Schedule HCBS Rate Setting: Developing a Rate for Direct Service Workers](#)
 - [Increasing Fiscal Protections for Personal Care Services](#)
- <https://www.medicaid.gov/medicaid/hcbs/training/index.html>

Questions & Answers

For Further Information

For questions contact:

HCBS@cms.hhs.gov

**Thank you for attending
our session!**