Transcript: ***Overview & Discussion on CMS guidance for Additional Support for Medicaid Home and Community-Based Services (HCBS) - NHTD/TBI Advocates***
May 28, 2021

Hi everyone, this is Brett Friedman just announcing that we're going to get going in a minute or two to give all the attendees a chance to join. So, we'll expect to start until about 12:03/12:04. Thanks so much.

Okay, let's get going. Good afternoon everyone. Happy Friday before Memorial Day weekend. This is Brett Friedman. I'm the Director of Strategic Initiatives here for the Medicaid program, and I'll be leading today's session and we have an agenda slide on the WebEx for those of you who are logged in. And it'll be a very short presentation by us here. And the topic is to discuss the uses for the enhanced Federal Medical Assistance Percentage (FMAP). So, the additional federal money was authorized by Congress, as part of the American Relief Plan Act (ARPA) and the guidance that was issued by CMS, the Centers for Medicare and Medicaid Services, on May 13th, 2021 that helps define the amount of money that New York State will get and how it gets to reinvest that money in various forms of home and community based services (HCBS), including the services provided under the NHTD and TBI 1915(c) waivers.

And so, we wanted to set up this call, and we're doing it quite quickly given the arc of the CMS guidance, to solicit feedback that this group has on potential uses of this enhanced FMAP. We have received some direct feedback already through the various stakeholders within the NHTD and TBI spaces. So, thank you for sharing that. But we thought would be helpful to just cover three things today.

The first is to provide this group an overview of the CMS guidance that was issued with regard to, again, the amounts of money and how we can spend that money on HCBS programs and services; to outline very briefly some of the guiding principles that we're using within DOH and across other agencies and how we're going to assess proposals for how to spend the money given the CMS guidance; and to really hear from you and try and take as much time over the next 40 to 45 minutes, giving everyone a chance to speak and hear your perspective on where to reinvest these dollars.

To make a comment, and I'll announce it, but you'll see in the bottom right hand screen of the WebEx, there are a few buttons. The one, all the way to the left looks like a hand, or it's supposed to look like a hand, thanks to the folks at Cisco. If you click that hand, your name will pop up on the attendee screen for us. And we can unmute you and give you a chance to make a comment or ask a question. You can also type in anything you want into the comments box and we'll either read that out or record it for consideration if you don't want to speak or use the Q&A box. All three are viable options, but our preference is folks could raise their hand. It's the most prominent displayed and it gives us a chance to make sure we can call on you.

So, with that very quickly, we'll give an overview of the CMS guidance. As I mentioned, it was issued on May 13th, 2021. It was a result and it was long-awaited for after the enactment of the American Relief Plan Act of 2021 in mid-March. And what that statute said was that Congress would provide 10%, enhanced Federal Medical Assistance Percentage (FMAP) on qualifying forms of home and community-based services. And that spent expenditures would have to supplement, not supplant, existing state funding and that the uses must strengthen, enhance, and expand existing HCBS programs and services. It is a very broad statutory mandate and so, we were waiting, as every other state's Medicaid program, on additional guidance from CMS, which again came out about two weeks ago.

The guidance had four critical points in it. The first is it told the state how to calculate how much this 10% enhanced FMAP would be for the Medicaid program. So, it has outlined the services with a level of granularity that we needed to conduct the calculation and it's quite a complex calculation because it's looking at estimated HCBS expenditures over the next year from April 1st, 2021 through March 31st, 2022 and it's across programs that we would view as traditional HCBS, right? Like the 1915(c) waiver programs, including TBI and NHTD, but also, things that were more historical State Plan services, like personal care, that we wouldn't have necessarily considered part of the narrower category they've asked but will count towards this enhanced FMAP. And with that we were determining - and we don't have an exact figure yet - but the total number across all of the HCBS programs and services will be somewhere in the two billion dollar range and that is a reflection of the size of New York State's Medicaid program, and our historical commitment to HCBS.

Once we generate this enhanced FMAP in the 2022 period allowed by the statute, what the CMS guidance says is we can reinvest that money. So, we can take the money and we can spend it directly in the delivery system, or we can use it as our State share portion of Medicaid spending in additional HCBS, and so for expansions of new and/or supplemental HCBS services, there would be a State component associated with those increases. We could utilize this 10% enhanced FMAP, apply it towards the State share obligation to increase the overall spending in the program. And so, what that does in a practical sense is it gives us the ability to take every dollar that CMS is providing in 2021 and 2022 and make it at least two dollars. And so, the result of the guidance was very favorable for all states looking to expand HCBS services, that our ability to reinvest the proceeds of the enhanced FMAP isn't just limited to the money that we generate on the existing expenditure, but we can apply it again in those investments and generate additional enhancements. So, it's a significant investment potential across all of our HCBS programs, which include everything in the OPWDD space that's funded under the 1915(c) waiver, a lot of OMH and OASAS supports and services, including NHTD and TBI, which is important to this group, as well as home and community services and the personal care and CDPAP industry. So, it covers a broad part of our Medicaid program and there's a lot we can do with it, but it is a substantial amount of money to consider and to reinvest. CMS indicated that, in addition to claiming the money in April 2021 to March 2022, we can fund services that are furnished in programs services that exist. So, while we're generating the enhanced FMAP in this first year, we can spend it over

the next three, which was also a very important consideration because the way the statute was written, we were concerned that we would have to essentially spend it as quickly as we were getting it. But this way, CMS has clarified that they're giving us time to, once we claim the money and figure out how to reinvest it, we can spend it over the next three years.

There's a drawback of course because everything comes with pros and cons. The drawback, at least from a planning perspective on the state side, is that there are "maintenance of effort" requirements in the guidance as derived from statute. And what those maintenance of effort requirements do, is it says that we cannot make certain changes in our HCBS programs and services for as long as we are claiming and spending this money. We essentially have to freeze the HCBS programs, or we can't shrink them. We can certainly grow them, but we can't shrink them in three critical ways.

The first, is we cannot change eligibility criteria, or apply more restrictive processes to entry into HCBS programs prospectively. So, we can't make it harder to qualify for HCBS.

The second requirement is, we can't reduce the amount, duration, or scope of HCBS benefits as they existed on April 1st, 2021. Again, we can increase, but we cannot decrease the amount, duration, or scope.

And the last restriction is, we can't reduce rates. We have to keep the rates constant. And so, what we're really doing is preserving the existing HCBS system as it currently stands, and we're looking to make fortifications, enhancements, improvements to the program to achieve the objectives of ARPA.

And so that leads to the last point, which is permitted uses. The guidance and Appendix C lists a really broad array of permitted uses that CMS uses in enhancing and strengthening HCBS programs. I won't go through the laundry list of what those enhancements are, but it could be workforce enhancements, it could be systems based enhancement, technology, PPE, training, anything that the state will justify and support to CMS as improving the program.

The process for ensuring that we intend to spend the money on permitted uses is twofold. The first is, we have to submit a plan to CMS. The initial date was by June 12th, 2021, they give us 30 days from issuance of the guidance. CMS indicated this week that they'll give up to an additional 30 if needed, so July 11th, to submit a plan to CMS that contains our fiscal estimate, our fiscal calculation, and how we intend to spend the money. So, CMS will approve our spending plan at the outset. Then, once they approve our spending plan, we need to actually make changes to our programs and services to then claim the money. So, in the TBI and NHTD space, we would actually need to then amend the 1915(c) waiver through an Appendix K or through a normal waiver amendment, depending on the changes we're making. And that will allow us to implement the changes for which the enhancements go through. And if we make those

changes before the end of March 31st, 2022, we actually generate additional enhanced FMAP on that expenditure.

So, CMS's two bites of the apple for approving our expenditures. The first, is through submission of this plan, and then through submission of the waiver documents or other approvals themselves that will allow us to claim match on those funds and that we have to do quarterly reporting to CMS over the course of the expenditure process to ensure that CMS is aware of how we're spending the money, and we haven't made any changes to our program as indicated in the maintenance of effort requirements.

So, the guidance says lot. It's very complicated. We have a lot of questions for CMS as to the impact on our Medicaid program and the process by which we're going to claim the enhanced FMAP. We've conveyed a lot of those questions. We can certainly convey more if there are any, but at this point, we are in the midst, about halfway through, soliciting feedback and putting together the plan to CMS to ensure we can access these critical funds.

And so in doing so, to move on to the second agenda item, we want to go through a few of the guiding principles that the Department of Health with our agency partners, OMH, OASAS, OCFS and OPWDD, will be assessing how to apply those funds because there are going to be more proposals than funding to spend. That is just the nature of this, but some of the guiding principles that we're going to use in determining funding and certainly how to allocate the funding is just to just to eliminate a few quick things.

The first is as a general matter, the programs and services that generate the enhanced FMAP will get to spend that funding. This was reflected by this year's State appropriations bill, but if OPWDD for example, is generating that portion of the enhanced FMAP through their 1915(c) program services, they will get that money to reinvest in their delivery system. Right? The money won't be fungible across delivery systems, it'll be used to improve that delivery system. So, we intend to allocate to the extent possible that we want to reinvest in the NHTD and TBI space based on the size of the program, and the enhanced FMAP that it is generating. That helps us allocate big picture how much we're going to invest in each component of the HCBS industry.

The second principle is that we're going to prioritize uses that are matchable. As I mentioned, CMS is allowing us to spend it on matchable services, things claimed through waiver or through direct grants and investments and things that might otherwise be matchable, like social determinants or technology investments in the field on a comparative basis. It's not to say we will not apply the dollars to non-matchable things if that's the consensus view, but we will prioritize those that generate additional federal money going through the waiver itself, that's appropriate fiscal management. We want to maximize the amount of federal money we have to enhance the delivery system.

Principle number three is that the investments themselves should be sustainable. We don't want to make one-time investments that are not going to result in long term improvements to some of the access challenges, for example, that may exist within an

industry. And so, we're going to prioritize and look at proposals that really in our view, and your view, promote sustainability to the model. And so, I think that's an important component as well, but at the same time and as I mentioned earlier, we only have three years to spend this money. And so, to the extent that we can select proposals that have a natural break point, sometime between 2021 and 2024, those too will receive our preference and our consideration of how to spend the money.

As a fifth principle, we want to address known risks and challenges. I think that goes a little bit to the sustainability point that to the extent that there's ongoing legal risk or challenges to the space, we want to look at investments that help address those known issues.

Sixth principle, we want to ensure alignment with prior and current year Budget actions. The MRT II was such a transformative process to ensure overall Medicaid program sustainability and fiscal oversight that to the extent something's in an MRT II proposal, we want to ensure alignment with it.

And the last, and the seventh principle that's guiding our consideration of proposals is COVID-19. We want to look at the experience through COVID-19 and help providers and help the delivery system and consumers overcome those experiences and challenges. We cannot retroactively fund costs incurred from COVID-19, so you can't present us the receipts and say, reimburse these receipts. But the idea is, we would make changes to delivery system to help with ongoing COVID-19 challenges and help sustain the delivery system against future pandemic responses.

And so, with that, hopefully, that's been a helpful overview of the CMS guidance as well as how we're thinking about the analysis of proposals. And at this point, I want to open it up to your comments and questions so that we can hear from you as to the areas that you think are critical for NHTD and TBI and how we can support the space through their reinvestment of these federal dollars. And if you don't want to speak on today's call or ask or type your question, there's a mailbox that's being posted here for questions to answer and we're happy to utilize that method as well. So, with that, please, please raise your hand, or type questions.

So, John McCooey asks: The Alliance sent DOH suggestions for how the money might be spent. Would you address the first five suggestions?

Sure, I mean, John, if you want to walk through them, I'm happy to hear them out. I know that came late last night. So, I can read them, or we can sort of talk through them. Whatever folks think would be most helpful. And if we want to unmute you or not, you know.

So, I just brought up the list and I would have had it up earlier. I apologize. But those five suggestions were hazard pay and related costs for all direct support staff, workforce costs are permitted use under the CMS guidance and to the extent, it relates to

workforce development needs we can say that is a strong consideration across all of the permitted uses.

The second, recommendation deals with HCSS provider pay for additional expenses, incurred due to the PHE workforce shortage, overtime expenses, shift differentials, among others. Again, I think the extent that promotes workforce we're supportive of those proposals. The limitation, as we read the guidance and this question has been asked, but it's hard to reimburse for prior incurred expenditures prior to April 1 of 2021, but to the extent that we can make workforce industry improvements, especially through changes to the labor itself, that would help with workforce shortage issues based on the PHE, those are things definitely that we're considering.

Sign-on bonuses to attract direct support staff to the waiver workforce. Also, something that we support. Sign-on bonuses were specifically mentioned, recruitment strategies to getting more direct support staff into waiver services again are things that we would also view as a funding priority.

Transportation expenses to and from HCSS shifts and other waiver staff visits. That's a more innovative proposal in terms of paying for things that, you know, as opposed to wage costs like a sign-on bonus, or even training incentives that directly tie to workforce time, transportation costs would be more of an innovative application as we understand it under the waiver strategy. It's something that we can certainly pursue with CMS, as part of our plan and part of any waiver approval, but to the extent that transportation expenses themselves would not be something claimable through the 1915(c) waiver, it would take less of a priority based on the principles we discussed for consideration of proposals. We would be, in short, leaving federal money on the table based on how we would prioritize things that are matchable under the waiver, on things that aren't.

And then the last suggestion just to read it out is incentives for family and other unpaid, natural supports of waiver participants who may provide care in the absence of pay supports due to a shortage of workers. That's also one that I think is important as a PHE related workforce tool, looking at member incentives is something or family incentives to encourage natural supports. This isn't something we typically paid for through the waiver. And so, we'd have to look to see if these are these types of family incentives, or not or informal support incentives are something that we could claim through the waiver. If it's not, then I think we're going to have the same challenge that transportation might arise, which is doing something that would allow for less money to be spent on things that would be matchable under a waiver. So, again, we're willing to consider all of these options; we'll assess each proposal. But we wanted to give a framework today of how we're viewing and considering proposals compared to one another given that the money is substantial but also finite.

So, with that, can we unmute Michael Hurley and we'll give him a chance to make a comment or ask a question.

Hi, can you guys hear me Okay?

Yes, we can. Hi.

So, I think it's very similar to what the last person said, but I mean, from our perspective here in Rochester, New York you know, the front line workers across the board are not getting paid enough, even though two billion sounds like a huge amount of money, and it is, if you just start dividing it by 100,000 or 200,000 workers, it's nothing. I mean, we all know salary's the biggest expense. So, if I'm you at the Department of Health, I'm wondering, how do you make sure that the money doesn't just pad the coffers of the agency owners, which I am one by the way. So, I'm not speaking out of school too much here. I'm just worried about it from a taking care of the client perspective, because we have to rely on - we're all interdependent on each other, especially as a service coordination agency so we depend on everybody being okay, and right now, you know, people aren't going to have any care. CDPAP is the only option around here and even that's like a nightmare right now, which I think you guys probably know that. So, I'll shut up now and just let you comment on. I guess the question is, how do we make sure that the money goes to the most good, which I think is the workers, which then will go to frontline to the people needing the care. That's my question. How do we make sure? You might not know the answer either, but that's what I'm wondering.

Yeah, no, and you know how to make sure that money goes into the pocket of the workforce has always been a challenge. It's been that way with minimum wage increase system, wage parity dollars as well when those have gone through in prior years. And we've gotten better at monitoring the expenditure of the funds. But to go to a point to which I think you started with, and it's critical in the way that we're viewing this exercise, is that, you're right, two billion dollars is a lot of money. The NHTD/TBI portion of that will be less, but I think what's going to result in the most sustainable impact on the delivery system and the workforce is fewer bigger uses, as opposed to many smaller uses. And I think that's part of the discussion we want to have today, which is the money. It's a lot of money, but it's still finite and we want to be able to utilize and create the biggest financial impact that we possibly can to really make sustainable changes to the delivery system. And to us that is, I think some of it, you know, some of the money will inherently, and have to, flow through agency admin. And you know, as an agency owner, you provide critical administrative services to help run your program and so we do expect a portion of dollars to be spent on agency admin but we do want to get money into the pockets of the workforce to address the issues. This is our fourth or fifth listening session this week, as we're trying to do very quick stakeholder impact work around this money, given the 30-day timeframe that CMS has put us on. And the refrain we've heard across all HCBS sectors is workforce, workforce, workforce, right? There are pre-COVID, post-COVID, creating a larger and more sustainable and retained workforce is essential, but it's helpful to hear that within the NHTD and TBI space it's the same challenge, just so we can think aligned across these different sectors.

Thank you very much. Appreciate everything.

Yep. Thank you, Michael.

Can we unmute Nancy Pirro please? And then and then we'll go back to John. I know he was trying to unmute himself.

I just was wondering if we were going to get a copy of this information.

I mean, this is the slide. You're welcome to screenshot it. You know, there's not much information to provide, you know, we're working very quickly here in terms of trying to provide - the CMS guidance is out there. We can provide a link and the comment field. You can certainly read the CMS guidance as we had. This is a formalized process consistent with CMS, but DOH has been put into place given the very short time frame that CMS is requiring us to operate on to submit a plan. So, we're trying to turn around and do this and tell you at least what our thinking is, but the principles I mentioned aren't not set in stone. I just wanted to give you a sense of how the guidance works and how we're going to think about it when we submit the plan. And, you know, I think what we're hearing today is hopefully there's agreement in trying to maximize federal dollars to reinvest and to make bigger investments presumably in workforce. But again, if you think our principles are off base, we want to hear that too.

Okay, thank you.

Yep.

Can we go back to John? If the moderator can unmute John? You should be able to speak now.

Brett and all of the people at DOH just want to thank you for doing an unbelievable job under a lot of pressure, time pressure and facing great needs. This is great. We really want to congratulate you. The thing that I would want to emphasize on behalf of the Alliance of TBI and NHTD providers is there's a real crisis. A lot of providers are operating at a loss and draining down their reserves and you know, there's just, as you definitely have heard, there is just a real lack of staff and an ability to actually give access to people to the services in the in the waivers. And to address that we were hoping that DOH, and I think it aligns with your goals as well, would have the most efficient, easiest, and simplest way of getting money to providers. If it could be simply assigned in some way to providers and then they attest and have a way of dealing with that in the backend in order to do the accounting that would be great because what's happening right now much more so than a year ago when the pandemic was raging in New York City is that there's a real crunch with workers and so, we're not seeing any let up and in fact, we think it's going to go right through the summer. It's really proving to be very difficult for the people we serve. So that, and I just wanted to ask if there's waivers, do you have a calculation on how much money they have generated of this two billion?

We're trying to work on that as we consolidate the plan. Unfortunately, the way that the CMS-64 lines are, it's not easily broken down by source and so we're trying to reconfigure and back into that information. So, we should at some point but we don't

see them here today, we've been working sort of very quickly to try and size the amount and to do the planning, but we don't have it specific to waiver program yet.

And can you actually get some money out in bulk fast allowing providers to do an attestation and then do the accounting in the backend, or you know, we just want to to the extent possible, avoid a complex system of applying and getting approved and going back and forth to get the money. In other words, the providers need the money now, in order to staff the cases they have.

No, that's it's a very good comment. I think I will say it aligns both of us to find the options that will get the money to you quicker. And I say that, because one, for the reasons you mentioned programmatically, to hire the workforce you need to have the money in your bank accounts to be able to pay the workers. But two, the quicker we spend the money, the greater the enhanced match we generate. So, we can generate match again if we spend the money in this calendar year and it through March 31st, because if you think about it, right, we're getting 10% on our expenditures from April 1st through March 31st. So if we start spending more money, we get more match, but if we spend money beyond April 1st, 2022, we don't get that extra 10%. So I would say your interest in getting money to providers quickly fully aligns with our interests in getting money to providers quickly because it benefits all of us because then that'd be more money to spend. So, we will look to pursue any flexibilities we can with an appropriate state safeguards to do that.

And one thing I heard, you say, you know, it's hard to go back retro past 4/1/21, but it seemed that there is a tiny bit of an opening in that door and I just was wondering since the pandemic really blossomed in terms of staffing from, you know, really the holidays and Thanksgiving through the current period, if there were a way to go back, just to that, to where the crisis happened, we would very much encourage you to explore that with the federal government.

Yeah, I mean, I will say we, and other states have asked that question, right? Which is, can you present us say with PPE expenditures and then can we reimburse for those? And so far, what CMS has told us is the statute of authorization didn't apply retroactively. It applied as of March 15th and CMS said April1st. So, I guess this is an entry to everyone to think critically, which is, how do we spend money on things today that help you recover some of the costs you spent yesterday? I think we're open to suggestions to get up there, but I think waiting for CMS to say “okay, yeah, if you incurred a cost and you could present a qualifying invoice from December, we'll pay for it.” I think that's going to be a bigger stretch, just realistically given the timeframe we have to work with.

You are really very encouraging and you guys are doing an incredible job. I mean, if we can be of assistance as we go forward in this and work out some of the details, because I think that we have a lot of the information on the providers that were actually on the ground seeing this, talking every day to staff, who were really having a hard time getting to shifts, and recipients who are not getting the support that they need. If we can give

you help and assistance and guidance in developing the plan that would be something we'd be really enthusiastic about at the Alliance.

Thank you. Yeah, I mean, one thing seeking guidance on from CMS is sort of how detailed we need to be in this initial plan. Right? So, we submit our initial plan within 30 days, CMS approves it and then, let's say our initial plan, we say we want to invest in workforce, right? It could be that general and the, and CMS says great workforce counts. Then we'll have to submit a waiver, an Appendix K or just a waiver amendment itself to the 1915(c) NHTD and TBI and then at that point, we will go through public comment and make sure that in the waiver itself what we're paying for through the waiver document, is doing what you need as provider. So I would say this is the first bite at what we expect to be a collaborative public transparency process, but also a quick one, to my earlier point, to get this money into the pockets of agencies and workers as quickly as we possibly can.

Great.

Great, thank you John. Can we move to? Well, I guess those were the only hand raises, but if we can unmute Angie Longwell, if Angie wants to ask her question, we can, do that Angie?

You're unmuted. If not I can, I think I see your question here in the chat field, which is to incentivize agencies to begin to provide HCBS in the regions where there are waitlists. And I'll say that waitlist relief is definitely something that CMS has called out specifically in the guidance and I think that aligns with our principles of trying to address known risks and challenges within HCBS programs and services. Similarly, one of your other comments sought reimbursement rates for providers, sign-on bonuses, enhanced rates for areas with decreased service areas. Again, I think, you know, to the extent those reimbursements focus on things like workforce development with historical provider shortages I think that does align with a lot of the feedback we've heard already, and again would also be consistent with the guidance that CMS issued.

And then I see here in the Q & A box, you have a third suggestion, which is if an amendment is made, revisiting the enrollment process or having an incentive for the enrollment process. By the time we get through - and I don't know what the NE requirements are, I apologize - many times individuals have needed to go through nursing home timeframes and it increases enrollment processing waits. If there's anything more you want to say there just so we can hear it, we're happy to hear that one out too because that seems very specific.

With the service coordination part, even to get to the point of accessing services, there is just such intensive process with connecting with the staff, they reside in nursing and stepping down during transition services. Even getting feedback from the providers and the nurse evaluator to do the assessments, it takes sometimes months to get people from the referral to enrolled and in that timeframe, there's many people that’ve dropped off and are no longer eligible because they have reached a nursing home or they had

higher levels of needs, so they can't access the service anymore. So I think if we minimize part of or revisit that enrollment process and have an incentive of some sort to make that easier on the coordination side, then it would also improve access of the services as a whole, the waiver service.

No, thank you. That's really helpful feedback.

There's a question here from Traci Allen, which is, will the plan be posted prior submission to CMS for public review and comment? Also, do you have specific thoughts regarding funding for TBI and NHTD providers? We don't anticipate that the plan will be posted prior to submission for review and comment and it's only because of the very short timeframe that CMS has given us, and we need every one of the 30 calendar days that CMS has. If it was just NHTD and TBI, I think we could've done it, but given it involves deep seated coordination across the agencies, and even within our own different divisions, it's going to take every bit of time. You know I saw another comment that Georgia is just doing a 10% across the board increase for all of NHTD and TBI services and that's one way to do it. And it's not to say if New York is going to go that route, but I think we're hoping to be a little bit more targeted. And because we're doing the solicitation process now and we're going to do a second round as we submit State Plan Amendments or waiver amendment to effectuate the uses that we seek as part of the CMS approval process at this point, I don't anticipate that we're going to have time for a full public comment and review process prior to the submission. My hope is that we will be broad enough and general enough in our descriptions of the uses where we'll be able to refine those things further between CMS approval of our plan and submission say of the waiver amendment necessary to apply those funds or the design of the grant award program, if we have to go that route for the uses. So, this is my way of saying, the plan itself won't be posted for public comment, but there'll be additional opportunities for public comment prior to when we start spending the funds.

I think we answered the questions: How will we make sure that it doesn't just pad the agency pockets and go to the workers, which is an actual problem. We agree, I mean, there's a significant concern of ours anytime we try and spend money on workforce and I think there's going to be a tension between speed of getting the money out the door to the entities that are capable of receiving it and administering the programs, versus ensuring that every is dollar spent entirely appropriately. Whether we do an attestation approach, like we've just start doing them with wage parity certifications on the DOL and DOH side for those of you who that would apply to. I don't know if anyone has friends in PCS agencies, but we have experience with different mechanisms and we will be as flexible as we can to both ensure and safeguard the dollars versus trying to promote speed and getting the money into the pockets of workers given the challenges already addressed.

Sophia asked a question about creating a cohesive online training program for all providers to utilize when training their SCI, LSE, PBI, HCBS etc. staff on online portal with modules that can be started and stopped at their discretion. It'll create consistent training. Training and onboarding programs again is I think a theme of a lot of proposals

that we've received, and I think utilizing the expenditures on consistent training programs is aligned with what CMS wants to do. Again, if we can do that in a way that's federally matchable through the waiver that would check almost all of our boxes.

Similarly, Sophia recommends creating a statewide online portal system similar to that used by OPWDD, where all service plan documents are uploaded and stored and viewed by approved users rather than relying on paper documents and share back and forth. That's also, I think a great suggestion in terms of looking at technology improvements, because technology improvements are things that are very ripe for a one-time investment. So that's going to have a sustainable difference in the way that the delivery system operates. So, we'll happily consider that that proposal.

We talked about the Georgia, 10% across the board. I hadn't heard it yet before this call, but I'm not surprised there are a lot of states that are looking to be fast and easy with the money, and just get it out the door. I think there's a real benefit to being as thoughtful as we can be and targeted as we can be but I will say on the backside, CMS has given us a lot of a lot of challenges in terms of trying to present a plan and get the approvals necessary to spend the money quickly so there's going to be a tension between speed and simplicity and good program design. And that's what we're grappling with and hoping to get refinement on through these conversations today.

Dean Mancini makes a comment about investments and service coordination (SC). Without service coordination, a consumer cannot access the waiver. It's clear that most referrals need a homecare service more than an SC, but the SC spearheads the whole coordination of care. So, the SC is vital for the waiver programs. That we appreciate, that's a helpful comment that Beth and others will consider as we help design this plan.

Sean Dwyer asks is there an idea of how providers will pursue the funds? Can it be driven through rate codes? I think that will dictate what the improvements are, whether we do so through the waivers. If it's a service credit rate enhancement, and we can like Georgia, for example, we can just add reimbursement onto the rates that could be something that is accessible, or it could be something that operates like a grant program. Ideally, we would utilize the existing mechanics of the way that services are built under the waiver because those processes already exist and that would allow for speed in claiming the funds.

There are a few other questions here that we've covered a lot of already. I know we are being on time, which is just going to until 3:45. I'm happy to stay on for a few more minutes and go through, but I understand people have to drop off as well.

So, with that Sophia asks again, the future employees we are looking to attract need to want to work in a field where the paperwork is streamlined, efficient, up to date technologically. That is not the case. It is cumbersome, duplicative or duplicitous, I think it could be both. I think that goes to the earlier technology comment, which is a good one, to the extent we can make investments to streamline. That can be more of a longer term, three year investment, but I agree if we can eliminate hurdles and tensions in

NHTB/TBI services, that's going to improve overall workforce satisfaction, the ability to recruit and retain workforce, that would check a lot of boxes.

Dean Mancini makes a comment about logistics and workforce transportation getting to and from work and to invest in MAS and use of public transportation vendors to transport homecare staff to and from work. We've heard that proposal as part of the alliance submission as well. And I think it will be considered again, we'll have to think about how to get match upon it.

Sophia asks can money being used to assist with finding housing resources? Oftentimes applicants need a year or two to find housing, even to get into the program. I admit to not being studied on that question so we can, we can look into that one further.

We talked about technology enhancements.

Okay, the last question I have here is from Sean Dwyer, which is, how can we address speed if this will be executed through a grant? My concern is this would take longer than the grant request. Could you use a HRSA grant process that the hospitals use to accelerate the grant process? That questions is a really good one. In the appropriations bill that came out this year, we've not listed several provisions to the finance law to help expedite a procurement process if we have to go through a grant, but I completely agree that a grant process to the extent possible has to be competitive or will slow down things considerably, right? Any grant process is at least in 9 to 12-month timeline, the way that they're run and operated and utilizes enormous amounts of staff resources, especially if there are challenges. We would prefer not to go through a grant process if we don't have to. We'd prefer to do things as part of earlier comments, like rate codes, waiver-based programs that are enhancements that'll be time limited ones that create sustainability. And so those, those items are going to have preference as well just in terms of speed and simplicity and the ability generate match.

I'm just trying to find questions from people who haven't asked them yet.

Meg Everett asks since NHTD and TBI is not in managed care, can DOH get the double match on the spending? The answer is we can get match on the spending if it goes to the waiver. Right? So, if it receives approval, as part of 1915(c) waiver, which is not through managed care, we will get match on it, which is why we should think about proposals in the framework of the 1915(c) waiver.

I think those are the bulk of the questions we have; we're recording these as well so we're happy to consider those as well after the fact. I haven’t even looked at the comment box yet, but I'll stop there because I think we've covered a lot of ground today. I do want to thank everyone for joining, the helpful submission from the Alliance, the helpful discussions on today's call. You can email Beth, you can email me, or this mailbox on the slide with additional suggestions or comments and they'll be part of the consideration process. But I hope with the information provide today, you have a sense of some of the challenges with this program, the ways that we're considering the

challenges, and the priorities in which we'll try and get approval to spend the money on permitted uses.

So, with that, I'll wish everyone happy three-day weekend, and we look forward to your continued engagement and partnership as we trying to effectuate this exciting, but limited opportunity.

Thank you, everyone.