IMPLICATIONS OF COVID-19 FOR SECTION 1115 DEMONSTRATION MONITORING: CONSIDERATIONS FOR STATES

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Introduction

On January 31, 2020, the Secretary of the United States Department of Health and Human Services declared a public health emergency (PHE) as result of confirmed cases of the Coronavirus Disease 2019 (COVID-19). The President of the United States also issued a proclamation on March 13, 2020 that the COVID-19 outbreak in the United States constitutes a national emergency. The Centers for Medicare & Medicaid Services (CMS) acknowledges that most states have a Medicaid section 1115 demonstration and recognizes that the COVID-19 PHE could affect a state's monitoring of its section 1115 demonstration. CMS also acknowledges that each state could be affected differently, given the array of section 1115 demonstration programs and services, the local severity of the pandemic, and strategies to address the COVID-19 PHE in each state.

To the extent possible, CMS encourages states to continue to focus on section 1115 demonstration monitoring as required by 42 CFR § 431.420 and the special terms and conditions (STC) of each demonstration. However, demonstration monitoring in the context of the COVID-19 PHE may require a state to make adaptations to its monitoring reports.

Overview of this technical assistance document

To support state decision making on adjustments that may be necessary to section 1115 demonstration monitoring, this document describes four monitoring-related issues that a state is likely to face due to the COVID-19 PHE, along with suggested actions that the state can discuss with its CMS demonstration team: (1) changes in billing codes to address the COVID-19 PHE, (2) baseline reporting data affected by the COVID-19 PHE months, (3) challenges in assessing trends in monitoring data, and (4) pauses or delays in implementing demonstrations. This is followed by information on monitoring after the conclusion of the COVID-19 PHE.

This document is intended to offer technical assistance on responding to monitoring-related issues that may arise due to the COVID-19 PHE, for section 1115 demonstrations[1] in general. A few of the suggested state actions, however, are more relevant for specific types of demonstrations; that is, demonstrations for which the STCs require the state to document its reporting plans in a *monitoring protocol* and to use *structured monitoring report templates* to report standard monitoring metrics. These are generally part of substance use disorder (SUD),

[1] This issues discussed in this memo do not apply to the COVID-19 section 1115 demonstration opportunity outlined in the COVID-19 Public Health Emergency Section 1115(a) Opportunity for States State Medicaid Director Letter (SMDL # 20-002) available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.

serious mental illness and serious emotional disturbance (SMI/SED), or eligibility and coverage demonstrations.[2] However, a state with any type of demonstration may wish to review and consider the suggestions when producing monitoring reports. Because the COVID-19 PHE may affect states and demonstrations differently, explanations and clarifications in monitoring reports will help CMS to better understand the implications of the COVID-19 PHE for the state's monitoring data.

1. Changes in billing codes to address the COVID-19 PHE

CMS recognizes that many providers and facilities have shifted from in-person visits to telehealth or other service delivery . Furthermore, CMS has released updated technical specifications manuals[3] for SUD, SMI/SED, and eligibility and coverage demonstrations that incorporates these telehealth codes into the monitoring metrics, where appropriate. A state using these updated technical specifications manuals for demonstration monitoring should review the relevant manual(s) to determine whether any additional codes are needed to capture if and when services are provided through telehealth for its demonstration. Each state should work with its CMS demonstration team to decide how best to account for new codes. For instance, a state required to develop a monitoring protocol and report CMS-identified metrics could note the codes in the protocol or in the state's quarterly and annual monitoring reports. A state that is not required to submit a monitoring protocol or report CMS-identified metrics should also provide relevant information in the quarterly and annual monitoring reports about how metrics reporting may have been adjusted to accommodate telehealth or alternative service delivery models.

2. Baseline reporting data affected by the COVID-19 PHE months

A baseline reporting period for monitoring metrics serves as a reference point for each state's predemonstration (or early demonstration) performance. Demonstration STCs require each state to monitor progress on metrics or document the performance of the demonstration in its monitoring reports. Some demonstration STCs explicitly require the state to identify baseline reporting periods and use them for formal assessments of demonstration performance.

Each state commonly defines its baseline reporting period as the first year (12 months) of its demonstration's current approval period, or the year prior to the current approval period if data are available (such as with a demonstration extension). In either case, the planned baseline reporting period for a demonstration could include months affected by the COVID-19 PHE, beginning with March 2020. CMS knows that this may limit the state's ability to compare these quarters to subsequent quarters or that it might skew overall trends due to changes in health care delivery, enrollment, and beneficiaries' behavior in response to the COVID-19 PHE. As a result, a state may wish to identify an alternate baseline reporting period. However, given the varying degrees of impact on demonstrations and uncertainty about the duration of the COVID-19 PHE, there is no ideal alternate period for baseline reporting that applies to every state.

[2] A state with these demonstrations should also refer to the information included in the monitoring tools for these demonstration types, including the technical specifications manuals and Q&A documents.

[3] Technical specifications manuals for E&C, SMI/SED, and SUD demonstrations monitoring metrics are accessible to the state through Performance Metrics Database and Analytics (PMDA) in the Reference Materials Section or from CMS upon request and following the completion of the National Measure Stewards Terms and Conditions Agreement.

Months prior to the COVID-19 PHE may have limited comparability to future time periods because of changes in enrollment associated with the economic downturn and the maintenance of enrollment requirement in section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA; P.L. 116-127),[4] as well as longer-term effects of the COVID-19 PHE on health care delivery and beneficiaries' behavior. Consequently, a state can identify a later baseline period—for example, one that includes months in Demonstration Year 2. This may be more appropriate if the state is delaying or pausing implementation of its demonstration.[5]

Suggested state actions. Each state can determine the baseline reporting period that is most appropriate for monitoring demonstration progress. Each state should assess the appropriateness of a baseline reporting period for demonstration monitoring based on state-specific COVID-19 PHE impacts and demonstration-specific considerations, including monitoring requirements outlined in the STCs. When making this decision, the state may wish to consider the following:

- Each state can propose the most appropriate uninterrupted 12-month period for its baseline reporting period. A state may consider selecting an earlier period that excludes the COVID-19 PHE months, assuming the state can report monitoring metrics for that period.
- If the state chooses a baseline reporting period that includes months during the COVID-19 PHE, the state should describe any anticipated issues or considerations when reporting demonstration progress or interpreting trends in monitoring metrics relative to the baseline reporting period.
- The state should also describe any anticipated issues or considerations when reporting on demonstration progress or interpreting trends if it uses a baseline reporting period before the demonstration's current approval period.

Each state should discuss its planned approach to determining its baseline reporting period with its CMS demonstration team to ensure alignment with CMS requirements in the demonstration's STCs and approved monitoring protocols (when required by the demonstration's STCs). If a state has an approved monitoring protocol (when required by the demonstration's STCs), the state should also detail its modified baseline reporting period in its next monitoring report.

3. Challenges in assessing trends in monitoring data

Assessing trends in monitoring data is an important part of assessing demonstration progress in state monitoring reports. It is also a critical consideration for conducting demonstration mid-point assessments, when required by STCs. CMS recognizes that a state will often need many months, quarters, or years of data (depending on the metric) to interpret trends. CMS understands that the COVID-19 PHE will likely affect monitoring data, and trend assessments that include metrics for the periods affected by the COVID-19 PHE will be challenging for some

[4] FFCRA, enacted on March 18, 2020, and CMS regulations at 42 CFR 433.400 require states claiming a temporary increase in the Federal Medical Assistance Percentage to maintain the enrollment of individuals validly enrolled in Medicaid as of or after March 18, 2020 through the end of the month in which the COVID-19 PHE ends, unless the individual requests a voluntary termination of eligibility or ceases to be a resident of the state.

[5] The state must submit monitoring reports as outlined in their STCs, even if there are implementation delays.

metrics.[6] For example, inpatient admissions in some states greatly increased due to COVID-19, and CMS understands that any inpatient admission metrics that the state measures during this period may reflect this increased utilization. In addition, enrollment-related metrics may reflect higher enrollment and fewer disenrollments during the COVID-19 PHE as a result of FFCRA's maintenance of enrollment requirement or economic conditions in the state. For demonstrations that include home and community-based services (HCBS), metrics may reflect shifts in trends related to beneficiaries receiving 1915(c)-like services under flexibilities granted to states through COVID-19 section 1115 demonstrations, under Disaster Relief Appendix Ks, or State Plan Amendments. For example, states may observe an increase in the number of beneficiaries eligible to receive HCBS, greater or continued access to HCBS, gaps in performance data on quality and safety measures, or an increase in HCBS-related costs during the COVID-19 PHE.

Suggested state actions. The state should explain the implications of the COVID-19 PHE on the state's demonstration in each monitoring report (and mid-point assessment, when required by STCs). The state should also describe in its monitoring reports any monitoring data trends that could have been affected by the COVID-19 PHE.

4. Pauses or delays in implementing demonstrations

CMS recognizes that a state may experience delays in, or need to pause, its demonstration implementation due to the COVID-19 PHE. CMS seeks to understand how the COVID-19 PHE is affecting demonstration implementation and support each state in making adjustments, if needed. CMS also realizes that such delays or pauses in demonstration implementation may lead to difficulty comparing metrics data over time. For example, a state may decide to pause its demonstration activities after an initial period of implementation in order to focus on its COVID-19 PHE response. When resuming demonstration implementation, the state's monitoring data may be difficult to analyze relative to data for reporting periods prior to the pause in demonstration activities.

Suggested state actions. The state should discuss any delays or pauses in its demonstration implementation due to the COVID-19 PHE with its CMS demonstration team. The state should describe in its monitoring reports (and mid-point assessment, when required by STCs) how COVID-19 has affected its demonstration and any potential impact on monitoring data trends due to any pause or delay in demonstration implementation.

Monitoring after the conclusion of the COVID-19 PHE

During the course of the COVID-19 PHE, CMS offered states many flexibilities in their Medicaid programs to allow them to respond to local outbreaks and ensure continued access to services. CMS recognizes that state use of these flexibilities could have implications for the state's section 1115 demonstration monitoring data, and that a state may continue to experience changes, such as to enrollment, that might affect those data, when returning to normal operations after the conclusion of the public health emergency. CMS encourages states to review the Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public

[6] The COVID-19 PHE may also impede a state's ability to demonstrate progress at the mid-point assessments (when required by STCs).

Health Emergency State Health Official letter (SHO# 20-004)[7] for more details on conducting eligibility renewals, redeterminations, and other requirements that might affect monitoring data for section 1115 demonstrations. While this document focuses largely on how to handle monitoring for time periods during the COVID-19 PHE, the state should also explain in its monitoring reports how the state's process for conducting eligibility renewals and redeterminations at the conclusion of the public health emergency may be related to trends in enrollment-related metrics.

Conclusion

Monitoring section 1115 demonstrations enables the state and CMS to gauge demonstration progress. Capturing demonstration progress through monitoring is especially important for CMS and the state in the context of the COVID-19 PHE. Monitoring allows both CMS and the state to accurately understand the experience in the field and trends in data. The state should consider how to address key issues related to the COVID-19 PHE that affect the state's findings and interpretation in its monitoring reports. CMS understands the challenges that each state is facing as it implements and monitors its demonstration(s) and considers changes in response to the COVID-19 PHE. CMS encourages every state to openly discuss these challenges with CMS as needed.

[7] SHO #20-004 is available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf.