Transcript: ***Overview & Discussion on CMS Guidance for Additional Support for Medicaid Home and Community Based Services (HCBS)*** **- Home Care Associations**
May 26, 2021

Hi, everyone, this is Julianne Bouchard from the Department of health. We're just waiting on Brett Friedman to join so we'll get started shortly and it looks like some attendees are still trickling in.

Hi everyone, you've got Brett Friedman on I see we have 12 attendees and most folks I expected to be on. Let's just give it one more minute, we'll start five after, and we can walk through what we want to cover today on the agenda. There will be no further slides so really, the purpose of the next little while is just to have a discussion with you about ways and strategies to explore this new funding but we can talk through first what we look at - how we're viewing the guidance and some principles that we'll explore. So, let's give everyone a minute and we'll get going.

Okay, well it seems like the people joining, the attendees have stabilized so let's get moving. Good afternoon everyone, this is a small group of our favorite homecare advocates and we're here to discuss the recent CMS guidance on the claiming and permitted uses of the enhanced FMAP for home and community-based services and programs. We're very excited about this new funding provided by CMS. We are working expeditiously given the timeframes discussed by CMS to prepare a submission that will tell and result in CMS's approval of the ways we're going to reinvest this new enhanced FMAP.

As I just mentioned, we want to do three things on today's call. The first, is we'll give an overview of the CMS guidance and what it means to New York State's HCBS programs; we'll discuss a few guiding principles for how we're assessing permitted uses; and how to the extent that you will submit additional thoughts or refine your thinking on permitted uses for our reinvestments, to tell you how again we'll be assessing those for inclusion. And then, you know, to open up for discussion, there's only 12 of you so we want to have a dialogue on what's important, what you'd like to see, other considerations that we don't have so far in supporting and enhancing HCBS in the homecare space.

So, with that, and again, we didn't prepare any slides this is really designed to be a discussion, but just to level set, on May 13th CMS issued the State Medicaid Director 21-003. It provided a lot of additional guidance on the broad statutory authorization in the American Rescue Plan Act (ARPA) that committed to 10% enhanced FMAP through March 31st, 2022 for qualifying HCBS. What it did was it identified the HCBS by CMS-64 line, which helped us identify the amount of HCBS that we project to spend in, I'll say FY '22 is the shorthand, and what expected match we should be able to claim incremental to our computables already. That number - we're still finalizing it given the nature of our HCBS programs, but it looks like it will be upwards of two billion dollars over the year so that is a very promising number. It did define that the money once generated, and this is a critical piece, can be used as the State share portion of investments through March

31st of 2024. So, big concern of ours was, okay, we're going to generate it, how quickly do we have to spend it? And is the money limited to what we generate or can we use it as further match? CMS did confirm that we have a three-year period of which to spend it dating back to April 1st of this year and that the money we generate, the some two billion dollars, could be used as a reinvestment in matchable services and sort of Medicaid covered services so that we can enhance that money from two billion to four billion or more depending on when we invest the money and whether it can then generate additional enhanced match in FY 22.

The third component of the guidance - and this is the challenging component - is that the guidance did include strict maintenance of effort requirements (MOE) on our ability to impose new eligibility requirements, stricter processes, reductions in amount, duration, and scope of existing HCBS programs and services, as well, as rate reductions to existing HCBS services. We have analyzed our existing plan changes to the qualifying HCBS services and we have submitted questions to CMS to confirm that several of the MRT II reforms are either not impacted or grandfathered by virtue of when they were approved by CMS, namely, the new minimum needs criteria for CDPAP and PCS, the IRP and IPP process, and the 30-month lookback for eligibility for CLTSS, and then there's a fourth proposal, which involves the transition of certain behavioral health/HARP benefits into the rehab option. We have identified those four MRT proposals, as I'll say, potentially implicated by these MOE requirements, and we view, for various reasons that we could proceed on the minimum needs criteria and the IA process, which are at large in compliance with MOE requirements. We view the 30-month lookback as being implicated under any reading and OMH, as the lead on the behavioral health HCBS transition, is working with CMS to confirm the application of the MOE of those requirements.

So, we have a number of questions out to CMS on various aspects of the guidance but ensuring that we don't jeopardize this enhanced FMAP by proceeding full bore on those MRT recommendations, is certainly within our consideration process.

And the last piece of the guidance is on permitted uses. I referenced it earlier, but CMS enumerates really a number of permitted uses, both directly in the guidance and also incorporation by reference of the LTCSS rebalancing guidance and others of where we can invest the money. The money can be invested in both Medicaid matchable services that enhance, support, and sustain HCBS or non-Medicaid matchable services. We have to submit a plan - it was initially within 30 days of the letter but as of a call yesterday on an All-State call with CMS they indicated that we could request up to a 30 day extension, for 60 days total. So, CMS will have to approve the permitted use is consistent with the guidance to enhance, support, and sustain HCBS and we are working with our agency partners trying to collect the universe of uses that could qualify so that we can make reason judgments in our submission to CMS through this call and others appropriate stakeholder input.

With that overview in mind, we did want to enumerate some principles that are guiding our consideration of proposals. And this shouldn't be surprising to you but, as a general

matter, we intend to spend the enhanced match proportionately to the programs that generate the enhanced match. So to sort of say that the money is not fungible across HCBS programs - that's consistent with some of the appropriations language in this year's budget, but that to the extent the OPWDD system generates HCBS, they will get to reinvest their allocable portion of that enhanced FMAP based on stakeholder from their field. Same thing, OMH or OASAS or OCFS, some of it's collaborative across agencies. Right? Services like, for example, kid's crisis support services, may impact multiple systems, but as a general matter, the agencies and programs that oversee those services will get to reinvest the proceeds of FMAP in those services and that's in our view, very equitable to ensure that one program is not over utilizing the enhanced FMAP, given the historical needs for those enhanced services.

The second principle is that we're going to support matchable uses. So, you know, we recognize that uses can be unmatchable, non-matchable things, but to the extent we can take the services and reinvest them and generate additional matches, that will be a preference, right? It maximizes the federal dollar.

Principle number three is speed. The sooner we spend the money, the MOE requirements expire and that's an important component to us, especially if CMS takes a stricter view of some of the other changes in the space. But also, there's benefits to spending the money quicker because anything we spend in FY 22 will generate the enhanced FMAP one more time. And if we spend it before the end of the calendar year, assuming that's when the federal public health emergency expires, we get the 6.2% from FFCRA on top of that spend as well. So, the quicker we can get CMS approval to spend the money, the more money there will be to spend and so that's an important component of how we view the appropriate expenditures.

Another principle is, because this is a one-time expenditure, we will prioritize uses that aren't, for lack of a better word, hardcoded into the system. So, proposals that are startup in nature, capacity building in nature, will be preferable to the ones that would look like, say, a permanent rate increase because we'd have to unwind those in 2024. But at the same time, and consistent with CMS guidance, we want the investments to be sustainable. So, to the extent we can build lasting capacity or systems that will be preferable to one-time investments that don't result in meaningful reform.

The last two principles are that we do want to address known risks. You know, we do know that several of the HCBS programs have waiting lists or provider capacity issues. To the extent that we can address those where we wouldn't otherwise have federal or State funding to do so, that will be an important component.

And lastly, things that speak to specifically the COVID-19 experience and response whether it's PPE stockpiles, whether it's things like hazard pay or retention pay, given how hard this year was for everyone, those will also take special consideration.

I think all of those principles should make sense as we look to and select them on what we've already seen. We've already received over 90 proposals from people dating back

to mid-March when ARPA was passed, but to the extent that there are refinements to proposals in light of the CMS guidance we certainly want to hear them, but we do want to state that again, things that are matchable, things that things sustainable, things that spend the money more quickly, things that speak to COVID-19 experience, and address known risks, those will receive preference in our consideration and inclusion because while this money is significant, it's also finite.

So, with that, I know there's only 12 of you and that's great. So, feel free to type in your comments or use the little hand raise button, we will unmute you. And knowing this crowd well, I expect there to be lots of robust discussion over the next 30 to 45 minutes.

Okay. Perfect, Karen. We can unmute Karen.

Can you hear me.

We can, hi.

Great. Well, I just had a question first before we go into proposals if that's okay. I am not clear on what is what you're calling unmatchable. Is that all of the items in Appendix D or is that something else?

So, it's a very good question, right? So, think of it this way - things that are in existing State Plan service, that's matchable. Things that are approved through an existing waiver, although let's put aside 1115 for a moment, because that has its own complications, but like, in a 1915(c) waiver that we can amend easily through an Appendix K or through a longer term waiver submission, those would be matchable or something that we can pay through a managed care plan is matchable. But for example, a grant program in workforce training without considering whether it can be paid through a waiver or paid through a managed care plan, that would be a direct grant. We would only be able to spend the money that we generate through to the enhanced FMAP. Not two times it.

Okay.

So it's not it's not as easy to say Appendix C is matchable or not matchable, but we're going to…one idea is to do sort of a comprehensive workforce training and VBP readiness program and we would pay it through the plans to the licensed agencies and FIs. And so, because it's run through the plans, and we would get directed payment approval for it from CMS, that money would be matchable when loaded into plan premium. So, that's part of the strategy is we need help thinking through not just what the proposal is, but a match maximization strategy so we can be sure we're not leaving investment dollars on the table.

Got it, I was actually asking about Appendix D, which has some innovative ideas, some of which, I believe could be matchable either through the 1115 or more directly, but there, you know, they may not be already built into the system.

Yeah, and those are going to be harder to do, right? Because those are slower and the 1115 process – so, this is one thing I wanted to caution, I wouldn't rely heavily on 1115 waiver authority as the basis of claiming match unless it's very simple. For two reasons, one, as you know, CMS has not waived in its guidance any of the transparency requirements that go along with the mechanisms to get approval for the match on these transactions. So, an 1115 waiver process at a minimum takes six months to go through public transparency and approve and that's if CMS asks no questions and they always do. Some of our waivers, like for example, our nursing home carve-out took over two years to approve and so we're hesitant to rely on 1115 waivers because CMS puts them under such a fine tooth comb after public transparency that the approval timeline to get the match is very uncertain. The second component is we are going through budget neutrality rebasing right now under the waiver and CMS, even on yesterday's call, can't tell us what these reinvestments will do to budget neutrality. And I don't expect CMS to approve anything under our waiver until we finish budget neutrality rebasing. And so, where we stand as a State and our 1115 authority, despite the fact that it's so substantial to our Medicaid program, we are going to disfavor things that require an 1115 waiver amendment. We just don't think that they're, from a timing perspective and an approval perspective, the most ideal option. So, if we can approve things that are State Plan based or 1915(c) waiver based, those are going to be far more effective authorities to pursue approvals.

Okay. Should I keep going? I don't want to monopolize the conversation.

No one else has raised their hands so I'm happy to have you keep going until someone else usurps.

Okay, so workforce, as you mentioned, I think everyone on the call would agree is the top priority, demographically and because COVID has really negatively impacted the workforce in so many ways. I think at least from LeadingAge New York's perspective, while training programs to upskill workers are certainly helpful, what we really need is money to recruit more workers into the field and I'm not sure that a VBP training program will accomplish that. I think the concept of payments for things like hazard pay, signing bonuses, training stipends for new trainees - all of those ideas are ideas we've been advancing and if there's a way to work those kinds of compensation enhancements for direct care workers into the enhanced FMAP, that would be great.

We also want to make sure that you're not losing sight of the fact that assisted living is considered a home and community-based service under this, and the assisted living program should also be a beneficiary of the FMAP dollars.

Technology investments are another important need for our sector. And compensating providers for the losses they've experienced as a result of COVID and ongoing unbudgeted expenses for PPE, worker's support, et cetera, are also very dire needs. So I'm going to stop there.

Those are very helpful, Karen. Thank you. All right. Let's move on.

Adult Day Health Care is also one of the services that's referenced in the guidance and they are now starting to reopen after having been closed for a year and also need investment to manage the reopening process and ensure that it's done safely and effectively. Now, I'll stop.

You know, that's the first time that someone's mentioned. But I'm not surprised it's come up. So, thank you.

All right let's move on to Al and then Meg.

Definitely some new angles on that, that's the first time that we've heard of them, and they have some pretty major ramifications, in particular the ability to spend the money over a period of years. And I get you got to make the milestones, but that's really significant in terms of what that means for I think the capabilities of the program and the potential benefits, both fiscally and programmatically. Certainly a lot of what I would say, and I'll just save the time on the call, would echo a great deal of what Karen just referred to in terms of really the structural need to support the workforce, the recruitment, the compensation, the retention of the workforce, and different - bearing in mind your principles - the things that we could do in and around that that really maximize the impact of this on the workforce structure and capacity. There are many, many things in the CMS guidance that are just awesome if we truly had the resources and the wherewithal, the time, and the flexibility, an awful lot of good could get done. But again, it seems that the structural hole as it relates to the priority of the workforce is just so large that to whittle that down by pursuing a lot of the other avenues just seems like it would be a really critical missed opportunity to try to really advance and take a major step toward investing in and securing the workforce.

So it sounds like an enormous…So, just to reiterate what you and Karen are saying, because this is, you know, we had a call with others, you know, we're doing a number of the stakeholder calls and everything comes back to this workforce, workforce, workforce - I'm hearing the same thing yeah, unsurprisingly, right? So, it sounds like - and this is helpful, because it's not just what to spend the money on but what to spend the money on to the exclusion of other things. Right? Because again, the money is finite. It's time limited and so, you know, it sounds like from you and Karen and, you know, Megan, Diane and others, but that it's making a huge transformational investment on workforce, recruitment, and retention, right to the exclusion of maybe some technological improvements or SDH stuff or, you know, other things that I think would be really nice and we need, would be in people's view money well spent.

Yeah, and the temptation is profound, you don't look into those areas because we need improvement in those areas. I mean, you talk about technology and really the critical benefit of clinical integration using HIE exchange, just the extent to which telehealth and other technological techniques to deliver care. I would say, I do think that some of that stuff should be on the radar, the same thing with training. I mean, right now the training

programs are almost shutdown still even though the Department has permitted online training, I think they've only approved two programs and that means that all the other training programs for these workers are functioning at about a third or quarter of capacity and really having trouble catching up. So I do think the training part, the technology, those things are important, but I would say proportionally, I mean, the biggest sell here, component of this thing really should be, I think, the workforce and to try to do it in such a way that we structurally advance and I know part of it is difficult because there's not a guarantee of well, what are we going to see in 2024, 2025 and down the road but we sort of really need to get over the edge here or the system is never going to catch up. I would just offer this and then I'll stop. I think that the systemic issues and capabilities that are identified on that sheet on the CMS guidance, if we could otherwise have a process to all work together to figure out, how can we advance in some of those areas irrespective of how much or whether any of the dollars are going to come down, how can we still advance in those areas to improve the system? And ultimately I think create a better structure, even if most of the money is supporting on the workforce side. I think that that would be really well worth it. I do have to add into the mix hospice program - if we do things that enhance workforce capacity on the homecare side, and we're not also inclusive in that of hospice, we're going to shut down a lot of hospices. I'm going to stop.

ALPs in the hospice as well. Not just, you know, LHCSAs and CDPAP, I hear that. I mean it sounds like building a massive workforce infrastructure to get more workers into the field, whether through better pay or otherwise I think is the nature of the beast, especially in the homecare industry and we can think about ways to make modest technological investments to help with that. One thing we're thinking about just structurally - and again, this is with the idea of trying to maximize the available dollars to support the delivery system - is to run as much through - And I'll say this not in a pessimistic way - but run as much through the managed care plans as possible that have the provider relationships with the LHCSAs and the FIs, and hospice providers, and ALPs for that matter, in order to ensure that we're able to get the most money in there. We're aware of the experience with say, you know, the minimum wage, and FLSA payments, and we want try to avoid that. So, anything that we can do to utilize the existing infrastructure and the matchable infrastructure without revisiting some of the administrative challenges in the past and ensuring that the money flows down to the workers, would also be helpful to us to hear if you've thought through those issues.

Yeah, one thing I would just add that I think is really important is that while the dollars are quote Medicaid, and while we're looking for matches, I think it's really important to avoid dislocation, by - So let's say you do something systemic by, let’s say increasing the initial rates and salaries, wages and salaries, for people coming in, there needs to be an understanding that those people work, whether they're for Medicare recipients, Medicaid recipients, EISEP recipients, or private. So, we really need to be very cognizant of the extent to which dollars in one place don't create deficits in others with no capability to recover those expenses. That's a big issue. And I get it, I get this is an increase in Medicaid, but again, if we're building something on one end, it's like, putting a lot of stuff on one side of the boat, we're going to create an imbalance that there's no

ability for providers to be able to adjust. I mean, I've said for many years, we should be looking at the commercial side of how we do insurance and coverage in the State. But that's another conversation maybe for down the road. But if we don't do that, we're never going to get past the Medicaid conundrum.

Yeah, understood alright. Thank you. I want to go in order, but actually, if I can jump down to Kevin, just because that way I can go to HCP before going back to LeadingAge. That would be great.

Can you hear me?

Yep, I can.

Okay, great. Hey, everybody yeah, I just want to echo what Karen and Al have said, and your own comments, Brett. Its workforce, workforce, workforce, and I think the important part is, and you and I shared this the other day, is that the directed payment piece, and how to get that down to the providers without taking too much off the top going through the managed care companies. And I don't know if you've given any thought at any 30,000 or 60,000 foot level about kind of like a QIVAP process where there's an evaluation of some objective criteria, whether it's hours served or that sort of thing.

Yeah, just to that point one initial thought is that because it could be a three-year or multi-year payment that we start you know, broader, and then we invest in later years in the agencies that are doing better at pushing the money to the workforce. Right? So, it's yes, it's a qualification process but then there's evaluation metrics that then drive second year spend or third year spend if we could get it out quicker into those LHCSAs and other agencies that do a better job meeting the evaluation criteria in the first year so that you're continuously rewarding those agencies that do a better job passing that money through. And spending it quickly, right?

Yeah, I mean, that's kind of one of our major issues is getting it down to the agency level so that they can push it out and that as Al said with training programs, basically shut down the recruitment is a huge issue for the LHCSAs so anything that we can do to get more people in, whether it's pay for training, I don't know if that's Medicaid-able or not.

We can pay the plan to develop a program and that program can include training. Right? So that strategically, that's kind of where we want to go with this is to say the more we can pay for something high level that Medicaid will match through the plans, and then tell the plans that they're implementing a program that includes all of these things, it's a way to broaden the direct matchability, that's not really a word, but maximization of the funds that we try and use these for. So, we can have a really, really large workforce recruitment and retention program, and we can try and utilize the directed payment pre-print process to pay for things that themselves wouldn't be matchable, because the entire program is.

Okay.

And then as you mentioned with very defined evaluation metrics, so that we're continually reassessing and you're reprocessing the money in later years, so additional dollars as the match winds down, because it's higher in the first year than it will be in the second year to drive more of the funding to those LHCSAs that do the best job at building the recruitment work and building the workforce capacity, but that we can prioritize say LHCSAs or other providers that have relationships with the WIOs that can provide the training quickly, you know, in innovative ways to have a ready train workforce in the future.

Yeah, and I think that would be an important piece to look at whether it's through the WIOs or through agencies that have initial training programs themselves that have been shuttered that I don't know maybe it's about a fifth of agencies have training programs. I think there are 200 training programs or something like that out of all licensed agencies, so there could be some disparities there, depending on how that flows, or how the training is set up.

Got it, yeah and thank you, Kevin.

All right can we move on, I don't want to cut you off. I just want to make sure we have enough time to hear from everyone who has raised their hand.

Yup no, I'm good.

Okay, thanks.

Can we unmute Meg?

Thanks, Brett. Just to again agree with Karen and Al and Kevin about the workforce being the greatest looming challenge and also, Kevin's point about transparency. If you want to create matched funding running it through plans then hopefully transparency is the key component of that. But I wanted to - Karen had mentioned COVID support, support for extensive testing, PPE, additional expenses, and I was wondering what the parameters are for reimbursement of that type of funding expense after April 1st, 2021? Can they cover expenses before that date?

I don't see a way - And again, I asked that, there were two questions in our regard with the guidance that we posed to CMS because they were unanswered. The first is that, right? which is can this be used to reimburse unfunded past expenditures. It doesn't seem like that is so. The other question we asked, and I'm less certain of the answer is whether we can use the money to support natural growth in the programs. Right? So, we have a projected - and especially with pent up demand, and the fact that we haven't been able to reassess individual MLTC and fee-for-service for over a year that we expect there to be substantial PCS and CDPAS program growth just naturally and whether it has to be on wholly new uses, as I'm calling it, versus ensuring sustainable

program growth and capacity by funding previously projected growth. The guidance is not clear on either of those. I'm fairly certain on the former questions, you know, we're not going to be able to reimburse invoices, but to the extent that we can utilize new dollars to say, encourage homecare agencies to purchase PPE stockpiles so we're not left with a similar challenge into the future and there are existing and ongoing PPE needs that we would be able to fund those and do it in a natural way through the plans. And to the extent that we can fund say, sort of respite or retention bonuses or other things that reward workers for going above and beyond during the pandemic, that's also feasible but not some costs that existed previous to that.

Got it. Thank you.

Yeah, but we have asked that question to CMS because yeah, I mean, it's not - if someone has gone in the red buying PPE stockpiles for their workforce that they used and threw away already, you know, it's not very helpful, but, you know, can we try and spend this money in a fungible way to help recoup some of that. Right? I think that's where the creativity has to come in.

I think the point of that, if it's at all possible is that, you know, so many of these providers are on just really shaky footing right now due to all of those expenses so, you know, moving forward it's a concern.

I certainly agree with that.

So, can we move on to Diane, and then we'll hopefully close with Kathy.

Hi, thank you so much. You can hear me okay?

Yes, great.

I'm going to be very quick. I just have a suggestion that perhaps we set up calls like this to get feedback on the ALP and on adult day health care. I'm just concerned that maybe this wasn't on people's radar so much, and I know that you've had calls set up on different areas of services. So, perhaps we could have a dedicated conversation on those two issues.

Yeah, that's a good idea too, because I'd like to involve Adam Herbst because those – ALPS and adult day healthcare are more I would say hybrid programs within DOH given the way they're regulated so that we can work to find the time now with the additional 30 days to the extent - we have to make a decision how much of that additional 30 days we're going to spend, because there's a balance of speed versus thoughtfulness right, it's like, do you want it done quick or do you it done right and so we want to probably do it quick and right as best we can. So yes, I mean, we're trying to get the high-level core Medicaid funding conversations done first but that's a good suggestion.

Much appreciated, and I would say that what folks have already said is largely applicable, I think adult day health care does have some unique considerations. So that's all for me. Thank you.

Yeah, I mean, one area, and this goes back to the Meg's question too, there is revised guidance on retainer payments, that was one section of it, and I know with adult day health care given they were closed, whether there is a retainer payment suggestion, because I think that is a special consideration for several of the adult health programs that closed and DOH did close those programs fairly early in the pandemic.

Thank you.

Kathy, if you want to close it out.

Thanks, Brett. I just want to make you aware that HCP is just closing out a pilot program on peer-to-peer mentoring, that we had seasoned caregivers mentor new hires over the course of nine months, and they were mentored for the first 90 days of employment. And what we were able to show was that agencies that participated in the program reduced their turnover rate by as much as 170% over those that were not in the program. And just want to talk - maybe we talk offline about how could we look at doing this through the plans or through a matchable pathway. Those that were the mentors were receiving a pay bump for doing so; I can see how that might work.

Yeah, I think we can try and be broad about the proposal, right and this is kind of what we're thinking about doing, you know, kind of like a QIVAP kind of thing, which is we fund the plans to pay the providers to engage in the programs that we know are effective at workforce recruitment and retention. Right? And so, whether that's WIO connectivity, whether that's peer to peer mentoring, whether that's, you know, technology investments to do it sort of through an omnibus DOH funded and plan administered program with real evaluation criteria and metrics. And so, keep in mind we're going to have two bites at the design apple here. And I think this is really important. Right? The first bite at the plan design apple is to sketch out to CMS what we're going to submit in the next 30 or 60 days, is to say we want to spend the money on X, Y, and Z. Then we actually have to get approval for it through the permitted authorities. Right? So, the way this long-term care program would look is we would do a directed payment template subject to CMS's approval that builds out all of this specificity as to what the programmatic requirements are going to be that we're going to fund through the plans and the more specific we are in that design so it includes anything you've done on a pilot basis that we think is effective at promoting workforce recruitment and retention, we are happy to include. I think that's the opportunity to use this money not just in a way that's going to achieve results, but that can help guide the direction of the Medicaid program beyond the expenditure of the funds.

Okay, well, we're at our final report and our information and we'll be sure to send it to you directly and have a conversation around it. I think it might be a possibility to fit into what you're looking to do.

Awesome that sounds really great. All right, I mean, I'm happy to stay on for a little bit longer if anyone has additional comments or points that weren't raised. I know Karen or others I just want to make sure we've had the opportunity to hear most everyone's comments.

I have just one question. Is there any data available on the metrics or successes of the WIOs? What they accomplished? How many people were recruited? How many people accessed this VBP program, et cetera? because, you know, when you talk about funding proven programs, I can't find information about what the proven programs are.

We can take that question back. Cherlyn's not on, who is my resident WIO expert.

Okay.

But I mean would expect given their prominence in DSRIP that we do have some evaluation data on them.

And the mentoring program was funded through a WIO for us.

Okay they publicly share that information, right?

Well, I'll look to see what's out there.

Great. Thank you.

Brett, this is Al one thing that came to mind as you were talking about the funds associated with even keeping pace with the growth in the program. One of the things that the Department actually is statutorily behind on is the rebasing of the payment levels to certified agencies. I think, I'm not positive, I think they were rebased in 2015. They're supposed to be rebased by statute at least once every three years. And I think that one of the things is that the current base that funds certified agencies is below substantial cost increases that have been seen in the system, whether they're for wages or other things in recent years. So, I don't know to what extent these funds could help, in fact, bring the Department and the system into compliance with what's supposed to be provided for in the payment to those agencies. But it would just be an area I would raise to you if you're looking at those kinds of things. I mean, we raise it all the time. Presumption is that the with State Budget as it is it's just been overlooked, pretty much ignored in terms of the adjustment, but it's in the statute. So, I just mention that.

Yeah, can you send us additional information on that Al, in terms of what we're supposed to have done and what we haven't done? I'm not up on that issue, but again, to the extent that that sounds like a matchable service, it sounds like something we're required to do and we haven't done it that would be again consistent with any promising guidance from CMS that we can utilize things on growth because it's new growth, as opposed to just what we would've spent anyway that's what we're looking for.

And it would have an across the board effect, Brett, an across the board effect in terms of the, you know, the capability to be more market sensitive with respect to wage compensation. And then there's other aspects as well. Again, I don't want to get - I won't get into the weeds on this call. But there are even things that carry over to a potential impact on the Medicare side where currently providers are sometimes receiving, like, 30% discount, like, 30%, which are unsustainable and driving these agencies into a hole, but if Medicaid rates are where they should be then they become, in effect like the de facto benchmark in some of those negotiations. So, it could really help in a number of ways. I'll send you this, and you can take a look at it. Thank you for considering it.

Yep. Okay anyone else before we wrap up, I mean, this is a very helpful dialogue I really want to thank you for taking the time today, I think we have a little bit of additional time to help with this initial spending plan and then quarterly reporting but, you know, this is, I think, going to be a really exciting opportunity that carries with it a number of challenges as well. So, we're trying to get it all wrapped up. And so, we thank you for jumping on the pump so quickly and bringing good ideas and understanding our perspective and how we're approaching this exercise. So just, you know, this is probably less important for this group, just given that all of you have reached out to us in various different ways. But we do have a centralized mailbox, which we've called HCBS Recommendations. So, to the extent that - that's centrally monitored, and so if you do have questions and you don't want to email any of us that you normally deal with, that's a good way of triaging appropriately. So that's just my final plug. But I know from speaking with each of you, you know how to reach me up if need be.

All right, well, thank you everyone I appreciate the input you've given.

Okay. Take care. Alright. Bye.