HHS-CMS-CMCS

March 28, 2023

2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. During the Q&A session if you'd like to ask a question you may press Star 1 on your phone.

Today's call is being recorded. If you have any objections you may disconnect at this time. I will now turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon. And welcome everyone to today's All State Call In Webinar. I'll now turn to Dan Tsai, our Center Director, for opening remarks. Dan?

Dan Tsai: Thanks, Jackie. We're going to, no I think you all know this, but we're going to switch up the agenda. And we actually have no Medicaid redetermination unwinding topics for today's all-state call.

But we had a meeting extensively with every single state, stakeholders, et cetera, we're grateful for the partnership and engagement, and we know there's a ton of work, very important work underway. So I'm going to note that, acknowledge it, put that to the side for a sec.

We have been in a lot of discussions with a lot of states around how to approach within the Medicaid program health-related social needs, or the social determinants of health if you will, pick your term on that. And in particular certainly we have worked to establish a federal framework around in lieu of services and how to use managed care authorities to really think about the role of health-related social needs in Medicaid. We've also established and charted pretty groundbreaking paths through Section 1115 demonstrations around health-related social needs as well.

And so we've received a number of questions, including with some states kind of lining up around how to use some of these authorities, and we wanted - the team will walk through today the in lieu of service piece in particular. We had previously done a Webinar on the Section 1115 demonstration authorities for health-related social needs. Those slides, I believe, are also posted online.

The team will walk through a little bit more of the in lieu of service approach which - some of which is also codified in a recent state Medicaid director letter. And I think we'll also try, based on just discussions we've been having with states and others in the community, to help just eventually do a little bit of crosswalk for folks of how to understand the overall health-related social needs approach and possibilities within Medicaid.

So I'm just going to say a few more things around that, and then I'm going to pass it here to the team from our Division of Managed Care Policy to walk through more recent guidance and how to use in lieu of services around health-related social needs. So as folks - we are very focused as an administration on coverage and access, on health equity, and on whole person care.

And I think, you know, for a fair amount of time we all in the community have had a debate about what is the appropriate role of Medicaid when it comes to things like housing support, and nutrition and a range of other health-related social needs. It is clear, and it has been clear, when you think of it from a clinical standpoint, in a range of other arguments, that there should and can be a role for Medicaid to help address the clinical issues, clinical connections, and in some cases even some of the financing for these pieces.

But it's also clear that Medicaid is not here to supplant or take over the role of other social service agencies, and entities and funding streams. Where to draw the line in that milieu has been a big topic of debate. And I think folks hopefully saw that over the past year and a half. We spent a lot of time at the federal level trying to outline what some of those parameters and guardrails to be.

The punchline, which I think most folks hopefully on this call know, is that we do believe there is a really meaningful important role for Medicaid around health-related social needs. It's more than just how to pay for it, to be clear, and a lot of what we emphasize, and what many states are doing, is how to think about the role of everything from screening, and assessing, and person-centered care plans that incorporate whole-person care and some of the health-related social needs and successfully connect folks to the community in addition to what can Medicaid dollars be used for.

There are a set of things, particularly around housing and nutrition, that we have outlined with some of the recent 1115 demo approvals and with in lieu of service that address housing and nutritional needs. There are various - and that list is largely overlapping, but there are some things that can only be done in 1115, and some of those things were outlined in one of the previous Webinars.

The team will walk through very much the framework of where we are in the in lieu of service piece today. And I think we've had a number of states also ask us, how do I think about, as a state, I want to really address the health-related social needs should I be thinking about 1115 authority, or in lieu of service or, in the case of California, both?

And I think the answer to that is, it depends. It really depends on what the goals of the state. There are various pros and cons of going through the various avenues. I think our goal today from the team will be to walk through the in lieu of service path, and we can come back to other discussions to think about. And CMS is available to provide technical assistance to states about how to think about which of the authorities under which circumstances might better suit a state's particular needs.

So with that I'm going to turn it over to (Alex Boizes) and (Rebecca) is also here from our DMCP team, our Division of Managed Care, and John Giles to walk through the in lieu of service framework.

(Alex Boizes): Yes. Thank you, Dan, for teeing us up. And before we launch into the agenda I just want to state, because I know it's a question we will get, that these slides will be published on medicaid.gov.

So to walk you through the agenda, today's presentation is going to focus on in lieu of services and settings. And we'll start off with a background on in lieu of services. We'll then talk about the SMDL that we published earlier this year. We'll talk about the process for technical assistance, and then we'll leave ample time for questions and answers.

Next slide, please. So with that we'll start off with a little background on in lieu of services. In lieu of services were first formally codified in the 2016

Medicaid and CHIP Managed Care Final Rule within 438.3(e)(2), which formally recognized states and managed care plans' abilities to cover in lieu of services or settings that are substitutes for services or settings covered under the state plan.

Prior to this plans had flexibility under risk contracts to cover alternative services and settings in order to meet enrollee needs. The final rule just formalized this practice to ensure consistency and to safeguard enrollee rights and protections.

And so there are four kind of key requirements that are codified under 42 CFR 438.3(e)(2). And those are, first and foremost, that a state must determine that an in lieu of service is both medically appropriate and a cost-effective substitute for covered services or settings under the state plan.

Next, in lieu of services are optional. Enrollees cannot be required to use them. Third, the approved ILOS has to be authorized and identified in the managed care plan contract.

And in the same way that in lieu of services are provided and are optional for enrollees they are also provided at the option of the managed care plan. And then finally, the utilization and actual cost of in lieu of services must be taken into account in developing the component of the capitation rates that represents the covered state plan services.

Next slide, please. So we would be remiss if we didn't mention one of the most common types of in lieu of services that we see, and that states operationalize on their level, and that's short-term IMD stays. All short-term IMD stays must comply with 438.3(e) and 438.6(e), which outline the manner

in which such stays are accounted for within capitation rates, as well as the 15-day stay limitation.

You know, and as over time as the use of the in lieu of services has increased, and states have increasingly sought new innovative avenues to address the unmet Health-Related Social Needs, also known as HRSN, of Medicaid enrollees, we've determined that additional guidance was needed. And I think Dan already touched on this, but we want to note that in lieu of services are a completely separate option from Section 1115 HRSN authority, which among other flexibilities permits states to authorize in lieu of services as actual covered benefits.

And as Dan mentioned, you know, we're happy to - please reach out to your DMC analysts. We're happy to talk to you about the pros and cons of kind of the different approaches.

Next slide, please. So now into an overview of our SMDL. On January 4, 2023, CMS released a state Medicaid Director Letter, SMD 23-001, which outlined guidance on the use of non-IMD in lieu of services.

First and foremost we sought to clarify the nature of in lieu of services that can be offered, including those that address HRSN. And then we also issued this guidance to provide additional parameters for in lieu of services to ensure appropriate and efficient use of Medicaid resources. And we note that the guidance that we released does not replace, it doesn't alter existing federal requirements related to the use of short-term IMD stays or the availability of FFP for capitation payments.

Next slide, please. So in the SMDL we outline how in lieu of services can be used as either immediate or long-term substitutes for state plan covered

services or settings. Or when the in lieu of service can be expected to reduce or prevent the future need to utilize state plan covered services or settings.

And we have an example here, for example, a state may determine that they want to offer medically tailored meals, they make the state determination that, that is a medically appropriate and cost-effective in lieu of service, they identify a clinically oriented target population, and the whole kind of theory of change is that this - providing these medically tailored meals then improves health outcomes for that individual, facilitates greater access to care and community integration. And then all of those kind of together then result in either preventing or delaying that enrollee's need for nursing facility level of care or just a higher level of care in general.

With this more expansive interpretation of in lieu of services, ILOS can be used by states and their managed care plans to address Medicaid enrollees, HSRNs, in order to reduce the need for future costly state plan covered services. You know, I think Dan mentioned this at the beginning, but in lieu of services is just one tool in the Medicaid toolbox that's available to states and their plans to improve population health, reduce health inequities, and lower overall health care costs in Medicaid.

Next slide, please. So within the SMDL we outlined six principles that make up our in lieu of services policy framework. And we'll go through each of these more in depth in the slides to come, so I won't spend time talking through them right now.

And then the other piece that I would call out right now is that CMS will utilize a risk-based approach to review an approval and monitoring of in lieu of services. And this risk-based approach is based on a states in lieu of services cost percentage. We'll talk much more about that in the slides to

come, but I think that's important to know at the offset, that that's kind of what's driving our monitoring and oversight and review and approval process.

Next slide, please. So in terms of compliance this guidance is effective with the date of publication, which is again January 4, 2023. And there are some nuances related to compliance that we want to highlight for you all.

First and foremost, that CMS's review and approval of in lieu of services, and our monitoring of state compliance with this guidance, will occur as part of our day to day review of associated managed care plan contracts and capitation rates. Next, we just acknowledge that there are a number of states that are already covering in lieu of services today and as of the date of publication of this guidance.

With this in mind we understand that states will need some time to digest this guidance, they'll need some time to conform with the guidance. So with that in mind states with existing in lieu of services, meaning that, that in lieu of service has already been documented within the contract, will have until the rating period that begins on or after January 1, 2024 to comply. Now if a state opts to add new in lieu of services, you know, on or after January 4, 2023, then they must comply with this guidance immediately.

Next slide. And so to illustrate our approach to compliance we've outlined some state scenarios. So state X, we'll walk through them together, so state X let's say currently has eight non-IMD in lieu of services.

They do not intend to add any new in lieu of services, and they're on a calendar year basis. So this calendar year, calendar year 2023, they're just going to maintain those eight existing in lieu of services, they're not going to add any new ones. In this situation, in this scenario, state X has until January

1, 2024 to comply with the guidance for those eight non-IMD in lieu of services.

In the next scenario, we have state Y. Let's say state Y does not currently provide any non-IMD in lieu of services, and they want to add a brand new in lieu of service effective March 1, 2023. They're also on a calendar year rating period.

So in this instance, because they are adding that brand new in lieu of service after the effective date of this guidance, state Y must comply with the guidance for the new in lieu of service as of March 1, 2023. And they'll have to provide the associated contract and rate amendments that cover that effective period, so from March 1, 2023 to the end of the year.

And then finally, we have state Z, which currently provides for non-IMD in lieu of services. They would also like to add some brand new in lieu of services effective July 1, 2023, and they operate on a July to June rating period.

In this instance the state must comply with this guidance for the rating period beginning July 1, 2023 through June 30, 2024 for that brand-new in lieu of services, or in lieu of service. And then that state has until January 1, 2024 to comply for those existing non-IMD in lieu of services that have already been documented in the contract.

Next slide, please. All right, so we've made it through a basic overview of the SMDL. Now we're going to walk through those six principles that were listed on the earlier slide.

So the first principle is that in lieu of services must advance the objectives of Medicaid. And what we mean by this is that in lieu of services cannot violate any applicable federal requirements, you know, including but certainly not limited to 42 CFR 438.3(e)(2), nor can they violate general principles on payment for room and board costs under Title XIX of the act.

And then this next part I would really highlight for states, in lieu of services must be approvable as a service or setting through either a state plan, amendment authority, or a waiver under Section 1915(c) of the Social Security Act. This does not mean that a state must actually seek and receive approval of an in lieu of service through one of those authorities, it just means that the in lieu of service itself could be approvable under one of those Medicaid authorities.

Next slide, please. So our next principle, which is codified in 438.3(e)(2), is that each in lieu of service must be cost-effective. And what we mean by this is that a state must determine that each in lieu of service is a cost-effective substitute for a covered service or setting under the state plan.

You know, I mentioned earlier we have this risk-based approach to our review and oversight of in lieu of services. And so to ensure - as part of that risk-based approach and to ensure appropriate and efficient use of Medicaid resources, we are implementing something called an in lieu of services cost percentage.

All states are required to submit both a projected and a final in lieu of services cost percentage certified by the state's actuary for each managed care program that includes non-IMD in lieu of services. And the cost percentage itself is a calculation as follows.

The numerator is the portion of total capitation payments, note total capitation payments that are attributable to all in lieu of services, again, excluding short-term IMD stays for that specific managed care program. And then that's then divided by the denominator, which is total capitation payments that are specific to that managed care program. And that must be inclusive of all state directed payments and all pass-through payments. So that's the calculation.

And then in terms of reporting the projected in lieu of services cost percentage is submitted annually in the applicable rate cert. And then that final in lieu of services cost percentage is submitted retroactively no later than two years after completion of the contract year that includes that in lieu of service.

And this is included along with a summary of actual managed care plan costs. And those are both submitted as a companion actuarial report.

And then because in lieu of services are provided as substitutes for state plan covered services and settings, CMS believes that there should be a limit on the amount of expenditures for in lieu of services. This is in part so that we can help to reduce inequities across varied - for beneficiaries across varied delivery systems also to help ensure appropriate fiscal constraints.

So for these reasons the in lieu of services cost percentage per program should not exceed 5%. Oh, I'm sorry, next slide. So, right, so what I was saying is that in lieu of services cost percentage cannot exceed 5% per program.

And then you'll note, and (Rebecca) will talk more about this in her slides, but if the projected in lieu of services cost percentage exceeds that 1.5% de minimis threshold then we require additional documentation from states. And so one of the things that they must submit, if they exceed that 1.5% threshold,

is a description of the processes that they used to determine that each in lieu of service is cost-effective.

So that would include a description of any key factors, any data that they used, the processes or methodology that they relied on. And so with that, I will turn the rest of the presentation over to (Rebecca).

(Rebecca): If you want to go to the next slide. Thank you. So first of all, before I go into this slide, I will just say these slides are a summary of the SMDL. The SMDL has a lot more detail, so I would encourage you to kind of go to that SMDL, which kind of outlines each of these six principles in much more detail.

But (Alex) went through the first two of six principles in the SMDL, so I'm going to cover the last four. The third one is that the in lieu of services must be medically appropriate. And this is, again, required in regulation.

So states must determine each in lieu of service to be a medically appropriate substitute for a covered service or setting under the state plan. And this must occur before the in lieu of services can be included in the managed care plan contract as an option. And it must be determined by the state, not solely by the plan.

States must also include detail in their contracts. And we delineate this quite a bit in the SMDL, but I'm going to highlight the three key areas where we really felt that key detail had to be included in the managed care plan contract.

So first of all, the name and definition of each in lieu of service must be documented in the contract, as well as the service or setting in the state plan that it is a substitute for. And we also feel for program integrity, and monitoring and oversight, that that contract must also document the encounter

data and claims information that will be used for the coding of each in lieu of service. So for example, either the HCPCS or the CPT codes and associated modifiers.

Additionally, in the managed care plan contract there should also be a description of the clinically oriented definition for the target population for which the state has determined that in lieu of service to be medically appropriate and cost-effective. So as Dan talked about, at the beginning of the call, you know, Medicaid can cover when an in lieu of service is medically appropriate and cost-effective.

So it is not something that can be covered with Medicaid dollars unless it meets those two key pillars. So we really do need that clinically oriented definition for the target population for each in lieu of service.

Also in the same vein of ensuring that it is medically appropriate, there is also a contractual requirement that the plan utilize a process for a provider to determine that, that in lieu of service is medically appropriate for a specific enrollee. And so that also needs to be documented. It can be documented in an enrollee's care plan or a medical record, or another mechanism, but there must be a process for that provider in their professional judgment to determine that it's a medically appropriate service.

Next slide. And then just as (Alex) summarized, in the second principle, we're also using a risk-based approach for medically appropriate. So a state determining that an in lieu of service is medically appropriate and cost-effective.

If the projected in lieu of service cost percentage in a given state's program is greater than 1.5%, just like a state would have to submit additional description

of the process of how that state determined an in lieu of service cost-effective, they also need to provide a description of how they determined each in lieu of service to be medically appropriate for the target population. And we give some examples on this slide of kind of a description of those state processes.

Next slide. Okay, so the fourth principle outlined in the SMDL, and (Alex) alluded to this, is really tied to regulatory requirements. So an in lieu of service is at the option of an enrollee. And we believe that it is really pivotal to ensure that the rights and protections guaranteed to enrollees remains in full effect.

So this slide really goes into a lot of detail with some examples of how enrollees retain all of the rights afforded to them in 438. I won't go through those examples for time, so we have adequate time for Q&A, but I will just kind of stress maybe two key points.

So really in lieu of services may not be used to discourage, reduce, or jeopardize enrollees access to covered state plan services and settings. They always have a choice not to receive an in lieu of service. And then also we believe that the enrolling handbook must also contain information on enrollees rights and protections, including those for enrollees that have elected in lieu of services.

Next slide. Okay, so the fifth principle as outlined in the SMDL, in a lot more detail than I'll summarize today, is really around how we believe monitoring and oversight by state of in lieu of services is a pivotal component and also already required in regulation such as in 438.66. So we believe that that ongoing monitoring and oversight activities of in lieu of services remains in full effect, especially around ensuring that enrolling in, in lieu of services must be medically appropriate and cost-effective substitutes.

So we believe states must be doing evaluation about compliance at least annually. One of the key areas, and you saw this kind of sprinkled throughout the principles especially in the one around medical appropriateness, is we believe that the coding must account for in lieu of services. And states and plans must also commit to have timely, complete, and accurate encounter data for in lieu of services.

There is also some reporting requirements that are outlined in the SMDL around in lieu of services. (Alex) already talked about the actuarial report required for the final in lieu of service cost percentage that's required for each program to document and ensure that that percentage does not exceed 5%.

We also require that if a state determines that an in lieu of service is no longer medically appropriate, or cost-effective or there's other areas of noncompliance with the SMDL or the regulation, that a state must provide written notice to CMS within a 30-day time period.

Also, if a state decides to terminate an in lieu of service, or CMS requires that an in lieu of service is terminated, there is a process by which the state provides an in lieu of service transition plan to ensure that enrollees have adequate access to state plan coverage services and settings. And then states must also submit an assurance to audit the related data around in lieu of services.

So next slide. Okay. And then the sixth, and last principle, is that in lieu of services must be subject to retrospective evaluation when it's applicable. So similar to the risk-based approach that we just described around documentation of the state process for determining an in lieu of service

medically appropriate and cost-effective, a similar principle is utilized for requirement and evaluation of those in lieu of services.

So if the final in lieu of service cost percentage is greater than 1.5% states will be required to submit a retrospective evaluation for each applicable program. The SMDL goes into a lot more detail on the specific detail in that evaluation. Here we've kind of summarized five key areas that that evaluation kind of encompasses, and that's cost utilization, grievances, appeals, and quality of care.

Evaluation would be due 24 months after the completion of the first five years that include the in lieu of services after publication of the SMDL. And then CMS always reserves the right to rescind an in lieu of service or require corrective action. And here we acknowledge that one time that, that may happen is if the retrospective evaluation shows that an in lieu of service is not medically appropriate, or a cost-effective substitute for state plan services or settings or there's other substantive issues such as around enrollee rights.

Next slide. And then I think we're going to end where kind of Dan started us. So as we talked about in lieu of services is just one option that states can utilize in Medicaid managed care. States might explore other options, especially for HRSNs.

I think we want to make sure that states are aware that if you require technical assistance on in lieu of services you can feel free to reach out to your analyst in the Division of Managed Care Operations and through the mailbox offered on this page. CMS will also be reviewing the proposed in lieu of services as part of our review and approval of the managed care contracts and capitation rates.

And you kind of saw that throughout this presentation around what documentation must be in the contracts, must be included in the rate certification or as supporting documentation when the cost percentage exceeds a certain amount. So with that I think we'll go to the next slide which is we're going to open it up for Q&A.

Jackie Glaze: Thank you, (Rebecca) and (Alex), for your presentations. So as (Rebecca) indicated we're ready to begin taking questions. So we'd like to take your questions today about today's presentation or if you have questions about unwinding or any other topics.

So we'll begin with the chat function. So I do see a few questions already, so continue to submit your questions. And then we'll follow by taking your questions over the phone lines. So I will now turn to you, (Ashley).

(Ashley): Thanks, Jackie. The first question says, "Can CMS help us understand what a cost percentage has to do with whether an ILOS is a cost-effective alternative for a state plan, service, or setting? The fact that a state spends X percent on an ILOS has no bearing on whether or not the ILOS in question is a cost-effective alternative to a covered service or setting."

(Rebecca): Sure, thanks for that question. I can take that, this is (Rebecca). So first I want to clarify that CMS is not defining what cost-effective means we are really as outlined in regulation the state determines that an in lieu of service is cost-effective and medically appropriate.

However, as we outline in the SMDL we really feel that because of the increased use of these in lieu of services, as well as ensuring equity and consistency, that there must be a federal standard and limit on the cost of an overall managed care program that can be for in lieu of services. So I just

want to be clear that the in lieu of service cost percentage is not a definition of cost-effectiveness. It is a federal standard and guardrail to ensure that in lieu of services are utilized appropriately and reasonably over the context and breadth of the entire program spending.

(Ashley): Great, thank you. The next question says, "Does the provision of 438-6(e) for coverage of ILOS's apply to fee-for-service as well as managed care?"

(Rebecca): No, the short answer is no, 438.6(e) is specific to Medicaid managed care.

(Ashley): Okay. The next question says, "Under CMS's interpretation of medically appropriate, an ILOS must be approvable under a traditional Medicaid authority. This limitation seems restrictive. If a state wanted to provide a service that can be approved under the state plan, or Section 1915, why would we not just provide them through the state plan or 1915? An ILOS seems unnecessary."

John Giles: Thanks, (Ashley). This is John Giles, and I'm happy to take this question. So I think the short answer is that under those authorities, right, under either a 1915(c) authority, or other kinds of state plan authorities, there may be further limitations on the populations that can be covered for that particular service.

And under the in lieu of service authority of course the state does need to comply with all of the requirements in the SMDL, including having clinically oriented definitions for the target population. But the state actually can pursue broader populations than would be otherwise coverable under the underlying authority.

The service itself has to be coverable under a previous Medicaid authority, but the population can differ. So we believe this does provide states more

flexibility in targeting the in lieu of service for a broader population than would otherwise be eligible for the service under a traditional Medicaid authority.

(Ashley): Great. Thanks, John. The next question says, "If it is a service without a code can the state use a supplemental or custom encounter billing process?"

John Giles: Yes, so this is John. Yes, as long as the state can track the in lieu of service, via a code in their encounter data, they can use some of the alternative coding that states may use for other services that don't necessarily have a traditional HCPCS or CPT code. It just needs to be trackable and reportable in their encounter data.

(Rebecca): Yes, and I would, this is (Rebecca), I would also add some states are choosing to use modifiers as well because they need to be able to capture an in lieu of service versus when that same service is provided through a traditional Medicaid authority.

(Alex Boizes): And this is (Alex). The last thing I would add is that, you know, this is part of the reason why we're requiring that states include the actual codes that they're going to use within their contracts so that we on a federal level can oversee and can monitor them.

(Ashley): Okay, thanks all. The next question says, "Is there any flexibility for one-time ILOS situations that may not be specified in contract because it's hard to specify in contract some of these new details? Our concern is how to meet client's needs who are hospitalized and need immediate and unusual services that have not yet been created as a SPA waiver or ILOS. We have a few of these complex cases today, so not sure how to reconcile these critical cases with these guidelines."

(Rebecca): So this is (Rebecca). I will take this, and say, first of all I think this is a very specific question. So I would encourage the state who submitted it to reach out to CMS, but I will say, in general, the answer is no.

So an in lieu of service, consistent with this SMDL, must be an approvable service or setting under a traditional Medicaid state plan authority or a 1915(c) waiver. I will acknowledge one thing that (Alex) really walked through, and this is in Slides 8 and 9 once this is publicly available, which is that states with existing in lieu of services have a glide path to comply with this SMDL for the rating period beginning on or after January 1 of 2024. So if it's an existing in lieu of service the state needs to kind of be working to comply with this SMDL by that 2024 timeline, but in essence the short answer is no.

(Ashley): Okay, thanks. The next question says, "Does CMS have any sense of how much time this will add to the managed care contract review process?"

John Giles: I think we understand the commenter's concern. I will note I think we tried to balance the administrative burden by including the 1.5 de minimis that does trigger the additional contractual responsibilities and documentation. You know, we did that in light of state concern about burden.

But we do appreciate that this is a new process that states will need to build into their contract and rate review processes, as will CMS. But, you know, we did try, you know, I think I would say with any new flexibility, right, there does need to be some accountability and processes behind it. And that's exactly what we're trying to do here for consistency across the country.

(Ashley): Thank you, John. We'll now move to the phone lines. (Ted), would you please provide instructions to the participants on how to register their questions? And if you could open the phone lines, please.

Coordinator: Yes, the phone lines are now open for questions. If you would like to ask a question over the phone please press Star 1 and record your name. If you'd like to withdraw your question, press Star 2. Thank you.

And as a reminder, to ask a question over the phone, please press Star 1. I'm currently showing no phone questions at this time.

Jackie Glaze: Thank you. I - (Ashley) I think I see another question.

(Ashley): Yes. It looks like we have one more question. It says, "What happens if a service that has been proven to be effective, like providing air conditioning for treatment for asthma in lieu of repeated ER visits, cannot be otherwise coverable? Does this mean plans need to stop providing that appropriate intervention?"

Jackie Glaze: Yes, thanks for that question. We actually do believe that that would meet the definition. This is a very specific situation, it sounds like, a very specific scenario.

We would note that environmental modifications are generally seen as coverable in multiple Medicaid waiver authorities. So I think generally we would say we believe this is likely approvable through the in lieu of service mechanism. But if the state has specific concerns about meeting other criteria in the SMDL we would encourage them to reach out to their state lead, and we could certainly help them with that assessment.

(Ashley): Thanks, John. It looks like there's no other questions in the chat right now.

Jackie Glaze: Thank you, (Ashley). (Ted), could you once again provide instructions on how to register the questions? And if you could open the phone lines once again, please.

Coordinator: Sure. As a reminder to ask a question over the phone please press Star 1 and record your name. Thank you. I'm showing no phone questions at this time.

Jackie Glaze: Thank you, (Ashley). I'm not seeing any additional questions either through the chat.

(Ashley): No.

Jackie Glaze: Okay. I'm just checking to see if there's anything additional. So I think we'll just give it maybe another minute or two and then see if we do get any additional questions, and then we may just adjourn early today.

Okay, I'm not seeing any additional questions. So in closing I do want to thank our team for their presentation today.

Looking forward we will be sending the topic and invitations for the next call. And if you do have questions that would come up before the next call please feel free to reach out to us, your state lead, or bring your questions to the next call. So we do thank you again for joining us, and we hope everyone has a great afternoon. Thank you.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time.

[End]