nysdoh_20180619_1_2.mp3

OK. We had the last I looked we had two people signed up for public comment. But people are able to come in and sign in any time before 2:00 o'clock. So we will be here until then in case more people come. I don't personally have the list of who's signed up but you know if you were the first one on the list and if you were perhaps there you go.

Ok.

With a little intro if we could ask if you could just hold we know you've been very patient. We're just going to present a refresher on the 11 15 waiver and the timing. So great. We have the slides.

Oh do we.

Why don't you have a seat.

OK.

So we're going to take a quick 30 second IT break.

Great. Good afternoon everybody. My name is Kalin Scott. I'm the director of the Medicaid redesign team project management office, the assistant director of the Bureau of Medical Dental and pharmacy policy, and I work with our waiver team on the 11 15 public waiver. So we're entering the second half of our day which is a MRT 11 15 waiver public comment day. And the way that this will work is I'll go through a very short overview of our 11 15 waiver. We'll take public comment from from the field and we'll run through the guidelines for providing public comment. If you are here and you haven't signed up to give public comment but you'd like to stand up and give us your feedback, you can sign up with the registration table just outside the doors and they'll give you a number and we'll call up numbers at the conclusion of this presentation. So quickly we want to walk through our 11 15 Waiver. Thank you Greg for getting me set up. So we're here today to take feedback on New York's 11 15 demonstration waiver. A waiver is an agreement between the federal government and New York state to implement certain programs that are innovative in nature and work together on waiving certain provisions of the federal Medicaid program in order to test those innovations throughout our Medicaid program. The state can work with the health and the Department of Health and Human Services at the federal level to come up with a waiver agreement that can last for five years and then be extended upon mutual agreement. The 11 15 waiver is governed by special terms and conditions. These are if you've ever seen the states STC's these are hundreds of pages of intricate details on how our programs operate, what requirements we put on providers that participate, and what evaluation requirements we have there. There's quarterly and annual reporting that's associated with the 11 15 waiver and all those reports are available on our public website. A very important element of our 11 15 is the provision of budget neutrality. So our expenses with waiver programs can exceed what our expenses would have been without waiver expense without the waiver programs without the waiver. And a big element of our work with the Federal Government is demonstrating that budget neutrality in all of our Waiver programs. The 11 15 waiver in New York was formerly called the Partnership Plan and is now called the Medicaid redesigned team or MRT waiver. It's been in operation for more than 20 years and has evolved significantly over those 20 years. Our most recent renewal was in December of 2016 and it extends the 11 15 waiver through March 31st of 2021. The goals for our waiver overall are to improve access to health care for our Medicaid population in New York, to improve the quality of health care services delivered, and to expand coverage through managed care efficiencies to additional low income New Yorkers. We have a series of programs in the 11 15. Many of you who joined us here this morning are most familiar with the DSRIP program which is one of the largest programs in our

waiver but are our waiver allows for a Medicaid managed care throughout our state. We have some different elements to our waiver programs including our mainstream Medicaid managed care program, our health and recovery plans our HARP's, community service home community services HCBS, our managed long term care and long term services and supports, and our MRT waiver amendment which includes our DSRIP program. So these are all programs that are governed through the special terms and conditions in our 11 15 waiver. With our 11 15 waiver we have a couple of pending amendments with the Centers for Medicare and Medicaid Services. We have the children's systems transformation which includes the merger the transition of 6 1915 C waivers over to our 11 15 waiver. It allows for alignment in the service that we provide to these populations. Comprehensive health care management for children receiving home and community based services, transition some benefits and population to managed care as well. And it includes six new state plan services. So this is a pending amendment. There's information about this on our our website with materials documents and other resources with more context. And in addition another pending amendment we have as the OPW DD 1915 C transition. This transitions the steet system of services for people with IDD to better integrate services, provides again comprehensive health care management for individuals, and moves the federal authorization for HCBS from the 1915 C waiver to the State's 11 15 MRT waiver. Another one of our most significant programs in the 11 15 currently is the DSRIP program. And so if you join for this morning meeting you heard a comprehensive update on the progress to date, the achievements that have been met. And we wanted to just reiterate those accomplishments for this group. So the big news is that the DSRIP program is subject in DSRIP years 3 4 and 5 to meet statewide accountability milestones. And for the measurement of DSRIP year three all four accountability milestones were met which means that the state continues on with its DSRIP program alongside with its PPS's and there's no reduction in federal funding for the DSRIP program. More information on this and more details also available on the state's Medicaid website and DSRIP Web site so that's a very quick overview a very complex document but there are lots of resources available to learn more about the different programs covered by the 11 15 waiver. And there's a number of websites linked here and on this page as well you can go into more detail on this. The overall I1 15 framework including the STC's air quality strategy. And that information on the federal websites that are related. These documents are generally available on our website. But if you have specific questions on any of these links you can talk to our team that's at the registration table and they can provide more information for you. So with that we're going to go into our public hearing. Just a couple of reminders on how we generally move forward in our public hearings. If you'd like to speak as I mentioned before you can sign up at the registration table and they'll give you a number. We'll call numbers up to the microphone five at a time. I think right now we have two speakers so we'll call everybody up to come forward and give their comments. We ask that you limit your talking points to five minutes. We'll have a timer. Jason if you want to wave your hand so folks know so we ask that you keep your comments to five minutes of possible. If you prefer not to speak you can go to the registration table but you have comments to submit, you can go to the registration table and either share a written comment or get an e-mail address that you can send those comments to. And if you have a question specific to your own Medicaid coverage or eligibility you can also talk with folks at our registration table who can help you connect to the right person from our Medicaid team. So with that I'll move over here and we'll go ahead and get started. So if the two speakers want to come up to the microphone.

Hi, Greg Baritone, center for disability rights. Also with Medicaid Matters New York. I listened to this and kind of felt a disconnect hearing the words innovation and the waiver spoken together. And that disconnect comes from the fact that we're living in a state right now that that is currently implementing a policy to incentivize nursing home placement, incentivize institutionalization. And this came out of the most recent budget. There is some debate over whether or not to call it a carve out or a limitation. In any event it is encouraging people to be placed in nursing facilities. The the way the policy works if someone is placed into a nursing facility for more than three months they no longer are the problem of the managed long term care company. They are taken on by fee for

service. The state's own responsibility. Now DOH has argued whether or not this will incentivize nursing home placement. But I would point you all to the states own Olmstead plan which actually said building on the care management for all initiative reforms in the 2012 2013 budget removed the financial incentives that may have encouraged nursing home placement. Previously nursing home costs were carved out of managed care rates and were instead covered by the state. This policy had the potential to encourage managed care plans to pressure high cost people served in community based settings to enter nursing homes. I've seen nothing since 2013 that would say this has changed. This will still have the same effect. So I'm I'd like to ask Donna and whoever else wants the comment but is this what you know the federal government gives us money for. Is this what we're you know doesn't this mean that it's really disingenuous for us to be drawing down millions of CFCO dollars intended for community integration when we're actively encouraging institutionalization. Thank you.

Good afternoon. My name is Brooke McConnell and I am vice president of community relations and strategy for the Alliance for Better Health. Thanks for the opportunity to provide feedback on the New York 11 15 waiver program. Alliance for Better Health participating performance system was established to participate in the DSRIP program. We serve over 190,000 Medicaid and uninsured members across Albany, Fulton, Montgomery, Rensselaer, Schenectady, and Saratoga counties. We drive a dynamic and collaborative dynamic collaborative of over 2000 providers and community based organizations. Our vision is health equity. We are driving toward a united and collaborative care delivery community transforming care to improve the health of the most underserved. We believe there's an opportunity for New York state to build on the pioneering PPS work to date. PPS activities have served as the foundation for collaboration. Alliance is exploring a sustainability plan to continue our community based efforts and transition to a business model that integrates social services and social determinant agencies with traditional medical models. Short term objectives will focus on infrastructure that strengthens the CBO network and our long term vision is to establish a foundation of activities to pursue risk sharing or other value based payment agreements and develop services that are responsive to neighborhood level needs. DOH continues encouraging community based services and social determinants of health use. Funding should pass through to providers and agencies engaging in those activities. It is imperative that DOH stablish a nimble regulatory structure to support innovation in health delivery and there needs to be a mechanism to align regular regulatory relief and modernization that enables services integration and convergence across all silos. We also believe workforce development and training must be prioritised as the state pursues delivery transformation and policy efforts. Needs extend beyond traditional care models and require efforts that teach clinicians and direct care workforce about population health and social determinants. Regulatory Flexibility and barriers to sharing staff in areas of workforce shortages should be explored. You have our commitment to work with you in the continued design of groundbreaking programs here in our region and across the state. Thank you for your consideration I'll submit these outside.

Good afternoon. My name is Faye Monraya and I am here on behalf of the Arthur Ashe Institute for Urban Health who serves as the lead agency for the communities together for health equity. Also known as CTHE whose through advocacy efforts was awarded a one year strategic planning grant. For those who aren't familiar CTHE is a diverse and representative Network of New York City based community organizations who came together as a result of the absence of community voices and the perspective in the redesign of our health care system. Though it's been proven social determinants of health play an integral role in health outcomes. The system has been resistant, negligent, and pervasive in the inclusion of community based organizations. Recognizing the diverse populations of New York City and the failures of the health care delivery system to appropriately address the social determinants of health, members of CTHE have come together to strategically plan and collectively develop and implement the infrastructure necessary to ensure robust CBO engagement. Unique to CTHE our strategic plan will be informed by CBOs who are on

the ground who witness the complexity of real life experiences in which structural economic inequities, institutionalized racism, and intersectionality define the outcomes of people lives of peoples lives. Our plan is not a report that will sit on a shelf because it reiterates the challenges that were set forth before on previous reports but will serve as an implementation action plan that demonstrates the values of CBOs through our collective experiences to guide the healthcare system and its in its effort to achieve health equity. If addressing Social Determinants of Health is in fact essential it must be reflected by equitable partnerships, bi directional communication, sustained by resources, and with an understanding that all players must be seated at the table because the unique and valuable perspectives they bring. Thank you.

Great thank you. So at this time we don't have other speakers. I'll just say one more time if you'd like to speak please go sign up at the table outside. We do have until 2 p.m. for members of the public to come forward and give us their comments on our 11 15 programs. So if folks are okay we'll recess now until 2:00 p.m. and then reconvene to see if we have other speakers who have come forward hear them or close for the day. OK.

A few PAOP members want to say some things. Is that appropriate at this point. OK Judy and then Lara.

Since we have time I think we had some important things said in the public testimony and I wondered if we couldn't talk about them. One is clearly the need to not move towards we rein can't get the word out reinstitutionalization. And the other is the importance of community based organizations and the social determinants of health. And I think it's be great to have some dialogue about those issues. And I just have one other question and that is will there be a New York City hearing.

So there will be a New York City hearing later this fall. The date hasn't been set but will be announced throughout the listserv when we're ready to do so.

We could have some dialogue about those at least those two issues.

I guess I need to turn to Kalin to just understand the protocol here. How do you how do you want us to proceed as the PAOP here. What would you advise.

I think we're I think we're certainly happy to use the time here today to hear from the PAOP members concerns that they might have either on the comments that were already made and we heard here today or on other other areas. So if you would like to you know tell us more about your thinking on those we're happy to hear that or if there's other concerns related or comments related to the waiver we're happy to hear those as well. While we see if there's any additional public comment.

Thank you. Thanks Judy. I agree with Judy we might as well use this time to have discussion in particular because this is a public session and this is our opportunity to have a public discussion about some of the issues that are raised. I also have a few comments related to the public comment session process which I'm happy to get into now or we can table that for after we talk about some of the substantive issues.

Your call. I think we're happy to talk about both. So what do we do about the substantive issues and then we look to hear comments as well on the public forum process.

So on on the public comment process itself you know we had three people which is great. And thank you to those three people. Not to diminish their input. And I and others have done a lot of thinking and work on why for instance these public sessions are provided and we sometimes only

get as many as three people and it's a very difficult nut to crack in some ways. In this case as as Peggy or someone else indicated earlier today is one of the very last session days. I think in the future if if DOH could consider the calendar in scheduling public session public comment sessions you know no one expects the department to you know avoid every meeting or every conference but the end of session I think you know it's on the calendar for months and I think it occupies the time of many people who occupied the space and would otherwise be here. Also related to outreach and awareness about the public comment sessions. The the understanding about what the 11 15 waiver is is still a mystery to some people. And Medicaid Matters and many other groups and many other people have done have tried to do some awareness raising over the years but in particular since these opportunities have come about since the waiver rules changed around public comment. And so we've done things like factsheets one pagers about what is the 11 15 waiver and why is it important to comment. But I think if the state could maybe even taking some of the bullet points from Kalin's slides very clearly in the announcement about the public comment sessions say in plain English words what is the 11 15 waiver. It used to be called the Partnership Plan. Now it's called the MRT waiver. This is what it does. This is what it allows the state to do this. It is the agreement between the federal government and the State Government very clearly and succinctly and more explicitly letting people know what it is and why and why the state is taking public comment I think would help. And then lastly and perhaps most importantly there is still not enough understanding about what happens to the comments. I've heard many people lots of people have asked me Well I would go but I don't know what happens after I after I stand up there for five minutes. I think it would help a lot if you would include in the announcement some information explicit information about what the state does with the public comments. You know summarizes them and sends them to CMS or summarizes them and then staff you know whatever it is very explicitly say after the public comment session the state Department of Health will X Y and Z with your public comments. I think that could go a long way in helping people understand how their comments could potentially have an impact. So thanks. And you know perhaps others have other ideas about improving on the public comment sessions.

Thank you.

So to go back I don't know as much about the reinstitutionization issue but certainly I know more than I want to about social determinants of health and contracting with community based organizations and I have been a proponent shall we say of that as an issue for the three or four years that I've sat on the PAOP and I'm still not that clear and did request an update on the contracting issue to see if there has been some improvement. If we're serious about not solely relying on the health system or even more specific hospitals which a lot of the money is going to and really interested in seeing a system more focused on prevention on doing things in the community on you know a working together the health system and community partnerships then I think the continued and hopefully stepped up effort to to push for that kind of work. I was listening to the presentations which were excellent but did not there were not navigators what was the.

Peers. Thank you. The Peers which is a great way of providing supportive services but those peers it sounded like still work within the system and not necessarily in the community. And you know I and many others firmly believe that to really reach the populations that need to be reached that you have to be working within the community, have an understanding of communities, and know how and where and when to reach out to people which I still don't feel is happening in the way that it should happen. And I'd love to have more of a discussion about that issue.

From listening to the folks who presented I would say that I think there's a mix of peers. Some community based peers and some system based peers. And I think a further discussion of that and the whole CBO piece might be an appropriate topic for another meeting.

Perhaps at the New York City meeting OK. Yes Steve.

I want to say this carefully because not that I mind disagreeing with Judy it would be boring if I didn't disagree with Judy but I with all due respect I don't think you're wrong about our not having figured out how to engage the community based organizations. But I don't think that's the center of the problem when you deal with prevention agenda. I think the center of the problem is we're not the center of attention in discussion of the things that have to be done in terms of changing the shape of Human Services services in the state of New York. That the the that is a major political issue which has not been and is not being engaged in by other than people sort of in cul de sacs and Niche places you know. My good friend Joe Ivey Buford and the prevention group have worked very hard to create an environment. But it is it hasn't taken it hasn't taken hold. It's you know it's sort of a paper discussion to a large extent and the reason it's a paper discussion to a large extent if you think about the social determinants of health they're massive problems and there are massive problems. And I tend to focus on housing but they're massive problems which require very substantial resource commitments in order in order to make a change. Some of those commitments would fund CBOs to to to work with people. But we're talking about massive amounts of capital that are needed and that and that's why at the moment it doesn't show up on our political agenda because right now you know our political our political agenda and the capital costs and the expense cause are being consumed with a whole bunch of other things which right now are at the top of the agenda. It's very hard to argue you know that the education needs and the transportation the breakdown of the transportation system and a lot of other things aren't absolutely important important pieces. And my judgment is the only way we can have a discussion which I think is a discussion that we could be part of going forward is the fact that a large chunk of this is going to have to come out of the health budget. You now out of the health budget because the health budget still to this day is overweighted substantially in the sick care, acute care, bricks and mortar institutionalized institutionalized existing network that's been built up over the last 75 to 100 years. Funded we funded it. We built that up. And the second part of that to be honest is that as a result of this it also provides a a a work environment and a workforce that is a very important part very frankly of the communities across the state including minority communities. And you can talk about the excess costs in the acute care system without recognizing that there's a second there's there's not secondary, there is a concurrent concomitant human issue relating to how you deal with taking those dollars and moving them into other parts of human or social services. I don't have an answer for it but I know we're not going to we're not going to add additional funding. It's not it is not going to happen. But I think that we have to have a more comprehensive and we have to find a way of having a more comprehensive discussion. It's not us. With all due respect although as important as we all are it is not us. It is a broader political discussion about human and social needs and how we rearrange those dollars in order to attack some of the things which are on the prevention agenda. We don't I mean we all we don't attack some of those we're in a vicious cycle no matter what we do we're still going to we're still not going to be able to break through. But how you break through in some of the areas we want to break through on without having strong capital availability is just frankly very hard. And so you know I started to say before it's the some people over here, I think that ought to be a part of what we debate and what we do going forward. But we are just not enough. It's got to be made part of a broad political discussion about the about the future. And I don't know how to get there given how much is it how much of the spending I'd like to get my hands on to do other things is as embedded strong institutional and political support to try to disrupt that would be a political nightmare. Other than that Mrs. Lincoln how do you enjoy the theater.

Maybe I should sign up because I do want to make a comment about the 11 19 Team the waiver whatever it is the waiver. I know that in the waiver you talk about managed long term care etc.. I never hear results about how that's working but I'm very concerned that in the DSRIP program the sense of older people is missing totally and I know that can be dismissed because we say well that's Medicare but it's not if we look at the cost of nursing homes as probably the highest cost that we

pay here in New York for out of Medicaid. And I don't know how. And I listened to that to the man who spoke about the institutional new law. I'm not sure I understood exactly where you were but I am concerned about the in the systemic incentives to move people out of home and community based services into long term care that is going to break the Medicaid program and there won't be money for not just prevention but there won't be money for doing the work that we need to do unless that's addressed. So I don't know if this is a time to ask questions and if not you know I'll just make the comment. But how does the department under the 12 27 waiver how do you see the integration of those things as having an impact on the overall cost of institutional care particularly at the nursing home level. I'm very concerned about that and anything that's going to move the dollars back into fee for service for institutionalization is only going to exacerbate that problem I believe because it will decide incentivize home and community based services so my comments relate to how the pieces of the waiver relate to one another and reinforce each other in moving to a more effective efficient person centered system for the people of New York. And I think it's what the 11 19. Is that what it is.

11 15. You could tell my strengths. And think the department answers these comments. But I would just like that to go on the record.

Ann. So let me ask the leadership. You know when you gave the report today I can remember if you said this or not. You did talk about the the sort of the top line metric of this whole program which is 25 percent reduction in unnecessary hospitalizations. Do you believe that given where we are we're going to achieve that. And again I'm not saying that along with Ann's comments earlier this is not a gotcha question. I'm just interested in your perspective at this point in time.

We're on track to achieve that but it's going to get harder from here on in I think is the best answer to that question. We have as you can see a lot of the work the groundwork that's happening on the blocking and tackling side has been done. The challenges in front of us in closing that remaining gap in this next two years which is really one measurement year are significant. We also have are looking at ways to measure that that are broader than the measures that we use for performance because many of the activities that are picked up here in reducing avoidable hospitalisations are not just readmissions and ED preventable visits they are mid surge preventable visits. We're looking at other metrics to measure that as well.

Thank you. Appreciate that. That's a that's a terrific I guess a challenge inherent in your question frankly which is that we may get we may get there and if we do it's going to be really tough slog. But my comments would be along these lines in the context of what we're talking about. And again I hesitate to agree with Steve too much so I'll I like to agree with him but it's a little bit different perspective. I but what I do appreciate about what he just said is that ultimately I think what we are talking about here is not so much politics but we are talking about let's call it a culture if you will, a political culture, and that is that this program was designed to build an infrastructure for all of the Medicaid beneficiaries in the state which I think on its face is almost revolutionary. And I congratulate everyone who worked on this for the years leading up to it and the execution. I mean we should recognize that on its face this is a phenomenal probably almost unique effort you know at any time in American history where this many people and this many dollars have been reorganized to attempt to deal with the underlying causes of disease and illness and injury and try to get ahead through preventive measures and others. Phenomenal. At the same time I think there's a couple of things that we have to grapple with. It's built fundamentally on financial incentive and whether or not financial incentive is the right way. I don't know. I think everybody around this table has read plenty of behavioral psychology behavioral economics. We understand that the jury is definitely out on whether or not financial incentives really do drive changes in behavior. I know plenty of people as do you who would say well if you're going to do financial incentives they better be fairly substantial so people actually will take the money and build something based on something that that

really does provide people with the kind of financial support that they need. But those are very very complicated questions. First of all whether or not financial incentives are actually going to change the culture and if so they probably ought to be much greater than they are. And I do agree that unless that money actually comes from the savings itself there's no there shouldn't be any new money. There is no more there isn't any more money in healthcare. We're already spending far too much. So I think my comments are as we think about not just the role of this oversight committee but all of us together whether it is this panel it is an important question for us to say how are we going to influence the political culture necessary to continue this work. Because my sense is that a lot of the PPS's and a lot of the constituent parts are going to have a very difficult time sustaining what they've built. I mean in the PPS's I've visited that may be the biggest issue. And to Steve's point about the workforce the workforce to the extent that they have been involved in DSRIP programs it's actually relatively small because many of the projects are relatively discrete actually doesn't involve that much transformation of that many people's roles. But the question is as we go forward you know how are we laying the groundwork for that to take place on a larger scale so that the workforce actually does feel valued and a part of the process. And will their jobs be secure. Because one of the biggest things I hear when I visit in the field a lot of people say well you know these DSRIP jobs are kind of interesting kind of exciting but there's no security in them because many of them are posted as kind of temporary or grant jobs if you will. So without getting into too much detail I do think that between the question of incentive versus culture, role of the workforce, and what we actually think we can achieve in the state at least within the Medicaid world is something that I think we've only begun to touch on. And whether or not we should take that up or who's going to take that up Peggy and to our new leader it'd be interesting to know what the planning is going forward because I'm sure you're all thinking about these things not just because I'm saying that obviously these are all questions we're grappling with but what is the future of building on this. What I would say extremely by any standard extremely successful experiment in transformation of healthcare.

OK John. Sherry.

I'd like to go back to three people who stood up to speak and the fact that this is a public comment meeting about the waiver. A couple people had said they did not understand what the First Gentleman and did not know a great deal or enough to comment about what you had said I would I would like to ask you to come to the pod to the microphone so that whatever it is that we don't understand we understand more so that we can respond the next time.

In the latest budget managed long term care was was told that basically people placed in nursing homes for more than three months and maybe Lara can explain it if I'm not making sense but people who are placed in nursing homes for more than three months who are deemed permanently placed there are no longer the responsibility of managed long term care so they don't have to pay for them anymore. So these may be the small portion of disabled people who cost more to serve in the community than in a nursing facility but they have a right to live in the community under the law. What this does by the analysis of the state's own Olmstead plan by moving those people into fee for service into the states responsibility, it incentivizes the managed long term care plans to move those people to nursing facilities to have them permanently placed so they don't have to worry about that extra cost because perhaps the capitation rate doesn't cover everything they get for those individual individuals. Now DOH would say it's all actuarially sound and that it balances out. You know the managed long term care plans sometimes disagree about this. The advocates certainly disagree I believe. But we've seen this start to happen already. We've seen plans notify people that they will be permanently placed and that after three months they will be told they will be the responsibility of the state not the plan anymore. There have been some adjustments made by DOH in terms of how this will be operationalized and those plans that have told people that certainly shouldn't have because it hasn't been finalized. I'm not trying to mislead anyone on this but this plan is moving

forward. DOH is working on CMS approval. Personally I know we've got the state Medicaid director here I would love to hear her take on what this means and how we can possibly say we're supporting community home community based services when we're actively encouraging institutionalization.

May I ask a follow up from what he said.

I'm sorry. What does that mean.

It means its their decision.

Go ahead Sherry. And then I'm going to just briefly address this issue to let folks know the current status of the implementation discussion and then we're going to.

No I think he was asking to hear from you and I.

OK. Do you have a question.

No I'm a let it go. I'm going to let it go.

OK. So thank you for the comments both from the public and from our PAOP colleagues. We appreciate them. We will take them all back. We hear Lara's suggestion that it may be more clear what the point is of the comment as well as what we do with comments to this specific issue being raised about the 2018 19 budget initiative related to payer source for nursing homes for people who are in the nursing home for more than three months. There are there are work groups that are established that are having ongoing discussions about the implementation of those enacted proposals. And so those comments and feedback are happening there as well and we'll certainly make certain that the people that are leading that work are aware of the comments here today. So with that I'd like to thank everyone for attending. We know it's a long morning. Thank our PAOP panel members and ask one more time if we have any additional public comments for today's forum.

OK seeing none. Thank you for your input. Thank you for your advice today and we look forward to talking to you soon. Bye.