Centers for Medicare & Medicaid Services
COVID-19 Medicaid and CHIP All State Call
June 29, 2021
3:00 pm ET

Coordinator: Thank you all for standing by. At this time, I would like to inform all participants that your lines are in a listen-only mode until the question-and answer session of today's conference. Today's call is being recorded. If you have any objections, you may disconnect at this time. Ma'am, you may begin.

Jackie Glaze: Thank you, and good afternoon and welcome, everyone, to today's All-State Call and Webinar. I will now turn to Anne Marie Costello, our Acting Center Director, and she'll share highlights for today's discussion. Anne Marie?

Anne Marie Costello. Thanks, (Jackie), and welcome to today's All-State Call, and thanks to everyone for joining us.

Today, Jen Bowdoin from our Disabled and Elderly Health Programs Group will join us to address a number of additional frequently asked questions that we've been hearing from states related to the enhanced funding for home and community-based services provided by Section 9817 of the American Rescue Plan Act.

After (Jen)'s presentation, Ryan Shanahan who's also from our Disabled and Elderly Health Programs Group will present on how states can use the 1950(c) Appendix K to implement temporary rate increases that account for the extra time off needed by direct-service professionals to receive the COVID-19 vaccine.

This is an important issue because we have heard that the need to take time off to receive two vaccine doses presents a barrier to receiving the vaccine to many workers. After Ryan's presentation, we'll open the line for your questions. We"ll use the Webinar for Ryan's presentation today. So, if you're not logged into the Webinar platform, I suggest you do so now.

Now, before we jump in. I wanted to ensure that you were all aware of our upcoming leadership transition in CMCS. Yesterday, the CMS Administrator, Chiquita Brooks-Lasure, will announced that Dan Frye become the next director of the Center for Medicaid and CHIP Services.

Many of you know and have worked with Dan in his role as Assistant Secretary for Mass Health and the Medicaid Director in the Commonwealth of Massachusetts and know he has extensive experience across Medicaid, Medicare and work with stakeholders to design and implement innovative models of health care coverage, delivery and payment.

Dan officially begins at CMS on July 6th. Until Dan's arrival, I will be transitioning back to my permanent role of Deputy Center Director of CMCS. It's been truly a great privilege to collaborate closely with you all as the Acting Director of CMCS. But I look forward to welcoming Dan and working closely with him and you all to better serve the individuals who rely on Medicaid and CHIPS for health coverage.

With that, I'll turn things over to Jen to start her presentation. Jen?

Jen Bowdoin: Thanks, Anne Marie. And hi, everyone. This is Jen Bowdoin. I am the Director of the Division of Community Systems Transformation in the Disabled and Elderly Health Programs Group in CMCS. It's nice to talk with you again today.

As Anne Marie mentioned, I'm going to address some of the questions we've been getting related to Section 9817 of the American Rescue Plan.

Before I get to those, so I wanted to remind any states that have requested a 30-day extension that the Initial Funding Plan and Narrative is due on July 12th. And those funding plans and narratives, as well as any questions you have, can be submitted to the dedicated mailbox that we have for Section 9817. And that email addresses is HCBSincreasedFMAP@CMS.HHS.gov.

Also, just for awareness, we answered a number of questions that we believe related to Section 9817 on the last All-State Call. If you weren't on the last call, which was on June 8th, or you would like to review the questions and the answers, again, the transcript and audio recording are available on CMS.gov.

We are continuing to make our way through the many questions we have received related to Section 9817 and appreciate your patience as we respond to them. We are trying to get through them all as quickly as possible.

So, I'm going to head on to a handful of things that have been coming up quite a bit in the questions that we've received.

So, the first question I'm going to address has to do with the requirement to expend the funds by March 31, 2024. So, the question is, "Are states required to have fully-expended state funds equivalent to the amount of federal funds attributable to the increased FMAP by March 31, 2024, or is it sufficient for states who to have fully-obligated the funds by that date? Will funds obligated through grants, contracts, intergovernmental transfers or other state mechanisms count as spent?"

So, the answer to that is that states are expected to fully expend state funds equivalent to the amount of federal funds attributable to the increased FMAP by March 31, 2024.

However, CMS may provide states with a good-faith effort exemption if they can demonstrate that they've made a good-faith effort to comply with the requirement to fully expend the funds and have encountered unavoidable delays.

That extension, however, would not exceed one year, which would be March 31, 2025, and states would need to continue to meet requirements to maintain covered benefits, eligibility and payment rates, at least at April 1, 2021 levels. We will provide more more information on how to request a good-faith effort exemption and the expectations for states requesting an exemption in the future.

So, the next question has to do with the intersection between Section 9817 and the ACS settings requirements. So, the question is, "So, does the provision in the SMDL that requires states to preserve covered ACS, including the services themselves and the amount, duration and scope of those services in effect as of April 1, 2021 prohibit states from implementing efforts to support compliance with the home and community-based settings, regulatory criteria, Olmstead implementation or other rebalancing activity?"

So, the answer to that is no. This language in the SMDL should not be interpreted to prevent evolution that at the HCBS provision to enhance individual autonomy and community integration in accordance with the home and community-based settings criteria, Olmstead implementation or other rebalancing efforts.

For example, if states are reducing reliance on a specific type of nonresidential facility-based service in increasing beneficiary access to non-residential services that are more integrated into the community, CMS will not interpret such action as conflicting with the requirement to preserve covered ETS.

They should be clear with stakeholders as well as in their submission to CMS of required ARP Section 9817 spending plans and narratives and any resulting waiver and state plan amendments about how these changes enhance the availability of integrated services in the specific waiver or state plans, and offset any reductions in previously-covered services in compliance with the home community-based setting criteria or other efforts to increase community integration.

So, the next question has to do with actions that would violate the requirements to maintain covered benefits, eligibility and payment rates. So, the question is: "If a state (submits an) action for approval prior to April 1, 2021, that would violate the requirements to maintain covered benefits, eligibility and payment rates at April 1, 2021 levels, will CMS deny the request on that basis?"

The answer to this one is dependent on whether or not the action requires retrospective or prospective approval. In instances where the approval can only be prospective in nature, CMS cannot approve the action without causing the state to be in violation of the requirement to maintain covered public benefits, eligibility and payment rates.

We will flag these issues to the state's awareness and work with the states to determine how to move forward. And this will often be the case with actions in the section 1915(c) or 1915(I) application.

If the approval results in effective date on or before April 1, 2021, CMS can approve the request if it satisfies all other requirements for approval because the change will establish a baseline for April 1st.

So, the next question has to do with Factor-C decreases. So, the question is: "Some 1915(c) HCBS waivers have waiver spots not occupied by waiver enrollees. Can a state decrease the number of those empty, unduplicated slots for those Factor-C, which identify the total number of individuals to be served annually in the 1915(c) HCBS waiver?"

The answer to that question is no. This would be a violation of the requirement to maintain eligibility standards and as of April 1, 2021, by constricting the number of slots available in the state to individuals wishing to access HCBS.

CMS further clarifies that at the time a 1915(c) waiver is renewed, states must, at a minimum, incorporate the same methodology used in the previous authorized waiver or use CMS 372 data to project waiver slots through March 31, 2024.

The next question has to do with actions to enhance state IT systems. So, the question is: "If a state wants to use the enhanced FMAP to improve IT systems that support HCBS services, will an IAPD be required?"

An Advance Planning Document, or APD, is not required. However, there is an enhanced match available should the state elect to submit an APD. Approval for enhanced match requires the submission of an APD. A statement may submit a APD request - requesting approval for a 90/10 enhanced match for the design, development and implementation of their Medicaid Enterprise

Systems. Interested states should refer to 45 CFR, Part 95, Subpart F Automatic Data Processing Equipment and Services Conditions for Federal Financial Participation for specifics related to APD submission.

States may also request 75/25 enhanced maps for ongoing operations of CMS-approved systems. Interested states refer to 42 CFR, Part 433, Subpart C, Mechanized Claims Processing and Information Retrieval Systems for the - Related to Systems Approval. If there are any further questions related to these topics, we encourage the state to contact their Medicaid Enterprise Systems State Officer.

And then, the last question I'm going to answer today has to do with the scope of claiming for Section 115 Demonstrations. So, the question is: "Does the enhanced FMAP for ACS services in Appendix B apply when those services are provided to Medicaid populations authorized under a Section 1115 demonstration?"

The answer to that question is that states can claim the increased FMAP for all Medicaid expenditures for the qualifying services listed in the Appendix C for services provided to individuals eligible under a Section 1115 demonstration. We will work with states on Section 1115 demonstrations, budget neutrality and other implications.

And with that, I'm going to hand the call back to (Jackie). (Jackie)?

Jackie Glaze: Thank you. Thank you so much, Jen, for your presentation. We'll, now transition to Ryan Shanahan, and he will provide information on the rate increases to account for vaccine time. Ryan?

Ryan Shanahan: Great. Thank you, (Jackie).

So, my name is Ryan Shanahan, and I'm with the Division of Long-Term Services and Supports, and I'm going to give a brief overview of how states can use the Appendix K authority to increase 1916(c) service rates to account for time needed for direct service professionals to receive their COVID-19 vaccinations.

So, states have been using the Appendix(k) authority to temporarily increase rates to help compensate providers for increased costs due to the pandemic - that's just cost needed for PPE.

This authority can also be used to temporarily increase rates to account for the extra time offs needed for providers' employees to receive the COVID vaccine. These increases can be retroactive and/or time-limited and can not exceed six months after the end of the Public Health Emergency for COVID-19.

In order for providers to be eligible for the increase, states can require that they document that their employees received the vaccine and/or are scheduled to receive a vaccine. And they can also include any other stipulations in order for providers to receive the increase.

So, next, I'm going to go ahead and walk through an example of how states can increase their rate by adjusting their full-time equivalent factor to account for vaccination time.

Next slide, please. So, the full-time equivalent factor is the component of a rate methodology that accounts for the time an employer is unable to bill for direct services due to vacation time, personal days, sick time and/or holidays taken by their employees.

How would this typically be calculated and incorporated into an hourly rate? Let's say, for example, the state determines that 360 hours are needed for an employee's vacation, personal, sick or holiday time each year. To calculate the FTE, they would divide 360 by the total work hours in a year, which is typically calculated at 2080 hours, or 52 weeks times 40 hours a week.

This would then yield an FTE factor of 0.17. That factor would then be a multiplied by the base wage -which, in this instance, in our example is $20 per hour - to give an actual dollar amount of $3.40.

So, that dollar amount is then added to the $20 base wage and any other cost factors included in the rate methodology, such as administrative costs or benefits, to give a final hourly rate paid to providers.

Next slide, please. In order to increase the rate to account for vaccination time, states can increase the FTE factor based on the number of hours needed for vaccination and recovery. For example, if two vaccine doses are required, the state may determine that four days of additional sick time are needed - one day for each dose and one day to recover after each dose.

This results in an additional 32 hours of time that was not included in the original FTE calculation, increasing the total time to 392 hours, which, then, is similar to the previous example. The state would divide by 2080, which is the total work hours in a year to give a new increased FTE the factor of 0.19. And that's increased from 0.17 from the prior example.

So, following the same process as before, the state would multiply the new FTE factor of 0.19 by the base wage, $20 per hour, giving a new dollar amount of $3.80, which is a 40-cent increase from the previous calculation.

And that then gets added to the base wage, and any other cost factors and rate methodology, to give us our increased final hourly rate.

Next slide, please. A (subsistence) document, temporary rate increases to account for vaccination time, in Section K2(f) of their Appendix K application. And when doing so, this should include the percentage of the rate increase, the purpose of the rate increase - which in this case would be to account for vaccination time - the factors and assumptions that were used to determine the amount of the increase - so the hours that the state determined would be needed in order for service professionals to receive the vaccine and to recover from the doses.

They would also include the services and/or provider types affected, as well as the effectiveness of the rate increase as they differ from the effective dates for the overall Appendix K, and any conditions that either direct-service providers or or their employers and providers must meet in order to receive that rate increase.

So, this could include, for example, any documentation requirements that providers must maintain to verify that their employees actually received the vaccine or are scheduled to receive the vaccine.

So, I think with that, I will now hand things back off to (Jackie). Thank you.

Jackie Glaze: Thank you so much, Ryan. Appreciate your presentation. So, now we're ready to move to the Q&A session, so we'll begin taking your questions, as we have in the past. We'll start taking questions through the Chat function. So, you can start sending those questions now. I just see one, as we're talking. And then we will follow up, taking your questions over the phone line. So, with that, I'll turn it to you, (Ashley).

Ashley Setala: Great, thanks, (Jackie). So, the first question that came in said, "Can you repeat the point that you made on (waiver slots)?"

Jen Bowdoin: This is Jen. So, I think the questions have to do with the Factor C (decrease), so I'll repeat the Q&A, and if that's not the question that folks are looking for, just I guess put it back in the Chat and we'll clarify.

So, that question is: "From 1915(c), HCBS waivers have waiver slots not occupied by waiver enrollees. Can a state decrease the number of those empty, unduplicated slots, which identifies the total number of individuals to be served annually in the 1915(c) HCBS waiver?"

And the answer to that is no. This would be a violation of the requirement to maintain eligibility standards approved as of April 1, 2021 by constricting the number of slots available in the state to individuals wishing to access HCBS. So, the question is - that is being asked - is, can the state decrease the number of empty, unduplicated slots so they can implement a Factor C decrease? And the answer is no, because that would decrease access to HCBS for individuals who would like to access HCBS.

And just, there's a little bit of addition on that. So we are further clarifying that at the time a 1915(c) waiver is for new states must, at a minimum, incorporate the same methodology used in the previous authorized waiver or use CMS 372 data to project waiver slots through March 31, 2024.

Ashley Setala: Great. Thanks, Jen.

It looks like that is the only question that has come in through the Chat. Actually, here, it looks like we have another one that just came in. And it says:

"Does CMS plan to release updated guidance on renewal processing posts PHE? Will states be given 12 months to evenly distribute renewals that were postponed during the PHE?"

Jessica Stevens: Hi, this is Jessica Stevens. And yes, we are working on guidance that incorporates a lot of the feedback that we've received from states, and that should be coming out very soon, including not only renewals, but some of the other eligibility and enrollment - eligibility and enrollment actions that states have talked to us about. And hopefully that will address many of the concerns that states have already raised to us. No more additional detail at the moment, but hopefully, in the next few weeks we'll be able to talk through that in more detail.

Ashley Setala: Thanks, Jessica. The next question says: "Some of the activities and spending plan budgets will be eligible for administrative claiming. Are states to reflect the budget amounts for activities before for administrative claiming, or based on after-projections? In other words, should we budget funds attributable to ARP FMAP estimated at 50% for those activities eligible for admin claiming.?"

Jen Bowdoin: So, I would suggest the states indicate specifically what portion of the ARP, the state funds that are attributable to the increased FMP that they indicate specifically what amount of that will be used. And then, it's also helpful for us to know if the state is claiming additional match. And so the state needs to kind of indicate, you know, that if the total cost of a project is $1 million, but they're using $500,000 of the funds attributable to the enhanced match in their spending plans.

That's helpful for us just to know so we kind of fully understand how the state is paying for. And it does allow us also to ensure that we're kind of tracking things appropriately and that we're communicating with other groups that, for instance, may need to review - and this may not necessarily be applicable here - but like a waiver request or something else.

So, it is helpful. So, to see it can also kind of include specific numbers to say, "This is how much we're using for this," it's going - the total cost is going to be $1 million, but we're only using $500,000 since we're drawing down a federal match for it. You know, that, I think, is helpful for us. So, we would encourage states to do that.

Ashley Setala: Okay, then the next question says: "Can a state choose to accept the enhanced FMAP on a subset of the service categories described in the May 13, 2021 SMD letter?"

Jen Bowdoin: We have received that question, and we are working on responding to it and hope to have an answer to that question soon.

Ashley Setala: Okay. Then we have a question that says: "Does CMS have any insight as to an ETA on the end of the PHE? Is there any update on this beyond the letter to Governors that indicated the Public Health Emergency is likely to run through 2021?"

Jackie Glaze: (Ashley), this is (Jackie). I'll take that one. We don't have any additional information, this is information that we still have. And and as soon as we know more, we'll certainly update the states and territories.

Ashley Setala: Thanks, (Jackie). It looks like those are all of the questions that have come in through the Chat.

Jackie Glaze: Now, while we're waiting for additional questions to come through the Chat, we'll check the phone lines. Christy, can you give instructions to the participants to submit their questions?

Coordinator: Yes. If you would like to ask a question, please, press Star-1 on your phone. Please make sure that your phone is unmuted and state your name clearly when prompted. Again, that is Star-1 to ask a question. I have a question from Judy Moore Peterson. Ma'am, your line is open.

Judy Moore Peterson: Thank you. Can you hear me?

Coordinator: Yes, we can.

Ashley Setala: Yes, we can hear you.

Jackie Glaze: Yes, we can.

Judy Moore Peterson: Thank you. Hi, this is actually not a question. This is a thank you. Thank you to Anne for stepping in as the Interim Director. What a what a huge job to take that on. And so, grateful for your leadership during this really challenging time. I'm looking forward, of course, to working with with Dan, but I would be remiss if I didn't take the opportunity to say thank you. Thank you for your leadership.

Jackie Glaze: Judy, I think Anne Marie had to step away, but we'll certainly pass on your appreciation of her. Thank you for that.

Woman: Yes, that's done.

((Crosstalk))

Judy Moore Peterson: Thank you, (Dottie). She's done a fantastic job. Really appreciate Anne Marie's leadership.

Coordinator: I have no further questions in the queue.

Ashley Setala: Okay. We have a couple of other questions that have come in through the Chat. The first one is on changes in circumstances and renewals after the PHE ends. And it says: "For states that have been maintaining coverage in accordance with the FFCRA, would changes in circumstances reported during the PHE be considered inconsistent information if at renewal, following the PHE, the changes do not appear on a renewal form?"

Jessica Stevens: This is this is Jessica again. Maybe let me talk through what the process would be. And maybe we can follow up if there's more. I"m not sure it would necessarily be inconsistent information. But we did note in the guidance that states have the option to account for changes in circumstances at the point that the state completes the renewal after the end of the Public Health Emergency.

I think what you're referring to, likely, is a situation where state does an ex-parte renewal for an individual after the Public Health Emergency, and the change that the individual might have reported, say in June of 2021, does not come up as part of that ex-parte renewal.

We would expect in those circumstances that the state either act on that change in circumstance separately, prior to their renewal within the unwinding period, or account for that change when the state completes the renewal.

So, that would be information that is known to the state that the individual reported. And therefore, when the state completes the renewal, it should account for that information, along with whatever might be available in the record, or more recent data sources when conducting that renewal. If there's a followup, kindly let us know, or we'll also have to follow up offline, if I didn't answer.

Ashley Setala: Okay , thanks, Jessica.

We have a question that says: "Is there an update on when CMS will issue guidance related to the 12-month extended postpartum coverage permitted under the ARP Act?"

Jessica Stevens: This is Jessica again. And we are actively working on that guidance at the moment. And, you know, we don't have a concrete update at the moment in terms of timing, but we have received a number of questions from states that have been helpful in ensuring that, as we develop our guidance, that we're answering, - addressing - many of the issues that states have.

In the event that many states have specific questions that you're thinking through, or even if it's not a question as much as a statement or a proposal, we are very happy to hear those and can make - even if we don't have an immediate answer - we'll make sure that as we continue to develop and finalize the guidance, that we will address those concerns when we do.

Ashley Setala: Okay, great.

Then we have a question that says: "Is the report due on July 15th?"

Jen, I think this may be a question for you.

Jen Bowdoin: I'm not sure if this is asking about the Initial Spending Plan and Narrative. If it is, the Initial Spending Plan and Narrative for states that request and accept an extension to the deadline, that first one is due on July 12th. It's - I'm not sure if that's answering the question, though. So, is the person asking, then - if that isn't answering your question, maybe just clarify in the Chat what you're looking for.

Ashley Setala: Thanks, Jen. It looks like that is all that has come through the Chat right now.

Jackie Glaze: Yes, so we'll circle back around to Christie. Christie, could you open up the phone lines to see if we have any questions there?

Coordinator: We do. Our first question comes from Diane Hess. Ma'am, your line is open

Diane Hess: Hi, this is Diane Hess for Delaware.

I think this is a follow-up to the question that you just asked. In the 513 SMDL, the first quarterly report is due 75 days before October 1st, which is July 15th. So, we were just wondering if there was any updates on that. If you even approved a spending plan, it probably wouldn't be for a few days before that 715 date. So, it's looking for updates and spending in that first quarterly report, which appears to be due soon. So, I was just wondering if there was any updates on that.

Jackie Glaze: We will up with the states that have submitted spending plans and narratives to let them know when their first - their next quarterly submission is due. In some cases, we may need additional information from states have submitted them. And so, some states, obviously, some states will get approval before

others. And so, we will follow up with states to confirm when the next one is due.

Diane Hess: Okay, thank you.

Coordinator: Our next question comes from Eve Lickers. Your line is open them.

Eve Lickers: Thank you. I'm calling from Pennsylvania, and I was calling because we have a question related to the requirements for the Medical Care Advisory Committee participation requirements under 42 CFR 431-12.

And we appreciate that this was partially addressed in the FAQs, but we - as we're looking at, I guess, some of our possibilities for having in-person meetings, we were also looking at whether or not we could have, say, the Committee Members and the State support staff meet in person and then have the audience meet, I guess, remotely.

And although I know that the FAQs give us some some alternatives, it seems to be that basically you would provide something consistent, or that anybody would have access to any of the alternative formats that you might use.

The - what we're proposing is, is that essentially it would be one group that would be in person, and another group would be remote. And so, we were just calling to get CMS' position on that.

Ashley Setala: Jen, can you respond to that?

Jen Bowdoin: I don't think that's specific to 9817. Is that a question about 9817? I'm under the impression it's about something else.

Woman: Oh.

Jen Bowdoin: I think that this is about one of the early FAQs that we released during the PHE, and I'm guessing we may not have the appropriate person on the phone to answer today, so we may need to take that offline and do a little bit of research and follow up.

Woman: Okay, thank you.

Coordinator: At this time, we have no further questions.

Ashley Setala: So, it looks like we have another question that has come through the Chat, and it says: "Can you please confirm that states must meet the MOE requirements for the period in which the state is spending the money. If the state expanded funds before March 31, 2024, the state would no longer be under MOE after the date at which the funds were expended, correct?"

Jen Bowdoin: Yes, that's correct. So, the state has to meet those requirements until the funds are fully extended. But if a state has fully expended the funds prior to that date, they're only required to meet those up until the point at which they basically spend them.

So, for example, state fully expended the funds by March 31, 2022, they only have to meet those requirements until March 31, 2022, not 2024.

Ashley Setala: Okay, thanks.

It looks like that's all that's in the Chat at this point.

Jackie Glaze: So, we'll check the phone lines one more time, and I think that might be the questions for today. So, Christy, can you - if we have any additional questions?

Coordinator: A reminder, if you would like to ask a question, please, press Star-1. Please ensure that your phone is unmuted. We have another question from Diane Hess. Ma'am, your line is open.

Diane Hess: All right, one more question on the MBES claiming. I know that you guys are working on updating the 64-9. Is there any additional guidance you might have about what that would look like? Is it still you have to wait for your spending plan, and then, sometime after that, you'd be able to claim?

Rory Howe: Good afternoon, Diane. This is Rory Howe.

So we are still working on updating MBES and the Form CMS 64, and we do plan to provide more instructions to states about the timing - that ties into the timing of the spending plans as well. But at this point - and I don't know, Jen, if you have anything to add, but the expectation is that that the reporting on the CMS 64 would take place after, and the spend plans are approved.

Jen Bowdoin: Yes, I don't I don't have anything to add other than the states can't start claiming the increased FMAP until the spending plan is approved.

Diane Hess: Okay, great, thank you.

Coordinator: I have a question from (Kendall Chite). Your line is open.

(Kendall Chite): Hi, yes, my question as regards to (unintelligible) show permits from, (unintelligible). When we are putting the population of those that we are able

to close at the end of the PHE, those within the six months who were sent the enclosure notice and those outside who we have to send through a redetermination to get the recent reliable information, how long do we have to send that group of population that do not - that we are not allowed to close, so we have to send through the redetermination?

Do we have to do all of those within a certain timeframe once the PHE ends?

Jessica Stevens: This is Jessica, I think you were breaking up just a little bit at the beginning, so I think I misunderstood. Do you mind restating your question, please?

(Kendall Chite): Sure. So, those at the end of the PHE, there's going to be a group of population that we cannot close, that we'll have to do a redetermination on. How long do we have to do that redetermination?

Jessica Stevens: Got it. So, based on the guidance in the in the show letter that we issued in December, it is six months to complete all of that work. So, it is six months to complete all outstanding redeterminations, verifications and changes in circumstances; less time for application. And so, that would apply in this situation as well.

I did note earlier that, you know, we are working to help states sort of figure out some of the timelines associated with some of those, based on the guidance that we issued in December, six months.

(Kendall Chite): Thank you.

Jessica Stevens: Sure.

Coordinator: Here at this time, we have no further questions.

Ashley Setala: Thank you, and we - I'm not seeing any additional questions through the Chat line as well, so we'll close a little bit early today.

So, I'd like to thank Jen and Ryan for their excellent presentations and the information that they've shared today.

Looking forward, we will meet with you again on July the 13th. The topic and invitation will be forthcoming. If you do have questions before the next call, please feel free to reach out to us, your state leads, or bring the questions to the next call. If you'd like to pre-submit a question for the next call, for the open Q&A portion of the call, you can email it to MedicaidCOVID19 - all one word – at CMS dot HHS dot gov by 1:00 pm Eastern Time on the day of the call.

We thank you for your participation today and hope everyone has a great afternoon. Thank you.

Coordinator: Thank you. This does conclude today's conference, you may disconnect at this time. Thank you. And have a good day.

End