Centers for Medicare & Medicaid Services
Medicaid and CHIP All State Call
October 26, 2021
3:00 pm ET

Coordinator: Welcome and thank you for standing by for today's conference. All participants will be in listen-only mode until the question-and-answer session. At that time to ask a question from the phones please press Star 1. Today's conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the call over to Jackie Glaze. Thank you, and you may begin.

Jackie Glaze: Good afternoon and welcome everyone to today's All State Call In Webinar. I'll now turn to Anne Marie Costello, our Deputy Center Director and she will provide highlights for today's discussion. Anne Marie?

Anne Marie Costello: Thanks Jackie and hello everyone and welcome to today's All State call. We have a couple of topics to cover on the call today.

First, Melissa Harris from our Disabled and Elderly Health Programs Group will provide an overview of the state health official letter providing guidance to states about the statutory requirements for states to cover COVID-19 related treatment without cost sharing and Medicaid and CHIP. This letter was released last week.

After Melissa's presentation we'll hear from Julie Boughn from our Data and Systems Group and a special guest, Ruth Kennedy. You all know her as a former Medicaid Director of Louisiana. And Julie and Ruth will talk about the Medicaid and CHIP telework playbook that we released as a resource for states last week.

The playbook provides states with examples of how organizations have adapted to the shift to telework during the COVID-19 public health emergency that allowed them to maintain their work capacity, to continue to provide essential services during emergencies, office closures and other unforeseen events that limit in-person work.

After Julie and Ruth's presentation we'll open the lines for your questions. We'll use the Webinar for both presentations and the open Q&A session at the end of today's call. So if you have not logged in yet please go to the Webinar platform. I suggest that you do that now. With that I'll turn things over to Melissa to start her presentation. Melissa?

Melissa Harris: Thank you Anne Marie. And so I'm going to provide a walkthrough of a couple of slides talking about a letter to state health officials that we released last week. And that letter was on coverage mandates in the American Rescue Plan Act for the treatment both of COVID-19 itself and for conditions that might seriously complicate the treatment of COVID-19. And we'll walk through all of these together.

As you can see on this first slide that we have the statutory citations of the new sections in Title XIX and Title XXI that were added based on the - or added from the American Rescue Plan for these treatment mandates. These mandates became effective on March 11, 2021. And like all other of the coverage mandates in the ARP they end on the last day of the first calendar quarter beginning one year after the last day of the COVID-19 emergency period.

And I'll also flag that individuals in the optional COVID-19 group, the group that CMS used to refer to as the COVID-19 testing group, are also covered by

these mandates. But it's important to note that they are only covered until the last day of the COVID-19 emergency period.

We can go to the next slide, (Ashley). So let's talk about the first component of the coverage mandate. So both state Medicaid programs and separate CHIP programs are required to cover without cost sharing what you see on the slide. COVID-19 treatments, including specialized equipment and therapies, and that includes preventive therapies.

And then also is a condition that might seriously complicate the treatment of COVID-19. There are some distinctions about the scope of these coverage mandates and we will get to those in later slides.

We can go to the next one (Ashley). So the treatment for COVID-19 itself is composed of two sections. One is non-pharmacological items and services and the other is pharmacological drug and biological services.

The first sub bullet here is the non-pharmacological items or services. And this has a very broad scope attached to it. And here you see that coverage mandate in the ARP really means that any service, non-pharmacological item or service, that could be covered under 1904(a) of the Social Security Act is a required component of this mandatory coverage for the treatment of COVID-19.

And you'll note this is very similar to the coverage mandate for individuals under the age of 21, the EPSDT Early and Periodic Screening Diagnostic and Treatment provisions, that also requires the provision of any medically necessary 1905A benefit. And that's for the non-pharmacological component of the coverage mandate for an individual who has COVID-19.

The second component is any drug or biological that is approved or licensed by the FDA or authorized by the FDA under an emergency use authorization to either treat or prevent COVID-19 consistent with its applicable authorization.

We can go to the next slide. So you'll see in the letter that services that could be used to treat COVID-19 that might already be reflected in a state to state plan those services might have hard limits on them. A state could have a hard cap on the amount, the duration or the scope of a service.

Those limits can remain in the state plan but they have to be removed in practice when a service is being provided for the treatment of COVID-19. So you can see here the last section of that - or the last sentence of that first bullet the state should not apply these limits when the item or service is covered under the ARP amendment because it is needed to treat or prevent COVID-19.

If the state doesn't already cover non-pharmacological items and services to treat COVID-19 you now as a state need to add that coverage for the treatment of COVID-19 as part of these ARP coverage mandates. That's not to say though that states are not allowed to implement utilization management controls. States can still do that including when an item or service is provided for the treatment of COVID-19 as long as those utilization management techniques are not done in a way that establishes an unnecessary barrier to accessing coverage.

Next slide (Ashley). So the second component of the treatment mandate, or the coverage mandate, is treatment for a condition that might seriously complicate the treatment of COVID-19. You'll see here though that the scope of this benefit is not quite as broad as the scope of treatment to treat COVID-19 itself.

The mandate here is for items and services that the state already covers under its state plan and those items and services would represent the treatment mandate for the treatment of a condition that might seriously complicate the treatment of COVID-19. And there's some specific language on the slide and in the letter itself about the period of time that this is a mandate. It's during the period when an individual has or is presumed to have COVID-19.

And again the scope of the mandate is only those items and services that the state already covered under the state plan as of the date of enactment of the ARP which is March 11, 2021. And you see here and again in the letter some examples, but certainly a non-exhaustive list, of comorbidities or conditions that could seriously complicate the treatment of COVID-19.

Next slide. So, you know, a state will need to make a determination about when an item or service is being provided for the treatment of a condition that could seriously complicate the treatment of COVID-19. And again cost sharing is prohibited on services provided in that context as are hard limits on the amount, duration and scope. But again utilization management controls are allowed to be included.

Next line. The letter provides some logistical or technical guidance on the submission of state plan amendments for both Medicaid and CHIP. There will be the issuance of some additional information around SPA submissions. CMS as always is available for technical assistance.

Given the breadth of some of these treatment -of the coverage mandates states will likely need to add something to their state plan even in the form of an attestation. So more information is coming on the content and the format of submitting an amendment to the state plan but please contact your state lead if

you have any questions immediately or would like to have technical assistance.

Next slide please. Okay, I thought that was it for me. So I'm going to wrap up and turn this back over. Thank you.

Jackie Glaze: Thank you Melissa. So now we'll transition to Julie Boughn and she will start her presentation on the Medicaid and CHIP telework playbook. Julie?

Julie Boughn: Thank you Jackie. So my name is, as Jackie said, I'm Julie Boughn. I'm the Director of the Data Assistance Group within CMCS.

And if you can remember back to around April of 2020, as pretty much the entire country was holing up and moving towards telework, the NAMD, and the National Association of Medicaid Directors, reached out to us and asked if there was anything that we could offer in the way of suggestions, or guidance or advice to states about embracing telework and using it effectively to keep their operations going during the pandemic, which I think we all thought would be much shorter than it has turned out to be.

That conversation led to this playbook. And although we truly say, as Anne Marie mentioned at the beginning, that this is not an area in which we would typically offer advice we do think the playbook offers a great set of resources in one place of the things to think through as you consider when and how to use telework especially to enhance your resilience in emergencies.

I want to emphasize again it's neither guidance nor requirements it's merely meant as a resource. The playbook was developed in conjunction with our partner from the Innovation Acceleration Program, IBM Watson Health. And

the primary author on that team was former state Medicaid Director, Ruth Kennedy.

I'm really pleased that Ruth was able to join us today to walk you through the major content areas of the playbook. Ruth, can I turn this over to you now?

Ruth Kennedy: Yes, thank you very much Julie. When we were looking and thinking about the format for the playbook we recognized that the skill sets on the team for Medicaid and CHIP programs would be very different for the planning and the ongoing operations of telework both in the event of an emergency, like we have all been going through, as well as telework for other reasons. You've got the human resource folks., the ongoing operations, training is a very big part of it -- those would maybe the different folks -- IT support and acquisition.

So we did plays. And we've got six main areas that we focus on. And the first one is just the planning process. And we talk about - we identified the benefits of telework. And they really fall within three buckets that we identified benefits for the employees, for the agency and for the community.

So it's important we lay those out what those are. But you know the goals that you wish to achieve because that's going to inform a lot of what comes after. Interestingly early telework very much was looked at from the community standpoint of avoiding cars on the road, that kind of thing. So I mean that's just one example of a community benefit.

We think it's important to recognize going in with your eyes wide open and know that there are some associated risks with telework. And that knowing those upfront you can have a plan for mitigation.

And when we look at the organizational and cultural change aspect because this very much for agencies, for offices that have it where telework is not - hasn't been really hardened it can be challenging. And we conclude this play by thinking about the inevitable questions that you'll likely be asked to answer downstream about to justify continuing telework or ending telework and how to plan early and often for evaluation and assessment.

Next. Next slide. So in play two we focus on the written telework policies and written agreements. We've got just a compendium of suggested policy topics that you may not have thought about for your written policy.

Customer service is of course an important consideration for Medicaid and CHIP agencies. We talk about not only our Medicaid and CHIP enrollees, applicants, the general public but also internal customers which would be other agencies, providers, our vendors. And then even another kind of our internal customer is coworkers.

We talk about and give examples of how you could set an expectation for employee accessibility and communication. And then the part that's very customized and individualized is written telework agreements with individual teleworkers and we include possible content for those are written agreements.

Next. We talk very much TW circa September 2021 and beyond is supported by different applications and technology that frankly did not exist in 2007, 2008 when we were pioneering telework on a wide scale in Louisiana, Medicaid and CHIP. The tools that are all there for document sharing, for video conferencing, instant messaging and chat applications were a long way from the days when email was the primary way of being able to communicate.

Of course we are, state and federal agencies are very much vulnerable and need to think about the security whether it is with equipment lost, or malware or breaching our systems. And then we talk about different examples that are out there for ongoing IT support for telework. Much of that first line support being online types of applications, self-service.

Next. Probably no one is impacted by telework more than the supervisors, the first line supervisor or the manager. The need to, as we say, measure productivity rather than preference. There's no line of sight, physical out of sight like there was when a person was working in the bricks and mortar office.

And this is a change for managers and it's important to recognize that we talk about choosing the most appropriate communication tool whether it's synchronous or asynchronous depending on, you know, the type of communication. And about setting expectations for responsiveness so that both the employee who's teleworking, the supervisor who may or may not be teleworking themselves, they know what those expectations are and go in with their eyes wide open.

Next. We' talk about the importance of the different, we call them telework supports, that the value of pilots and trial periods. Think of it as small scale testing so that you can get the kinks out. It's - has been very effective for telework.

The - even though someone is working remotely there's still the need for collaboration and teamwork. And we talk about ways to build that sense of team.

And training is such an important aspect. We've identified many training resources out there and we talk about the the variation in training. Every employee in the agency needs some training because if one employee is teleworking, you know, in fact it really impacts everyone.

Then a different training for people who actually are teleworking from a remote location. And then manager training. And then we have suggestions for maintaining worker engagement.

And then last we get back to where we started and that is telework in an emergency. In this case it was the pandemic but we talk about planning for telework in future emergencies. That may be your only use of telework or you could have all different policies and procedures that an emergency could trigger.

Waivers of certain policies or training. The alternative assigned task could be determined in advance. And we talk about that. Use of personal devices would that differ in an emergency?

One good assumption, which was just reinforced for us with the Hurricane Ida, is assume that communications are going to be very much compromised. And so thinking about how you could have things already predetermined on Web sites maintaining that continual state of readiness for telework in emergencies we have a checklist and suggestions for how you can do that. And so that is just a quick look at the six plays that we have.

Julie Boughn: Thank you Ruth. I'm gonna turn it back over to Jackie I think.

Jackie Glaze: Yes, thank you Julie and Ruth for sharing the resources to support telework. It was very helpful today. So now we're ready to take the questions from the

participants about today's presentation or any general questions that you may have.

So we will begin by taking your questions through the chat function. I do see couple questions now. So please submit your questions and then we will follow by taking your questions over the phone line. So, (Ashley), I'll transition to you.

Ashley Setala: Okay, thanks Jackie. So the first question that was submitted is around the expiration of the public health emergency. And it says, "With the recent extension of the public health emergency does CMS foresee continuing with this extension for the complete 90 days until January 16, 2022 or will states be receiving the 60 day notice any time soon?"

Anne Marie Costello: So (Ashley), it's Anne Marie Costello, maybe I'll jump in. We don't have any specific information about the end date of the public health emergency. We do know that the Department of Health and Human Services is committed to giving states 60 days advance notice.

But we do not know when that would be. So there's no reason to believe that you would not get the advance notice I mean that is a commitment that went out in a letter to states in January.

Ashley Setala: Okay, thanks Anne Marie. Then it looks like we have a couple of questions that have come in around eligibility and enrollment. And the first one says, "Why is the SDX interface treated differently from PARIS? Why can we not terminate a member for being out of state based off of SDX even if we take the additional steps that we do for PARIS according to the guidance and CMS 9912?"

Amy Lutzky: (Ashley), this is Amy Lutzky from the Children Adults Health Programs Group. I think that is a question we are going to have to take back to the team.

Ashley Setala: Okay, thanks Amy. The next question says, "For cases where," well, so this is an unwinding related question, and it says, "For cases where the state needs to make a disability determination and knows that the individual under review doesn't meet the disability criteria but the state could not close them due to the continuous coverage requirements under SFCRA will states need to conduct a full disability review again for these individuals before their cases can be closed?"

Anne Marie Costello: So hi. It's Anne Marie Costello again. So unfortunately we do not have a team that is working on the unwinding policy on today's call. They had an unforeseen conflict. So we'll take that question and bring an answer to the best we can to our next off day call.

Ashley Setala: Okay. Then we have a question that says, "Can states expect a template for CHIP and Medicaid SPAs for the COVID-19 cost sharing requirement?"

Stephanie Bell: This is Stephanie Bell. I can jump in on that one and say that we are working on a template that will encompass all of the requirements, so the coverage, the cost sharing I think drugs too. So all those requirements that are encompassed in the guidance that we just put out and that Melissa talked through.

Ashley Setala: Okay, thank you Stephanie. The next question is related to the HCBS spending plans. And it says, "What is the reporting period for the first quarter ARP report that's now due November 1, April 1 through June 30 or July 1 through September 30 when most proposals were submitted?"

(Jen Bowdoin): Hi. This is (Jen Bowden). So - and we may need some clarification on the question. But the spending plans, you know, should update any information that the state included in the initial plans and should include information on, you know, any activities the state plans to implement.

So it's not just to sort of tell us what's changed but it's really just update, it should be a comprehensive plan that updates what was included in the initial plans. And to the extent that the state has not just, for instance, the estimated cost of the activity for plans to implement the actual cost information it should include that.

And then, you know, as the states actually claims for the increased FMAP they should, you know, update with sort of actuals on their expenditures as well. And if that didn't answer your question please just provide clarification.

(Ralph Lollar): (Jen), this is (Ralph), and I'll just jump in and say because we've seen some recently. If the states are getting approval in their - under a program or authority for expenditures back to April 1 they should be including that in this - in their quarterly report.

Ashley Setala: Okay, thanks (Ralph) and (Jen). The next question says, "Is there an update on COVID testing relative to medical necessity for tests not ordered by a provider or where it is for say attending a wedding or just for travel?"

Melissa Harris: So this is Melissa and I'll start and then I'll invite others from the Division of Benefits and Coverage to weigh in. In the letter that we released a couple of weeks ago now on the testing mandates in the American Rescue Plan we pointed states and stakeholders to CDC guidance for both the definitions of diagnostic and screening testing and the circumstances in which those diagnostic and screening tests would be recommended.

And so states are to be following those CDC recommendations as they couldn't be modified over time as learning about the evolution of COVID-19 progresses. So it's hard to say yes or no to whether a specific scenario would require a Medicaid provided, or Medicaid funded test.

But we reiterate the global specifications about being in alignment with the current CDC recommendations for when both types of testing is recommended is recommended. Kirsten Jensen or Michael Tankersley, would you add anything on to that response?

Kirsten Jensen: No, you did a great job. Thank you.

Ashley Setala: Okay great. The next question says, "Could CMS give a specific example of a non-pharmaceutical device necessary for the treatment of COVID-19?"

Melissa Harris: Michael, feel free to take this one.

Michael Tankersley: Yes, thanks everyone. It's Michael Tankersley. I think one example could be a ventilator for instance if an individual need a ventilator when they were admitted to an in-patient hospital.

Ashley Setala: Okay thanks. I think will acknowledge that we got a question submitted about returned mail that as Anne Marie mentioned our SMEs had an unforeseen conflict today so we will take that question back and follow-up.

The next question says, "Does CMS anticipate issuing guidance or a SPA template on the CAA mandate regarding coverage of costs associated with clinical trials between now and the end of the year?"

Melissa Harris: This is Melissa. And the answer to that is, yes. We have guidance that has been developed and is currently in our clearance process. And at least guidance on the provision itself and the parameters of the new mandatory service that is in effect January 1 to provide coverage of routine services that are, routine costs associated with participation in a clinical trial.

So I'll ask my DVC colleagues to weigh in from the SPA template side but issuing guidance on the provision is on our short list and we hope to have something issued to you as quickly as possible.

Kirsten Jensen: And this is Kirsten Jensen. And we are also concurrently working on the SPA pre-plan and getting that into clearance so that we can get that issued as well.

Ashley Setala: Okay great. Then we have another question for our Disabled and Elderly Health Programs Group. And it says, "Prior to the MAT mandatory SPA requirement counseling and therapy services for individuals receiving MAT for OUD were covered under rehabilitative services, 1905A13. At CMS's direction we are moving counseling and therapy for individuals receiving MATs for OUD to the new Item 29 consistent with 1905A29. Does the enhanced FMAP described in ARP Section 9817 for these services apply to those services that will now be covered under the mandatory requirements in 1995A29?"

Melissa Harris: So this is Melissa. (Jen), why don't you go ahead?

(Jen Bowdoin): Yes, and so I was just going to say that we are aware of that question and we are talking internally about it, And I think that we'll have to follow-up with the state. But Melissa if you want to add more please feel free.

Melissa Harris: You know, the only thing I was going to say is that, you know, we recognize that over time, and sometimes in the not so distant past, decisions have been made that a - that coverage for a particular service or for a particular condition has generated guidance that has directed states to cover a particular activity under a particular benefit category.

And sometimes those categories don't neatly line up with the definition of home and community based services in the American Rescue Plan for purposes of the enhanced 10%. So we're aware of that. You know, it is often a conversation about where does coverage for that particular intervention really belong.

And so I understand the state saying I used to cover it here and if I had left it here I would have been eligible for the 10% and now I took it out of a category that is eligible for the 10% and I might no longer be able to receive the enhanced FMAP. We acknowledge that could be the reality in a couple of different scenarios.

This really is an exercise in determining not just temporarily for the for purposes of receiving an extra 10% on HCBS but really in the long term where does coverage for a particular intervention lie in the 1905A rubric? So we will provide the best technical answer that we can give you but just wanted to acknowledge that this is on our radar screen as a result of some relatively recent and a little more long term guidance about where coverage really goes in a particular benefit.

And we understand that might be generating some frustration but we're happy to walk through all of the technical reasons about why decisions were made about where coverage really belongs. Thanks.

Ashley Setala: Thanks Melissa. Well we'd like to now move to the phone lines. So the operator will you please provide instructions for the participants to register their questions and then we'll see if we have any questions there.

Coordinator: Thank you. And at this time for your phone questions please press Star 1. Please unmute your phone and clearly record your name at the prompt. To withdraw your request please press Star 2. One moment please for questions to come through. Once again at this time for phone questions please press Star 1. One moment please. Our first question is from (Renee). Your line is open.

(Renee Moller): Oh, hi. Thanks so much and thanks for the information. So this is (Renee Moller) with California. So I do have a quick question.

Do appreciate the guidance that was received in terms of the coverage for COVID-19 and for our Medicaid population and for the uninsured coverage group. Will there be some similar guidance that's going to be coming out regarding restricted scope eligible that are covered in our Medicaid programs and how that coverage for treatment services may be covered by CMS?

Melissa Harris: This is Melissa I'll start and invite others to jump in. So if you look at the ARP the specifics of the statute did not include the treatment mandates in the scope of services that limited benefit eligible could receive with the exception of individuals in what we used to refer to as the testing group so those testing group individuals in states that elected that eligibility group do receive these treatment mandates.

Other limited benefit individuals like those receiving family planning only services, or tuberculosis, or breast and cervical cancer their benefits were not amended by the ARP to include treatments of COVID-19 or treatment of a

condition that could seriously complicate the treatment of COVID-19. So their benefits continue to not include those services.

(Renee Moller): Okay thanks.

Coordinator: The next question is from (Henry Lipman). Sir, your line is open?

(Henry Lipman): Good afternoon. Thank you, Melissa, for your presentation. I was wondering if you could elaborate a little bit more on the SPA process that you referenced in your - towards the end of your presentation? That's all I wanted to see If you could do a little bit more there. Thank you.

Melissa Harris: Sure. So we are looking to issue SPA templates for a couple of things. We, in recent weeks, we have issued guidance on COVID testing, now COVID treatment and back some time ago through the vaccine toolkit we issued guidance on coverage for vaccines as mandated through the ARP.

All three of those different benefits lend themselves to SPA templates. And we are moving them all through our clearance in a pack. And so we will be issuing some templates as quickly as we can that really provide some streamlined guidance to really focus the state's attention on what information CMC needs in both a coverage and a reimbursement perspective for each of testing, treatment and vaccines.

Some of it will be done as checkboxes other components of it will be more text boxes. But we know that states are really interested in having that information on the street so they can tie up any loose ends in their state plan as it relates to those three ARP components and so we will be issuing those as quickly as possible.

In the meantime if you have technical assistance questions we're happy to try to answer those on a one on one call. States are using the disaster relief state plan template in different ways and so we're happy to look at what you already have in your state - your underlying state plan or your disaster related state plan and then provide you with TA on how to stand up these testing, treatment and vaccine mandates accordingly.

(Henry Lipman): Thank you.

Coordinator: At this time we are showing no further phone questions.

Jackie Glaze: Thank you. (Ashley), I did see one additional question in the chat.

Ashley Setala: Yes, and it looks like we have a couple of questions that just came in. So the first one is around Section 9817 of the ARP. And it says, "Regarding Section 9817 of the ARPA, oh sorry, regarding the Section 9817 state assurance to maintain services in the scope - amount, duration and scope in effect on April 1, 2021. Does this mean that a state may not reduce HCBS services authorized for members during the ARP implementation period or may states continue to apply medical necessity criteria for HCBS services authorized during the ARP implementation period. Specifically if the Medical Necessity Review determines that a member requires less services can the state reduce services?"

Melissa Harris: This is Melissa and I'll start.

(Ralph Lollar): Go ahead.

Melissa Harris: I'll start and then (Ralph) and (Jen) can weigh in. So the information in the state Medicaid Director Letter on 9817 was really at a program level or state

level that doesn't prohibit a state from making beneficiary level determinations based on a change in health status or what have you.

So what a state can't do in order to continue qualifying for the enhanced enhancement FMAP is for example take down a service that was in existence as of April 1 or reduce that service. Let's say put a cap on the number of hours of a particular service or make it harder for a beneficiary to qualify for a 1915(c) waiver or other HCBS program.

But at the beneficiary level as beneficiaries health statuses are changing and a beneficiary needs a different scope and maybe a lesser scope of services as time passes that is totally fine to do. Individuals should not be receiving unnecessary services as part of the MOE requirements in 9817.

It's really more a programmatic level decision on the state's part that is implicated in the MOE. But (Ralph) and (Jen) what else would you add to that?

(Ralph Lollar): There is specific language on Page 4 of the SMDL that says CMS understands that states may experience enrollment and utilization fluctuations unrelated to changes in state policies and procedures especially during COVID-19 PHE. CMS will not apply penalties or non-compliance restrictions on the receipt of the increased SNAP if states experience reductions in HCS enrollment, service utilization or expenditures that aren't related to changes in state policies or procedures.

So if your policies and procedures call for instance an annual assessment of the individuals needs and the plan of care is amended to meet the needs of the individual who demonstrates less need for service then that would be considered a fluctuation that was not occurring because of a change in policy

and procedure but rather a fluctuation that occurred as part of the state's standing policy and procedure that was in place as of April 1, 2021. (Jen)?

(Jen Bowden): The only thing I'll add is just I would encourage any states that are concerned about potential MOE violations either to reach out to their spending plan reviewer or their HCBS lead. And, you know, we can provide state specific technical assistance.

Ashley Setala: Okay, then I - let's see it looks like we have another question around SBX and eligibility and enrollment verification so we'll just flag that. Again, our SMEs were not able to make today's call so we'll take that one back and follow-up on our next call.

Then we have a question that says, "Will CMS be issuing guidance on the 12 months postpartum extension soon because their state is meeting to consider system changes?"

Amy Lutzky: Hey (Ashley), it's Amy Lutzky again, and I can enthusiastically say that yes we are working on guidance in this area. We know states are interested and eager and we should be able to get some guidance out soon.

Ashley Setala: Thanks Amy. And it looks like there are no other questions in the chat right now.

Jackie Glaze: Thanks Ashley. So we'll transition back to the phone lines. And operator, can you provide instructions one additional time on how to register your questions and then we'll see if we have any questions through the phone lines.

Coordinator: Thank you. And once again for your phone questions please press Star 1 at this time and provide your name at the prompt. One moment please. Thank you for standing by. We are showing no phone questions at this time.

Jackie Glaze: Thank you. (Ashley), I do see one additional question in the chat.

Ashley Setala: Sure. And it says, "Will CMS be issuing guidance on Medicare penalties for late enrollment for those who are on Medicaid and did not enroll because they were not aware they needed to?" And I guess I'll just say I think that this is an unwinding related question so we'll probably need to take that back and follow-up next week.

Jackie Glaze: So I'm not seeing any additional questions in the chat. We don't have any additional questions through the phone lines so I think we'll give everyone a few minutes back today. But I'd like to close by saying thank you to Melissa, Julie and Ruth for their presentations today.

Looking forward we will meet with you again on Tuesday November the 9th. So we will provide the invitations and topics very soon. If you do have questions before the next call feel free to reach out to us, your state lead or you may bring your question to the next call.

If you'd like to pre-submit a question for the open Q&A portion of our next 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 want to thank everyone for joining us today and hope everyone has a good afternoon. Thank you.

Coordinator: Thank you. That does conclude today's conference. We do appreciate your attending. You may disconnect at this time.

END