Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
August 11, 2020
3:00 pm ET

Coordinator: Than you for standing by. At this time all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time you may press Star 1 or your phone to ask a question. I would like to inform our parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to your host, Ms. Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon, everyone, and welcome to today's All state call. I will now turn to Calder, and he will share the highlights for today's discussion and introduce our guest speakers. Calder?

Calder Lynch: Thanks, Jackie. Welcome, everyone. Thanks for joining us today. We have a very full agenda this afternoon, so I'll just jump right in. We're excited to have another special guest with us to continue our Lessons from the Field Series. Henry Lipman from the state of New Hampshire has joined us to share their experiences in implementing state-directed payments in their managed care program in response to the public health emergency. Henry's of course the Director of Medicaid Services for the New Hampshire Department of Health and Human Services.

And then after hearing from his frontline experience, we'll also have John Giles and Laura Snyder from our own Division of Managed Care Policy, who will provide further discussion on reimbursement options that states can utilize to temporarily enhance provider payments and manage care in response to the public health emergency. These options were described of course in the May CMCS informational bulletin on this topic and now that we've had a

couple of months of experience under our belt, we want to share some of our early lessons learned. We'll then open up to take questions for Henry and our Managed Care Team on that topic.

Following that discussion, Chrissy Fowler -- from CMS's Office of Financial Management -- will provide an update on an announcement made earlier today related to the resumption of payment error rate measurement -- or PERM -- engagement with providers and states. Chrissy is the Group Director for the Payment Accuracy Reporting Group in OFM. And finally, Jeremy Silanskis from our Financial Management Group will provide an overview of the states - the steps that states need to take to terminate or reduce payment increases they may have enacted as part of their disaster state plan amendments during the PHE. If they want to end those or phased them down before the end of the PHE, there's some steps we want to make sure states are aware of that will be required there. After these updates, we'll then open up your lines for your general questions as always.

Before we get started, I do want to share a couple of announcements and updates. First, just to flag for everyone's attention that earlier today the Administrator announced a new Innovation Center model - the Community Health Access and Rural Transformation model or the CHART model. This is something we've been talking about for a little bit and many of you were aware that CMS was developing a rural health model and have indicated an interest in learning more. We pushed out detail on the announcement over our Listserv earlier today and we're also working to have experts from the Innovation Center join a future Allstate call to go into more in-depth detail on the model and the opportunities it presents for states and Medicaid agencies. For communities who are interested in applying for the model -- which will provide seed funding to invest in a community system transformation -- Medicaid will play a critical role and so we want to make sure Medicaid

agencies are aware and are part of those conversations that will be happening at the local level.

Another update on the Provider Relief Fund. The department announced yesterday that providers who received an initial payment from that first Medicare-focused general distribution but missed the June 3 deadline to apply for the additional funding -- that was part of that round of funding that would get them up to the 2% of their total patient care revenues -- have a new opportunity open for them to apply for those funds.

And we know that many of these providers include Medicaid, CHIP, and dental providers who might have had a little bit of Medicare revenue that made them eligible under that round of funding but assumed that they were ineligible for further distributions or need it, so maybe wait and apply for a more Medicaid specific distribution and therefore, missed that deadline. And we heard from many of you and many of your provider associations that there were a number of providers who fell into this situation, so they've reopened that portal and the application deadline is August 28.

So we would appreciate your help in making sure we get the word out to folks. We've I believe pushed out some communication about that and in addition to that -- and based on the feedback that we've received from you and others -- HRSA has simplified and streamlined some of the required fields in the application portal to help improve the success rate of providers who are going in and putting those applications. And again, HHS has been hosting a series of informational webinars to address questions and help providers through that process. The next one is in two days on Thursday, August 13 and additional information about these webinars is available on the Provider Relief Fund web site, which is again H-H-S dot gov slash provider relief.

Finally, I wanted to make an announcement for those of you who may not have seen the news about some upcoming leadership transitions that are occurring here at CMS. Last week CMS Administrator, Seema Verma, announced that her current Chief of Staff, Brady Brookes, will be leaving the agency at the end of the month after over three and a half years of service here at CMS, and I will be transitioning from the role of CMCS Center Director to serve as her acting Chief of Staff in the Office of the Administrator. With my transition to that role in the Office of the Administrator, Anne Marie Costello will become the acting Center Director for CMCS.

It has certainly been a great privilege to collaborate closely with you all in this role and the amazing team that we have at CMCS, but I know that the Medicaid and CHIP programs will be entrusted in very capable hands with the strong leadership of Anne Marie as the acting Center Director. This of course means you probably won't get to hear from me quite as often on these calls, but the CMS Medicaid Team will certainly keep these lines of communication open and they know where to find me when necessary. So with that, I'll turn the call over to John Giles to start our managed care presentation. John?

John Giles: Thank you, Calder, and good afternoon everyone. As Calder discussed, we published guidance in May to help states implement payment methodologies under their Medicaid managed care contracts to help address the impacts of the public health emergency. We know that states continue to be interested in ways to contractually require their managed care plans to make specific payments to providers to help mitigate the impacts of the public health emergency. Our May guidance was intended to help states comply with the regulatory requirements for state-directed payments in response to COVID-19 and provided a framework that will help states design these payment arrangements and facilitate CMS's review and approval process.

I'm not going to cover the entire framework from that guidance but I did want to highlight a few things. First, there must be a connection and tie to the utilization and delivery of services under the current managed care contract. In the May guidance, we provided states a few specific examples where states can require plans to provide a uniform dollar or a percentage increase in per-service payment amount for furnishing covered services to enrollees under the contract in order to affect the total payments to providers. Second, there must be a connection to quality and evaluation. We understand that most of these state-directed payments will be implemented to ensure the continued availability and accessibility of covered services for Medicaid managed care enrollees.

Third, we will require states to implement two-sided risk mitigation for these types of state-directed payments when states are seeking to utilize the flexibilities described in the May guidance. Since there is significant uncertainty related to cost and utilization due to the public health emergency, CMS will require implementation of a two-sided risk mitigation strategy when states implement new state-directed payments intended to mitigate the impacts of the public health emergency.

We do want to note that this requirement applies to new payment arrangements as well as amendments to existing payment arrangements when states are implementing state-directed payments that are specific to COVID-19. My colleague, Laura Snyder, will be discussing some additional options related to this requirement.

Finally, I wanted to highlight that we are permitting a few targeted administrative flexibilities in key areas of a state's implementation of state-directed payments for COVID-19. This includes one, that we are not requiring a comprehensive provider payment rate analysis but instead are asking states

to provide supporting documentation regarding total provider payment level.

Two, we are permitting states to implement state-directed payments retrospectively to the start of the current contract rating period. But we do want to note that we are no longer accepting preprints for rating periods that ended June 30 of 2020. We are also not requiring rate certification amendments for new state-directed payments if those amounts are within the plus or minus 1.5% per rate cell (de minimis) amount.

And with that brief overview, my colleague, Laura Snyder, will now briefly highlight the pre-populated template examples that we made available along with the guidance in May. Laura?

Laura Snyder: Thank you, John. As John noted, we did publish two pre-populated template examples for states submitting state-directed payments in response to the public health emergency with that May guidance, one, for effectuating retainer payments -- approved under for example in Appendix K -- a second for other types of state-directed payments to respond to the public health emergency. We do encourage states to use these pre-populated templates for state-directed payments being implemented in response to the public health emergency.

We have continued to receive questions about the expedited COVID-19 review process and framework outlined in the May guidance, particularly around when states are required to implement two-sided risk mitigation. We do want to reiterate as we have said on past calls that the two-sided risk mitigation will not be required when states are implementing retainer payments or effectuating them through managed care only.

However, if states want to take advantage of the flexibilities laid out in the May 14 guidance for other types of state-directed payments to respond to the

public health emergency, they will be required to follow the framework laid out in that guidance, including implementation of a two-sided risk mitigation strategy. If states are not interested in taking advantage of the flexibilities that are laid out in that May 14 guidance, states can elect to follow the standard review process, which will require, for example, a full reimbursement analysis and inclusion of all state-directed payments and rate certification. In response to the additional questions, we have started to implement a new procedural step to ask states to confirm which review process they would like to pursue -- the COVID-19expedited review process or the standard review process.

CMS will be asking for this information for all preprint submissions -- including amendments -- that come in. This email will provide a table to explain the differences between the two review processes and what will be required under each review type. Again, CMS is happy to provide additional technical assistance in this area if states have any questions or concerns.

With that, I will now turn it over to Henry Lipman -- the Medicaid Director for the state of New Hampshire -- to share his experiences with implementation of state-directed payments in response to the public health emergency. Henry?

Henry Lipman: Thank you, Laura. New Hampshire did use the uniform percentage increase for six safety net provider types using the COVID preprint. We used it for our FQHCs, our rural health clinics, critical access hospitals, SUD residential treatment providers, and home health providers as well as private duty nursing. It was implemented for a contract period that ended June 30 and we did use the full rating period, as John described earlier. It was funded actually by a 1.5% reallocation of the capitation rate for the full rating period and we did have a two-sided risk corridor program to support this.

When we began the work with CMS on this, it was in late March, early April ahead of an expected state surge in New Hampshire. There were a lot of utilization uncertainties. There were uncertainties in terms of the timing of CARES Act money coming to help our safety net providers and the timing of the Provider Relief Funds. We didn't want an effect to be the (cavalry) that was late to helping our safety net providers remain available to our Medicaid beneficiaries and we also didn't want there to be a potential windfall to the MCOs at a time later on -- where we might make a recoupment -- where it was too late to provide relief to our safety net providers.

I'd like to then share how the state work with our safety net providers. We were fortunate that a coalition of safety net providers itself formed to interact with the department here on concerns about viability and both short-term actions that they potentially would need to take to reduce access for Medicaid beneficiaries if there wasn't some level of certainty in terms of their financial status. We then took that in terms of how we work with our state's managed care plans and approached it as a shared responsibility for network adequacy, particularly of the safety net providers serving Medicaid beneficiaries. In other words, we let the MCOs know we weren't looking for them to hold up the whole system but that their fair share with respect to the Medicaid safety net.

We also -- going back to that guidance of May 14 -- looked at some of the recommendations around leeway to MCOs with respect to performance metrics and withhold in light of the impact of COVID on that and the public health emergency, and also obviously the risk corridor protections. We were approximately 7/10 through our contract period and so we also used -- in this period -- a slightly asymmetrical to make sure that the MCOs weren't overly penalized for the work that they had previously done in the rating period. Our actuaries -- this is the next part I'd like to cover -- in terms of how they

worked with the state that would provide some very important services to us.

First and foremost was calculating an estimate of where our MCOs stood with respect to their year-to-date MLRs, an estimate of available funds for directed payments based on that 1.5% re-allocation. In terms of the risk corridor, a very important thing was modeling how that might work out and coming up with probability estimates in terms of the financial impacts on both the state and the insurers. And then we also updated our rate filing to support our interactions with CMS and OACT as actuary and concerns to facilitate the contract amendment as well with the MCOs.

I guess another piece I'd like to talk about is in terms of working with Laura and her team and OACT was the interactions we had upfront saved a lot of time. We were able to work through the expedited process in about a month's time. We learned some things that I think are more clear in the guidance now, but it obviously had to be for services that were provided that in other directed payments it also has to apply to classes of providers. We had also at the time some option -- we wouldn't have it now obviously -- but some option to amend the directed payment based on the public health emergency evolved in New Hampshire.

We obviously learned about the risk corridor requirement, the rate filing update was beneficial to us, and it was beneficial for the full contract period in terms of working through with the managed care negotiations and getting those done in a timely fashion, and also in terms of what the evaluation for both the quality and compliance areas.

And lastly I'd like to wrap up with some of the lessons that we learned. I think in terms of our implementation thus far, we have had some experience in our managed care program with directed payments.

And I guess probably the number one thing that I think also helped us in terms of getting the funds out is we kept the program simple and we consulted with our program areas within the department in terms of what codes might be best to use to include in the program and by doing so, we were able to get the dollars out within a couple of weeks of the contract approval by our state government. The next contract period though we're approaching a little bit differently because we know more about what's going on in terms of some of the things I mentioned earlier, including CARES Act money and Provider Relief Funds.

We're approaching the next period. One of the key things that started for us for July 1 contract period is looking at modeling what the deferral of care might look like and we developed a model with our actuary and shared that also with the MCOs to -- if you will -- together define some assumptions about what that might look like. We've also included a retro rate refresh to be included in the contract based on more recent experience. We're looking to look at the March to August period to help inform us. This time we're looking, we have a symmetrical risk corridor because of much more known things it being a brand new contract period. We also have - need to keep in mind that our alternative payment method strategies and metrics still may need to be modified based on how the public health emergency continues to evolve.

And I guess finally I would say that our stakeholder communication, there were some providers that didn't fit into the directed payment but there were other things we could do for them. And an example was for our community mental health centers in terms of their capitation arrangement with the MCOs in terms of obtaining some relief for them and in terms of their maintenance of effort requirements due to the fact that they couldn't see in-person type care. I guess with that, Laura, I'm ready to pass it back to you and John.

Jackie Glaze: Actually, Henry, you'll pass it to me. This is Jackie.

Henry Lipman: I'm sorry. Sorry, Jackie.

Jackie Glaze: That's great. So thank you for your presentation, Henry, John, and Laura. So we're now ready to take questions from the audience on the presentations that they just heard So, Operator, will you open up the phone lines at this point?

Coordinator: Yes, thank you. We will now begin the question and answer session. To ask a question please press Star 1, unmute your phone, and record your name. Your name is required to introduce your question. To withdraw your question, please press Star 2. Again to ask a question, please press Star 1. It will take a few moments for the questions to come through. Thank you. Okay, we show no questions at this time.

Jackie Glaze: Okay, we will move onto the other presentations and they can certainly think about those questions, and we'll have more time at the end. So at this point we'll move onto Chrissy Fowler and she will provide an update on the announcement made today on the PERM. Chrissy?

Chrissy Fowler: Hi. Thank you, Jackie. So the PERM program measures the improper payments in Medicaid and CHIP, which is required by law -- it's the Payment Integrity Information Act of 2019 -- and the way PERM is set up is we have three cycles of states that we measure once every three years. So earlier this year -- due to the public health emergency -- on April 2, CMS announced that we were exercising our enforcement discretion to adopt a temporary policy of relaxed enforcement regarding the PERM program. So what it means is we suspended all improper payment-related engagement and communication and (data) request for the providers in the states and we continue to do internal

interviews with the documentation that we had at that time for the cycles of states that we were in the measurement with.

So, as Calder mentioned this morning, we made an announcement on our PERM web site at W-W dot CMS dot gov backslash PERM that effective August 11 -- today --we are going to resume PERM-related engagement with states and providers. This notification also went out to the state PERM contacts from our CMS PERM liaisons.

So what this means for Cycle 2 states -- which we would've reported - we would be reporting their rates in the 2020 report period that's usually the agency financial report that goes out on November of this year -- at this time, we had paused or suspended the contact from PERM. CMS had sufficient information and documentation necessary to actually be able to report out a national rate this November. So we will be notifying the PERM liaisons at the state level through our cycle call, which we plan on having one tomorrow with the Cycle 2 states at 1:00 Eastern Standard Time.

For Cycle 3 states -- this is the cycle of states that would be measured and recorded in the national rate for 2021 -- we're going to resume all improper payment-related engagement communication and data request to both providers and state agencies. Again, we will hold a call with these cycle of states tomorrow as well -- but it will be at 3:00 Eastern Standard Time -- and we will discuss but what that means for those cycle of states. And the reason we are recommencing the measurement right now -- but we had sufficient data for Cycle 2 states to report in 2020 -- we do not - we are not in that situation for the Cycle 3states and we must recommence the measurement now in order to meet the statutory required reporting of a national improper payment requirement.

So we do realize that states may have challenges with the resumption of PERM. But following the cycle call tomorrow, each of our states CMS liaison -- the CMS team -- will be reaching out to set up individual calls with each state in Cycle 3 to discuss any state-specific considerations. For Cycle 1 states, they are scheduled to be reporting on measured and reported out in 2022. We anticipate having a call with them - a kickoff call with them on Wednesday, August 19. And so the states will receive the (appointment) and materials prior to the meeting. So just in general, CMS will continually evaluate the PERM program activities to gauge whether any further suspensions might again become necessary. With that, that is all that I have to - as far as an update on the PERM resumption of communication with providers and states.

Jackie Glaze: Thank you, Chrissy. So now we're ready to transition to Jeremy Silanskis and he will provide an update on the termination of payment increases prior to the end of the public health emergency. Jeremy?

Jeremy Silanskis: Great. Thanks, Jackie, and good afternoon everyone. So we've had several inquiries from states. One, what options are available to terminate payment increases that they've applied through the disaster relief templates SPAs, and so we want to get out with this guidance to states early on so you're prepared to do what you need to do to get that in place. So the disaster relief templates, they automatically (fund) that at the end of the PHE. And these states sort of come in have said, "Well, you know, we didn't anticipate that was going to go on for this long," and states may have budgetary concerns about, you know, just having those payments continue on.

So the first question that we've received is, you know, can we use the disaster relief template to establish an earlier sunset date if we already have that payment in place through an approved SPA. And the answer is yes, you can

do that as long as you go through the normal SPA procedures, meaning that you do a public notice that's at least one day prior to the effective date of that change and you go through appropriate tribal consultation procedures. And you'd also need to submit the SPA within the quarter no earlier than the first day of the quarter in which you submit the SPA. So that's how you would handle that if you want to change your approved disaster relief SPA to end the payment prior to the end of the PHE.

If you are coming in with a new disaster relief SPA payment increase, we recommend that you -- at your option -- put in place a date that's prior to the end of the PHE to sort of offset some of these concerns. So some states have, you know -- for instance -- in this quarter, may set it for September 1 and then as you reassess whether you need to continue on that payment increase or terminate it, you'd have that automatic sunset in place so you wouldn't need to go through notice and consultation to, you know, modify that as long as you did that on the front end. So you'd submit your SPA, you do public notice and consultation now, you'd put that date in your disaster relief plan as the end date, and then you would be all good if you decided not to renew the payment as of September 1.

So those are the two options that we wanted to lay out. If there are questions, we are happy to work with states on these issues and you know, resolve them. I think the one, you know, piece of good news is in working through these questions with our legal counsel, they think we're relatively protected against having states do go through the excess requirements. In the event that you do go through appropriate notice and consultation practices since the reversion of the rates prior to PHE rates would assume that they were already consistent with Section 1902(a)30(A) So with that, I'll be happy to take questions at the end and appreciate your ongoing partnership in this. So, back to you, Jackie.

Jackie Glaze: Thank you, Jeremy, and thank you to all of our presenters. So that concludes all of our presentations and updates, so we're ready to take your questions, any of the presentations, or any general questions that you may have. So, Operator, please open up the phone lines now, please.

Coordinator: Thank you. If you would like to ask the question, please press Star 1, unmute your phone, and record your name. Your name is required to introduce your question. If you need to withdraw a question, please press Star 2. Again to ask a question, please press Star 1. Ms. Coleman, your line is open.

Jacqueline Coleman: Hi, this Jacqueline Coleman calling from the state of Michigan, and my question is, is there Medicaid funding available to cover the cost of Internet services for Medicaid beneficiaries?

Julie Boughn: This is Julie Boughn. I can probably take that one, Jackie.

Jackie Glaze: Go ahead, Julie.

Julie Boughn: Okay, so as a general rule, we can cover -- with enhanced funding new Medicaid dollars -- I.T. expenditures that are for the economic and efficient operation of the Medicaid program generally associated with the Eligibility and Enrollment Systems or what we call nowadays the Medicaid Management Information System. So it's not likely that we could pay for that kind of service that you're talking about, but I would say there's ideas that states have about things that they want to do. They should definitely reach out to their Medicaid Enterprise Systems' state officer have a conversation.

Jacqueline Coleman: Okay, thank you.

Coordinator: Okay Mr. (Bill Logan), your line is open.

(Bill Logan): Hi, thank you. This is (Bill Logan) from Maine. I had a question with regard to the discussion about stopping rate increases that have been enacted to the Disaster SPA. I guess a couple of questions. The presenter indicated that we should do that through our normal SPA procedures. My question is, does that mean we do not submit it as a - as a D-SPA -- in a second iteration of a D-SPA? And certainly understand the public notice occurring a day before, and you said normal tribal consultation. My question would relate if we had the flexibility around travel consultation in our D-SPA, whether that can be utilized in that submission as well?

Jeremy Silanskis: Sure. I think we've gotten some...

(Bill Logan): I have a follow up as well if you want to take those two first.

Jeremy Silanskis: Yes, so I'll start with the question about effectuating the change to the disaster relief template and that's a really good clarification by the normal SPA procedures.

I mean those that are already in regulation that apply to the timeframes and notification requirements, you can end your payments that were approved through the Disaster Relief SPA template, through that template, so you could come in and make your amendment to that template. You don't need to come through a separate state plan and end that process.

And then for tribal notification, I'm wondering if there's anybody on from the Division of Tribal Affairs so you could speak to that question?

(Sarah Delone): So, this is (Sarah Delone) I'm not sure that Kitty Marx is on, but can you just clarify, Jeremy, that this would be a, you know, would be something they - the

1135 authority that was used for the - to modify the tribal consultation was because it was, you know, in part, it was only - it's only for changes that promote access, right, that's the purpose of 1135 waivers.

So, if this is to increase rates or to do something that might be interpreted as lessening access, then that authority couldn't be used to modify tribal consultation.

Jeremy Silanskis: Right. So, that's the need to do the regulatory public notice and the tribal consultation processes is that we can't use the 1135 waiver authority to change those processes because it wouldn't promote access to end a rate increase. So, that's (the need) to go through, you know, the standard procedures when you're making those modifications. But again, you can use the template to establish a different date that ends earlier and we have confirmed that that's okay.

(Sarah Delone): So, the short answer is no, you can't modify your tribal consultation. You have to - you have to follow the - your state's tribal consultation policy that's set forth in your tribal consultation SPA.

(Bill Logan): Okay. So my understanding - all right, so if we were going to make a change to remove something, have some flexibility as opposed to adding something, we do need to do prior tribal notification as per the normal course?

(Sarah Delone): Correct.

(Bill Logan): And finally, in communications, we've had this issue come up with our second iteration of our Disaster SPA which is pending approval. We've been asked to split out the specific provision. We were looking to do this from the rest of it. I just want to know whether or not that's going to potentially create any issues

that you might see on our end. For example, creating a backlog on an issue where you might want to make another change.

Jeremy Silanskis: And I think (Todd McMillan's) on from our division, (unintelligible) (using that), could help out with that one.

(Sarah Delone): It seems like a very - if I can suggest, it seems like a very state-specific question. Maybe we should follow up offline to - Jeremy, to make sure we have all the right people to answer the question. Does that make sense?

Jeremy Silanskis: Of course. Yes, we'll do that.

(Sarah Delone): If that works - if that works for you? I'm sorry, I missed (your name)?

(Bill Logan): (Bill Logan). That's fine.

(Sarah Delone): Yes.

Jackie Glaze: And that's from Maine, so we'll do the follow up on that. Okay, Operator, we're ready for the next question.

Coordinator: Thank you. We show no questions at this time. Please press Star 1, unmute your phone and record your name. Your name is required to introduce your question. To withdraw your question, please press Star 2.

(Deborah Kensey), your line is open.

(Deborah Kensey): This is just to do a shout out for Calder as he heads off to his new post, fare thee well, but wanted to make sure to say, of the voice from the crowd of people that have been on these calls, week after week, month after month,

many kudos for the work in - and I'm sure long hours - for what you and all of your staff and everybody who's on this call that have been working to provide guidance to the states have been doing for us all throughout this public health emergency.

Karen Shields: Thank you very much, appreciate it.

(Deborah Kensey): You're welcome.

Coordinator: (Courtney), your line is open.

(Courtney Kane): Hi this is (Courtney Kane) from Alaska and I apologize, I may have missed some contextual information at the start. I had some noise interference here in the office.

So, is the need to go through the SPA process to terminate say, payment increases, does that only apply when you are wanting to terminate that early, before the end of the public health emergency? In other words, if we want it just to terminate with the public health emergency, we're okay bot doing any of that. Am I correct?

Jeremy Silanskis: Yes, you're correct.

(Courtney Kane): Okay, thank you. I apologize. I missed that part.

Jeremy Silanskis: Sure.

Coordinator: Thank you. We show no further questions at this time.

Jackie Glaze: We'll give it just another minute or two and then we'll wrap it up, so if you

could just let us know within the next minute or two if we have any calls that come in.

Coordinator: Yes, ma'am.

Jackie Glaze: Thank you.

Jackie Glaze: Operator, are you seeing any calls?

Coordinator: We show no calls at this time.

Jackie Glaze: Okay. So then I think we'll give everyone back a little bit more time on their schedule, but I want to thank (Henry), (Chrissy), and our CMCS staff for their helpful presentations today. Looking forward, CMCS staff will meet with you next week and the topics and the invitations are forthcoming.

So, of course, if you do have questions in the meantime, reach out to us, check in with your state leads, we're always here to assist you. So, thanks again for joining us today and have a great afternoon. Thank you.

Coordinator: That concludes today's conference, you may disconnect at this time. Hosts, please stand by for your line count and your post-conference.

Jackie Glaze: Thank you.

End