

**HHS-CMS-CMCS**

**May 30, 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 Ann Marie Costello, our Deputy Center Director, for opening remarks. Ann Marie?

Anne Marie Costello: Thanks, Jackie, and hi, everyone. And welcome to today's all state call. As you may have seen, CMCS issued two important releases in the last week. On May 23rd we released the Medicaid Program, Misclassification of Drugs, Program Administration, and Program Integrity Updates under the Medicaid Drug Rebate Program Notice of Proposed Rulemaking.

The NCRM addresses four key topics. The first is changes made by the Medicaid Services Investment and Accountability Act of 2019 regarding the Medicaid Drug Rebate Program drug classification enforcement and penalties. Second, the Medicaid Drug Rebate Program Administration and Program Integrity proposed changes. Third, coordination of benefits, third-party

liability regulation due to the Bipartisan Budget Act of 2018. And lastly, requests for comments on diagnosis on Medicaid prescriptions.

And then our second important release was on May 18th. We issued a Center Informational Bulletin that introduced a comprehensive guide, *Delivering Service in School-Based Settings*, a comprehensive guide to Medicaid services and administrative claiming. This guide is designed to improve the delivery of Medicaid and CHIP services to enrolled students in school-based settings. In light of these two critical releases, we're dedicating today's call to discuss both releases. We will also take any other unwinding or other questions that you may have for our team.

Before we get started, I wanted to let folks know that we will be using the webinar platform to share today's slides. If you're not already logged in, I suggest you do so now, so that you can see the slides for today's presentation. You can also submit any questions you have into the chat at any time during our presentation. Now, I'd like to introduce Richard Kimball from our financial management group, who will be discussing the school-based services claiming guide, and Cindy Denmark from our disabled and elderly health programs group, who will be discussing the drug misclassification notice of proposed rulemaking.

With that, I'll turn things over to Richard Kimball to start his presentation on the school-based services claiming guide. Richard?

Richard Kimball: Thank you, Ann Marie. My name is Richard Kimball, and I'm a technical director for the Financial Management Group, and I'll be going through some slides and providing some overview of Medicaid and school-based services. And as Ann Marie was talking about, the Comprehensive Guide along with

the SID that came along with that. I think - yes, thank you. If we get the right slides up. Okay, next slide, please.

So just giving some session objectives - we're going to try to understand a little bit about the current policies that exist for school-based services. We're going to do a little bit about the new flexibilities in the Comprehensive Guide that was just released and talk about compliance timeframe, and then we'll kind of step back and talk about the BSCA, which is the Bipartisan Safety Communities Act, and the timeline of that and the future work for technical assistance in the state grants. Next slide, please.

So I just wanted to talk a little bit about this administration - how it's a priority to strengthen and expand access to Medicaid and CHIP. We see that, you know, schools again, kind of the lay of the land here is that schools are important providers of Medicaid direct medical services, and they have been for many years for particularly the IEP and IFSP kids under IDEA. The Medicaid and CHIP, they cover now over half of all children in the United States. So it's extremely important to get guidance and rules out there to help people, you know, again, increase access in those direct services.

Again, school-based services can include any service under EPSDT, including physical and mental healthcare. We know and recognize that schools can face high administrative burden. They're not a usual place where, again, you know, services are provided for Medicaid or other healthcare. And so in this guide we're trying to decrease that administrative burden. Next slide, please.

So schools are primarily, again, the providers of education, not medical services. We recognize also that third-party healthcare payers, other than Medicaid, don't generally reimburse for services provided in schools. School-based services, the fee-for-service rates are generally the same as community

rates unless otherwise justified. And then Medicaid-covered services provided in schools, they always must meet the applicable statutory and regulatory requirements, regardless of the flexibilities, etc., that we're going to present here. Just realize that you have to go back to the statute and the regulations to, you know, govern Medicaid. Next slide, please.

So there's no benefit category that's called school-based services. It's not a 1905A service. It's not, you know, in the Social Security Act. So what we're saying here is that they have to be provided in schools. They can be qualified Medicaid providers. They have to be enrolled in Medicaid. And they can cover any of the services that are available under the 1905A or EPSDT. Next slide, please.

Medicaid services, again, are not limited to just the IEP and the IFSP anymore or the 504, you know, kids, which again, is governed by the Rehabilitation Act of 1973. Any Medicaid service now can be provided that a state would like to put and provide in schools can be done. Regardless of, you know, whether those otherwise be charged for service delivery, you know, in the state. And they can be for any beneficiary enrolled in Medicaid, including administrative services as well to get those kids enrolled in Medicaid - CHIP services, EPSDT, and any medically necessary service, again, that a child needs can be charged to Medicaid now.

And we want to reiterate that. So and again, all Medicaid enrolled services, and sometimes you'll hear this referred to as free care, and we'll talk about that in a little bit, but next slide, please. So again, you have the - states now have the option to receive Medicaid funds for school-based services delivered to any child that's enrolled in Medicaid, not just the IEP or 504 or other things. We encourage states to adopt all of the different expansions that are possible.

And we lay things out in the guide. We have a website up now that is providing more and more resources every day.

We're providing, you know, state plan amendments that have been approved. We have now 13 states that have some kind of expanded care, some of them are comprehensive like Arizona and California and Colorado. Others like Georgia only opened it up to school-based services for nursing for any, you know, a child enrolled in Medicaid. Nevada did, and they use a fee schedule. So there are various ways of doing this, but we encourage people to look at all the flexibilities and the guidance and to, you know, ask if they want to expand those services. Next slide, please.

Okay. So I'll talk a little bit about this act that kind of started it all. Really it probably goes back before the pandemic and things like the GAO report of 2019 that found that, you know, many young Medicaid-enrolled children were not getting recommended screenings. In fact, there were only three states that had 80% or greater in terms of the screening for just one well child screen. So we were failing the Medicaid enrolled kids in the screenings, and the GAO pointed that out. Of course, then 2020 rolled around and we had the pandemic that lasted a few years, and we're just now, you know, getting out of that and free and clear.

And of course that developed into a mental health crisis for many areas and for the whole country. Sprinkle in a variety of violence that occurred in schools, state legislative mandates in schools. And then the result was a behavioral health crisis. Finally, in 2022, Congress acted and passed the Bipartisan Safety and Communities Act. And that really provided some support. And it really redoubled our efforts at CMS, to get things going. And we started a collaboration with the Department of Education and others in Medicaid. And we started writing this new guidance.

We got out a SID last year in 2022 that kind of talked a little bit about what we were going to do and offered some, you know, leveled the playing field and kind of told people where we were going. And that's kind of where we are. And we're going to go to the next slide, please. So in 2022 we rolled out that SID. And in May, as Ann Marie said, we got the School-Based Services Comprehensive Guide.

Now in June 2023, later this month, we'll be starting a Technical Assistance Center with the goals of, you know, supporting those state Medicaid agencies to take that comprehensive, you know, guide, look at the different flexibilities to help reduce administrative burden, and to support the entities that are like the LEAs, etc., that are involved in that. And to help them, you know, expand services as much as possible. It's going to be an ongoing coordination and collaboration with the Department of Education, along with CMS. And they are, you know, rolling out other NPRMs to help reduce the burden in terms of FERPA.

And we're, again, going to provide as much guidance as we possibly can, on the utilization of funding. Finally, in 2024, part of the Bipartisan Safety Communities Act was \$50 million in discretionary grant funding to support states in again, implementing, enhancing, and expanding the provision of Medicaid services. We know it's not going to be a panacea for all these different issues and problems, but we feel it's a good, you know, first start. And we're going to be trying to help, you know, states implement with the flexibilities that are available, and where you want to go with your Medicaid program, and hopefully provide more services in school-based areas. Next slide, please.

So again, this guide is called Delivering Services in School-Based Settings, a comprehensive guide. And it's having to do with not just admin claiming, but also the direct services, which we really haven't done before. We published this on May 23rd. Again, a great collaboration with the Department of Education and many other entities within HHS and CMS. We redoubled our efforts as much as possible to get, you know, again, the Department of Education on board.

We started writing this last summer and it came in ahead of time. Our statutory, you know, limit was June of this year, and we finished in May. And I know we're getting already a lot of questions in our mailbox, and so we're trying to handle those. And then we're going to have a contractor later with us, to help with the Technical Assistance Center and provide some of those supports to the states. Next slide, please.

The new - so I'm just going to overview now that claiming guide itself and talk about some of the new flexibilities that are out there for billing. RMTS or time studies in general, provider and third-party liability that states can adopt to make it easier for schools in adopting Medicaid and CHIP services, and also some recommendations on how states can, you know, work with managed care plans and ways that you can simplify things like interim billing when using a CPE methodology or cost-based is what that's called. And particularly we try to think about as much as possible, you know, those small, you know, rural and under-resourced communities where access may be particularly problematic, and to try to increase those services. Next slide, please.

So again, one of the reminders that we put in the guide is, you know, there's a good point of why do we want to increase services for, you know, Medicaid services in schools? And we do that because it promotes health and

educational equity. And there's good research on this. You'll go to the guide and you'll find some more references. But just to go over the major points here, again we want to help eligible students and their families to enroll in the Medicaid program, connecting students to again, Medicaid-eligible family members with Medicaid coverage, so that everyone in the family is covered if need be,.

Providing Medicaid-covered health services in schools and seeking payment for those services and making it easier by reducing those administrative burdens, improving wellness, supporting at-risk Medicaid, you know, children; providing Medicaid-covered services to reduce those emergency room visits that can be very expensive. Another good reason why schools should adopt this and states should adopt this.

And then also providing, you know, Medicaid-covered services and performing Medicaid administrative activities that can also be, you know, conducive to the learning environment. Next slide, please. Okay. So specifically new flexibilities in terms of billing, and these are all having to do with - really when you use again, a cost methodology, not to be confused with like a fee-for-service or something else. So if states wanted to keep - or LEAs, I should say.

But if states wanted to implement these, LEAs could have a roster of the various students who receive Medicaid services. And as long as one or more of those Medicaid services that's provided in a month is checked off, then they could get a certain fee for those Medicaid services. The same thing with, or very similarly, I should say, with per child per month interim rates, where again, you could have a certain interim rate.



And it could be based on again, not the specific MMIS code or anything else, but just a list of maybe previous year's actual costs, for instance. And that's paid out, you know, each month or on a per child per month, you know, basis or average cost per service, or however they'd like to design that. We're opening it up to many options and choices. Next slide, please.

In addition, we generally have said in the past that if you use a fee schedule for providing school-based services, that it had to be the same as that community rate. So if it's a physical therapy visit on a fee-for-service, you know, fee schedule, it had to be the same rates. Now we're saying that those could be, you know, and we recognize that sometimes it's more expensive to provide the services in schools, so those could be potentially higher. The state just has to demonstrate that the rate is still economic and efficient as required, you know, again, by our Act, the Social Security Act.

And then also, for interim payments again, for a cost-based methodology, you can have bundled rates. We had a 1999 SMDL that prohibited the use of bundled rates. And that was really seen as for fee-for-service. But now with a popularity of using cost-based methodologies, we recognize that this could be a viable way of providing interim rate methodology. Next slide, please.

In terms of time studies, we're allowing the increase of the error rate. We used to say that it had to be a plus or minus 2% error rate in the implementation for the time studies. Now they can go to a plus or minus 5%. That makes it equal to the administrative claiming. So now you can do one unified time study. That's actually what makes it very attractive. And it also requires much fewer moments. We go from like 2,400 moments required to justify the time study allocations down to about 380.

And also the notification period, we landed - we talked to a lot of people on this and we decided that we would love to see a 0-0, so no pre-notification, and to the moment immediately. That's our gold standard. But we recognize that it may be difficult in certain situations. So we would recognize up to a two-day notification window to providers to - that you're going to get a moment and have to answer that. And you have up to two days to respond to that moment. Next slide, please.

We also looked at documentation. One of the things that we're going to allow and work with in the Technical Assistance Center is talking more about de-identification of data, and if need be, how you can re-identify that. There are various methods that are available. Particularly, this came into focus with some OIG audits with the Medicaid enrollment ratio, so we're going to kind of talk about that. You can get more information again, in the guide. But generally speaking, we're going to, you know, use de-identification of data if possible.

And also, if states want to, for ease of administration, use, you know, instead of various allocation ratios, a lot of times with the Medicaid enrollment ratio you have to use one specific for, for instance, the IEP kids and another one for the general population. If they wanted to, they could use just one of those, and generally it's the overall Medicaid enrolled students, you know, divided by the whole population of that LEA. Next slide, please.

We have also thought of this. We've not seen anyone implement it, and we're offering this flexibility as well. But in terms of a time study and documentation, you could design - right now, there's a two-step process to allocate to Medicaid, and that includes the time study results and then stepping down further by the Medicaid enrollment ratio. And we are now open to a one-step design. A time study could be designed, and it might not be

the provider themselves who knows who's Medicaid and who's not, but there may be someone in a back room that's able to code both the medical and the Medicaid activities.

And that could be, you know, done on a one-step level, and it could be done for the whole state. Next slide, please. In terms of provider qualifications, prior guidance made it kind of difficult for state Medicaid agencies to rely on the in-school qualifications because they were sometimes - they had to be the same in the rest of the state. So we're offering, you know, state Medicaid agencies can now establish provider qualifications specifically for school-based providers, that can differ from qualifications of non-school-based providers of the state Medicaid service, with a few caveats, and we talk about that in the guide in more detail. Next slide, please.

And also for third-party reimbursement, we're going to allow a little bit of easing of those rules and allow the states to suspend or terminate efforts to seek reimbursement on the third-party liability, if they determine that the recovery would not be cost-effective. And that's pursuant to various, you know, again, 42 CFR here. And you can kind of read again, more about that in the guide. We're going to go to the next slide.

So again, we talk about all these policies. We provide, you know, as much clarification as possible. And we reiterate, again, what are the existing federal requirements that have kind of not been written down before. We've also, you know, in this guide, looked at, you know, all the different policies that states have. We know that sometimes things get approved that are kind of all over the board. And so that's one of the good reasons why we wrote down, you know, the definitive, you know, guidance in this one, so we can level the playing field for everyone.

That does require states to come into compliance with a state plan amendment usually, but potentially with an admin claiming plan, as well as a time study implementation plan. And states have the flexibility to come in up to three years, so June 1, 2026 will be that deadline, to come into compliance. But if you want to take advantage of any of the flexibilities I just talked about, you need to come in sooner. Okay? So that's the one caveat with that three-year rule. It doesn't necessarily mean that you wouldn't be open to, you know, auditing or other issues. But this is where you have to come into compliance by three years. We'll certainly take that into consideration. Next slide.

So we just have some resources here. We have things like our Free Care SMDL that we talked about, our 2022 SID that came out. We have things from Ed about the IDEA and the differences there. We have our May 2023 guide, of course, Federal Cost Principles. And certainly you can email us for assistance. At the very bottom is our email, and that will be used for any school-based technical assistance, you know, going forward.

We're going to work - we are continuing to work with the Department of Education as well as our contractor, to provide as much technical assistance as possible to states. And we encourage you to look at the guide, attend these types of calls, ask more questions, send in emails. And hopefully we will start to see, you know, greater, you know, access to students as states come in with, you know, SPAs to take advantage of some of these, you know, flexibilities. That's all for me. And I'd like to hand it back over to Jackie, I believe.

Jackie Glaze: Thank you, Richard. So next, Cindy Denemark will provide updates on the Misclassification of Drugs, the NPRM. So Cindy, I'll turn it to you.

Cindy Denemark: Great. Thank you so much. So the Medicaid Proposed Drug Rule 2434 was placed on display a week ago and published last Friday on May 26th. It

contains 21 items that are proposed in the rule. Next slide, please. There are three major highlights within this proposed rule. The first deals with the misclassification of drugs. And based on the 2019 Act, Medicaid Services Investment and Accountability Act, it defines requirements and penalties related to the drug manufacturers participating in the Medicaid Drug Rebate Program.

Second area talks about the integrity and the operations of the program itself. And in the proposed rule we talk about definitions and clarification on some of our key points. And last but not least, how do we manage the drug spending within the Medicaid program? And we talk about transparency and the cost of drugs over the cost of administration. Next slide, please.

The Drug Misclassification Program proposal, as I said, was released last Friday and comments are due on July 25th. And we really encourage as many individuals and groups to submit their comments. We look forward to everyone so that we can see how, what the thoughts are. Next slide. So the drug misclassification Medicaid program really had only one way of acknowledging a manufacturer participating in the rebate program. They were either all in or all out. There were no penalties; no other penalties at all.

So this proposed rule identifies reports - that the manufacturers have to report all of their covered outpatient drugs that are on the market. And they need to supply their data timely, both monthly and quarterly data. And there are key elements to the data that are supplied; drug category being one of the most important, whether a drug is a single source, an innovator, or a non-innovator product.

This proposed rule will allow the agency to report to the manufacturer when they are out of compliance with any of the reporting requirements. And it will have 30 days for the manufacturer to respond to the agency's communication.

Manufacturers who have a change in the rebates that are owed to the state programs, will have 60-days to remit to all the adjusted rebates. Any manufacturer that is discovered to be out of compliance with their reporting requirements will be part of an annual public report.

The additional penalties that can be applied are a suspension for 90-days from the Medicaid drug rebate program and/or a referral to the Office of Inspector General. Next slide please. The proposed rule has CMS in changes that - with running the Medicaid Drug Rebate Program, that speak to the overall efficiency and operations of the program. The proposed rule will provide greater consistency and accuracy, and strengthen our data. It provides robust stewardship of the federal monies related to all the drug spend within the Medicaid program. Next slide.

In the proposed rule we identify seven items that need further clarification or defining, particularly what is a covered outpatient drug. The proposed rule clarifies the definition of the COD covered outpatient drug to not include any drug, biologic product, or insulin provided as part of or incident to, and in the same setting as any of the services in paragraphs 2(i) through 8 of this definition. More specifically, it talks about direct reimbursement for a drug.

So this clarifies when is a drug bundled and not subject to rebates versus when is it paid separately. This proposed rule defines what a vaccine means to the Medicaid drug rebate program. In the OBER-90 original legislation, vaccines were exempt from rebates, but there is no definition specific to what is a vaccine for the Medicaid drug rebate program. So this proposed rule suggests the definition. The other defined areas are drug product information.

Within a drug product there are 15 components to the reporting of the data elements, including the drug category, such as single source, innovator, and

non-innovator; the unit type; the product type; is it a prescription product or is it an over-the-counter product? Proposed reg goes over the definition of internal investigation. This is critical because the reporting of the average manufacturer price and best price can be only changed beyond three years if it is part of five specific areas, one of which is an internal investigation. So this proposal suggests the definition of what is an internal investigation.

Manufacture - again for the purposes of rebate agreement, all of the manufacturers' labelers should be participating as a unit in the drug rebate program. So we define the manufacturer. The market date seems like a simple thing, but it needed further definition. And so we go on to define what we believe is the market date that's the base AMP. Next slide please.

We have two areas where we are proposing to strengthen the program. The first is to set a time period for which a manufacturer may initiate a dispute after they have received a state invoice. Establishing a time limit for manufacturers to dispute would be limited to 12 quarters. This parallels their reporting period for their average manufacturer price, their AMP, and their best price. We believe that this is consistent with proper and efficient operation of the rebate program. Currently, there is no limitation for how far back a manufacturer can open a dispute and challenge the payment of a rebate.

The second area of clarification is to specify the collection of rebates on clinically administered or physician administered drugs. The rules that set this out were originally a titrated period of time, and we are clarifying that any drug that is a covered outpatient drug that is clinically administered should be invoiced and not limited to certain drugs. Next slide, please.

So this proposal talks about ways that we can add transparency to the Medicaid drug set. Next slide, please. Okay. This is a busy slide, and it has a

lot of information. This is looking for a verification survey for potentially four categories of drugs. We're looking at the highest price per claim drug, the highest drug expenditure within the Medicaid program, drugs with the greatest 12-month price increases, or new drugs that have significant launch prices. The first step of this program will be to identify any drugs that fall into one of these four categories, and we are estimating that there will be 200 drugs that will be identified.

Our second step will be to exclude those drugs for which manufacturers have participated in other coordinated CMS interaction initiatives or have recognized significant supplemental rebates for the majority of the state. If the drug list is greater than care drugs for this survey process, CMS will further reach out to the state and evaluate which drugs should be targeted for this survey. With the introduction of high-cost drug treatment such as the gene therapy, states have been looking for a way to leverage how can they control the drug cost then.

And we believe that requiring manufacturers to complete a survey with their pricing strategies will allow transparency into what is leading to these high-cost drugs. After the survey list is completed and based on the application of the criteria that I noted above, the agency will post on a publicly accessible government Web site the letters sent to the manufacturer indicating the name of the covered outpatient drug that is proposed for the survey and request the completion of the drug price survey verification. The proposed regulation lists the components of the survey that will be required. And that is a full list that will allow, again, as much transparency into the drug pricing as is available. Next slide.

CMS proposes that managed care plans structure any contracts with their subcontractors, such as their PBM, to deliver a more transparent approach to



the reimbursement of drugs and separating out the cost of the drug from the administrative cost. This is especially important as states try to delineate their Medicaid loss ratio calculation. Proposal to separate payment as part of these subcontracts will help states and managed care plans better understand whether they are appropriately and efficiently paying for the delivery of their covered outpatient drug. Next slide, please. So there are additional miscellaneous type items that are critical to the administration of the program. Next slide please.

In this proposed reg we talk about the establishment of a separate bank identification or institution identification number, usually called the BIN, and the processor control number, the PCN, and a group identifier for all plans. By establishing a separate BIN, PCN, and group number for the NCPDP transaction, states' Medicaid programs will be able to appropriately review for duplicate discounts from the 340(b) program, and also to appropriately utilize their prescription drug monitoring program for administering their program. Next slide.

In this proposed rule we are requesting information on requiring the diagnosis on a Medicaid prescription. The requirement for covering a drug within the program is limited to the covered outpatient drug being used for a medically accepted indication. And it is difficult to determine whether a drug is being used for a medically accepted indication without a diagnosis on the claim.

In other words, is it being used with an off-label use? So we are looking for information on what are the operational implications of this - are there privacy-related concerns; is there a burden associated with implementing this for either the beneficiaries or the provider; and what steps do states believe they would need to successfully implement this requirement? Next slide, please.

CMS proposes to revise the regulation aligned with statutory requirements regarding the of benefits and cost avoidance, allowing pay and change for the pediatric preventive services claim and medical child support, as well as detailed timeframe allowed prior to Medicaid for paying these claims. The revision will permit states to pay claims sooner than waiting period where appropriate. In addition to these areas there are also comments and sections about stacking of all discounts to determine best price.

There is a section that rescinds the accumulator adjustment rule based on a response from the courts in May 2022, and it withdraws the previous rule. And then it also discusses the removal of the max cap based on the American Rescue Act of 2021 that sunsets the limit of rebate to the limit of the AMP. I believe that should be the last slide if you want to forward it. Yes. Thank you.

Jackie Glaze: Thank you, Cindy. So we're ready to take your state questions now. So we will begin by asking that you submit your questions through the chat function, and then we will follow by taking questions over the phone line. So I'll turn now to you, (Krista).

(Krista): Great. Thanks so much, Jackie. I am seeing a couple of questions here in the chat. The first one is about the end of the public health emergency. CMS announced on May 1st in its guidance for the expiration of the COVID-19 public health emergency, that it will soon end the requirement that Medicare and Medicaid certified providers and suppliers must establish policies and procedures for staff vaccination. CMS also provided that it would share more details regarding the end of this requirement at the end of the PHE. Do you have any other information about when this requirement will end or when further information will be released?

(Kirsten Jensen): This is (Kirsten Jensen) from Benefits and Coverage. I think we'll need to take that one back and consult with some of our colleagues about an answer.

(Krista): Great. Thank you so much, (Kirsten). We can follow up on that one. The next question here in the chat is about the School-Based Services Claiming Guide. Does the School-Based Services/Medicaid billable apply to Part C services in an IFSP if those services are provided by an early intervention provider and not through the LEA?

Richard Kimball: This is Richard. I would say go ahead and send that to the School-Based Services Medicaid, you know, email box. It does generally cover IFSP, you know, Section 4, but I don't know specifically about, you know, the interaction. It would not be LEA. It may not be covered by the guide because it's not provided in schools. It might be, you know, provided in a different area of Medicaid or a different policy. So send that into the box.

(Krista): Sorry. I'm not seeing any other questions in the chat.

Jackie Glaze: Thank you, (Krista). So, (Ted), I'll ask if you could please provide instructions for the participants to register their questions, and if you could open the phone lines, please.

Coordinator: Yes. The phone line is 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 again, if you would like 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 do see at least one additional question in the chat. So (Krista), I'll turn it back to you.

(Krista): Great. There's another question in here around school-based services. If school-based services are provided virtually without an origination, how is the service reimbursable without a site of service?

Richard Kimball: I would suggest going through the Telehealth Services Guide that we published during the PHE and kind of take a look at those because, again, school-based is just one setting where Medicaid services can be provided and we've provided a lot of guidance on telehealth in that comprehensive guide and it's not really covered in our school-based services guide specifically. Thank you.

(Krista): Thank you. I'm not seeing any additional questions in the chat.

Jackie Glaze: Thanks, (Krista). So (Ted), I'll turn it back to you and ask if you could once again provide instructions for registering the questions and if you could open the phone lines, please.

Coordinator: Sure. And again, if you would like to ask a question over the phone, please press star 1 and record your name. Thank you. I'm currently showing no phone questions at this time.

Jackie Glaze: Thank you, (Ted). (Krista), I see one question, I think.

(Krista): Yes. I believe this question relates to the school-based services claiming guide. How does the minimum random moment affect any time studies that have a higher requirement such as IVE claiming?

Richard Kimball: I'm not sure what the references to IVE is talking about necessarily, but in terms of the random moment time study. I mean we are, you know, talking

about the flexibility, I guess, specifically. I can just reiterate that we're going from, you know, 2% to a 5% increase in that error rate. And that we're allowing, you know, a plus or minus two-day notification/response time for those. And maybe if the person can clarify what they mean specifically, or they can send it to the box again, and we can get back to them on the technical assistance side.

Jackie Glaze: Thank you, Richard. So in closing today, I would like to thank our team for their presentations. And looking forward, if you do have questions before the next call, please feel free to reach out to us, your state leads, or bring your questions to the next call. So looking forward, the topics and invitations for the next call will be forthcoming. So we do want to thank you for joining us today, and we hope that 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]