DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 12, 2021

Amanda Cassel Kraft
Acting Assistant Secretary, MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor, Room 1109
Boston, MA 02108

Dear Ms. Cassel Kraft:

The Centers for Medicare & Medicaid Services (CMS) approved the evaluation design for Massachusetts's section 1115 demonstration entitled, "Massachusetts COVID-19 Public Health Emergency Demonstration" (Project Number 11-W00355/1), and effective through the date that is sixty calendar days after the federal public health emergency expires. We sincerely appreciate the state's commitment to efficiently meeting the requirement for an evaluation design stated in the demonstration's Special Terms and Conditions (STCs), especially under these extraordinary circumstances. Along with the evaluation design approval, CMS is issuing a technical correction to the "Massachusetts COVID-19 Public Health Emergency Demonstration" project number. When the demonstration was first approved December 30, 2020, the approval letter and STCs referenced an incorrect project number. CMS has updated the demonstration project number (11-W00355/1) and is confirming the correction with this approval.

The approved evaluation design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved evaluation design on Medicaid.gov.

Please note that, in accordance with STC 16, a final report, consistent with the approved evaluation design, is due to CMS one year after the end of the COVID-19 section 1115 demonstration authority.

We look forward to our continued partnership with you and your staff on the Massachusetts COVID-19 Public Health Emergency Demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

[redacted]

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

[redacted]

Angela D. Garner
Director
Division of System Reform
Demonstrations

cc: Marie DiMartino, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **Project Number 11-W-00355/1**

TITLE: **Massachusetts COVID-19 Public Health Emergency (PHE) Demonstration**

AWARDEE: **Massachusetts Executive Office of Health and Human Services**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying authorities, shall apply to the demonstration project effective from March 1, 2020, through the date that is 60 days after the public health emergency (PHE) described in section 1135(g)(1)(B) of the Social Security Act (the Act), including any extension, expires. In addition, these waivers may only be implemented consistent with the approved special terms and conditions (STC).

Under the authority of section 1115(a)(1) of the Act, the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs for the section 1115 demonstration.

1. Statewideness **Section 1902(a)(1)**

To the extent necessary to permit the state to target services on a geographic basis that is less than statewide, in order to support the state's mobile testing initiatives.

2. Reasonable Promptness; Amount, Duration, Scope; Comparability **Section 1902(a)(8) and 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to permit the state to vary the amount, duration, and scope of services based on population needs; to provide different services to different beneficiaries in the same eligibility group, or different services to beneficiaries in the categorically needy and medically needy groups; and to allow the state to triage access to long-term services and supports based on highest need.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to permit the state to restrict beneficiary choice to a limited network of telehealth network providers and ambulance providers providing mobile testing services.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **Project Number 11-W-00355/1**

TITLE: **Massachusetts COVID-19 Public Health Emergency (PHE) Demonstration**

AWARDEE: **Massachusetts Department of Health and Human Services**

Under the authority of section 1115(a)(2) of the Act, expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from March 1, 2020, through the date that is sixty (60) days after the PHE described in section 1135(g)(1)(B) of the Act, including any extension, expires, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the United States Secretary of Health and Human Services has determined that the demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authority may only be implemented consistent with the approved STCs and shall enable the state to operate the above-identified section 1115(a) demonstration.

1. **Long-Term Services and Supports (LTSS).** Expenditures for 1905(a) LTSS services for individuals even if services are not timely updated in the plan of care, or are delivered in allowable alternative settings for the period of the public health emergency. The Commonwealth defines alternative settings as those which would have been otherwise-approvable via 1915(c), Appendix K (e.g. hotels, shelters, schools and churches).[1]

2. **Retainer Payments.** Expenditures for the state to make retainer payments for dates of service beginning in the month of July 2020 and ending after 30 consecutive days to providers of adult day health and day habilitation services (that include a personal care component) provided under 1905(a)(13) of the Act to maintain capacity during the emergency. The retainer payment time limit may not exceed 30 consecutive days. If the state has or submits and receives approval of an institutional facility bed hold State Plan Amendment (SPA) that is fewer than 30 days, then the state may only make retainer payments authorized under the 1115 authority that is less than or equal to the aggregate maximum monthly institutional facility bed hold limit in the SPA. In addition, retainer payments may only be paid to providers with treatment relationships to beneficiaries that existed at the time the PHE was declared and who continue to bill for adult day health or day habilitation services as though they were still providing these services to those beneficiaries in their absence. The retainer payments may not exceed the approved rate(s) or average

[1] See "APPENDIX K: Emergency Preparedness and Response" template, available at https://www.medicaid.gov/medicaid/home-community-based-services/downloads/1915c-appendix-k-template.pdf.

expenditure amounts paid during the previous quarter for the service(s) that would have been provided.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: Project Number 11-W-00355/1

TITLE: Massachusetts COVID-19 Public Health Emergency (PHE) Demonstration

AWARDEE: Massachusetts Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts COVID-19 Public Health Emergency (PHE) section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), operated by the state and partially funded by CMS. The STCs set forth in detail the state's obligations to CMS during the life of the demonstration. The STCs are effective March 1, 2020, unless otherwise specified. This demonstration is approved through the date that is 60 days after the Public Health Emergency (PHE) described in section 1135(g)(1)(B) of the Act, including any extension, expires.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. COVID-19 Public Health Emergency Program and Benefits
V. Cost Sharing
VI. Delivery System
VII. General Reporting Requirements
VIII. General Financial Requirements Under Title XIX
IX. Schedule of State Deliverables for the Demonstration Period

II. PROGRAM DESCRIPTION AND OBJECTIVES

The demonstration is approved in recognition of the PHE as a result of the COVID-19 pandemic. The demonstration will help the state to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

The state's title XIX state plan, title XXI state plan, and Massachusetts Comprehensive demonstration, as approved, will continue to operate concurrently with this section 1115 demonstration.

The demonstration also provides flexibility for the delivery of long term supports and services during the PHE.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state agrees that it must comply with all applicable federal statutes relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, and in understanding program rules and notices.

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration pursuant to STC 6. CMS will notify the state 15 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact of Changes in Federal Law, Regulation, and Policy on the Demonstration.** If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.

5. **Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, and other comparable program elements in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Federal Financial Participation (FFP) will not be available for amendments to the demonstration that have not been approved through the amendment process set forth in STC 6 below, except as provided in STC 3.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as specified in this STC. Amendment requests must include, but are not limited to, the following:

   a) *Demonstration Amendment Summary and Objectives.* The state must provide a detailed description of the amendment, including the expected impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes, and a conforming title XIX and/or title XXI state plan amendment if necessary;

   b) *Waiver and Expenditure Authorities*. The state must provide a list of waivers and expenditure authorities that are being requested or terminated, along with the programmatic description of why these waivers and expenditure authorities are being requested for the amendment;

   c) *Public Notice.* The state must provide either an explanation of the public process used by the state consistent with the requirements set forth in 59 Fed. Reg. 49249 (September 27, 1994) or an explanation of how the state meets the criteria outlined in 42 CFR 431.416(g)(3) for discharge from normal state public notice and input responsibilities to address any of the circumstances describe in 42 CFR 431.416(g)(1).

   In states with Federally-recognized Indian tribes, Indian health programs, and/or Urban Indian health organizations, the state is required to comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid state plan, unless the state has established the criteria necessary to obtain an exemption from the normal state public notice process requirements in accordance with 42 CFR 431.416(g)(3).

7. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration, including administrative and medical assistance expenditures, will be available until the effective date identified in the CMS demonstration approval letter.

8. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs or procedures, or possible changes in methods or levels of payment for

Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Withdrawal of Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX, as applicable. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

IV. COVID-19 PUBLIC HEALTH EMERGENCY PROGRAM AND BENEFITS

12. **COVID-19 PHE Program Benefits.** The state's COVID-19 section 1115(a) demonstration is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. The demonstration is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19. The waiver and expenditure authorities provided via this demonstration assist the state in achieving these goals.

V. COST SHARING

13. **Cost Sharing.** There will be no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals affected by this demonstration that varies from the state's current state plan.

VI. DELIVERY SYSTEM

14. **Delivery System.** The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as currently authorized prior to March 1, 2020.

VII. GENERAL REPORTING REQUIREMENTS

15. **Monthly Calls.** CMS may schedule monthly conference calls with the state. CMS may also schedule these conference calls at some other regular frequency, as determined by CMS. The purpose of these calls will be to discuss any significant, actual or anticipated, developments affecting the demonstration. The state and CMS will jointly develop the agenda for the calls. The monitoring calls for this demonstration may be scheduled in conjunction with other approved section 1115 demonstration monitoring calls.

16. **Final Report.** The final report will consolidate Monitoring and Evaluation reporting requirements for the demonstration. The state must submit this final report no later than one year after the end of the COVID-19 section 1115 demonstration authority. The final report will capture data on the demonstration implementation, lessons learned, and best practices for similar situations. The state will be required to track separately all expenditures associated with this demonstration, including but not limited to, administrative costs and program expenditures. CMS will provide additional guidance on the structure and content of the final report.

    Should the approval period of this demonstration exceed one year, for each year of the demonstration that the state is required to complete per the annual report required under 42 CFR 431.428(a), the state may submit that information in the Final Report.

18. **Evaluation Design.** The state must submit an evaluation design to CMS within 60 days of the demonstration approval. CMS will provide guidance on an evaluation design specifically for the waivers and expenditure authorities approved for the COVID-19 emergency, including any amendments. The state is required to post its evaluation design to the state's website within 30 days of CMS approval of the evaluation design, per 42 CFR 431.424(e).

    The state will test whether and how the approved waivers and expenditure authorities affect the state's response to the public health emergency. To that end, the state will use research questions that pertain to the approved waivers and expenditure authorities. The evaluation will also assess cost-effectiveness by tracking administrative costs and health services expenditures for demonstration beneficiaries and assessing how these outlays affected the state's response to the public health emergency.

VIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

19. **Allowable Expenditures.** In consequence of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President of the United States' proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States – and in consequence of the time-limited nature of this

demonstration – CMS did not require the state to submit budget neutrality calculations for this section 1115(a) demonstration. In general, CMS has determined that the costs to the federal government are likely to have been otherwise incurred and allowable. The state will still be required to track demonstration expenditures and will be expected to evaluate the connection between those expenditures and the state's response to the public health emergency, as well as the cost-effectiveness of those expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS.

20. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The State will estimate matchable demonstration expenditures (total computable and federal share) authorized for this demonstration and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and State and local administration costs (ADM). CMS shall make federal funds available based upon the State's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the State shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

21. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following:

    a. Administrative costs, including those associated with the administration of the demonstration;

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

    c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

22. **Sources of Non-Federal Share.** The state certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section

1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

23. Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating

expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

24. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

25. **Reporting Expenditures.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00355/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by demonstration year according to date of payment. All MEGs that must be reported are identified below in the MEG Detail for Expenditure Reporting table.

    a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

    b. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

    c. Financial Reporting Specifications Manual. The state will create and maintain a Specifications Manual that describes in detail how the state will compile data on actual expenditures under the demonstration, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Financial Reporting Specifications Manual must be made available to CMS on request.

Table 1. MEG Detail for Expenditure Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	MAP or ADM
LTSS	Expenditures for LTSS for individuals even if services are not timely updated in the plan of care, or are delivered in allowable alternative settings [Expenditure Authority 1]	N/A	Line 12, 18, or 23A	MAP
Retainer Payment	Expenditures for retainer payments to providers of personal care services and services provided in adult day health settings to maintain capacity during the emergency [Expenditure Authority 2]	N/A	Line 19A, 19B, or 23B	MAP

26. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 2. Demonstration Years

Demonstration Year	Start Sate	End Date
DY 1	March 1, 2020	60 days after the PHE expires[2]

27. Claiming Period. The state will report all claims for demonstration expenditures (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures.

IX. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION PERIOD

Due Date	Deliverable
Fifteen days from date of demonstration approval	State Acceptance of Demonstration, STCs, Waivers and Expenditure Authorities.
Sixty days from date of the demonstration approval	Evaluation Design is Submitted to CMS
Thirty days from date of evaluation design approval	Approved Evaluation Design is posted on state website

[2] To the extent that the PHE for COVID-19 and/or this demonstration is extended beyond a single DY, CMS will update this chart to include additional DYs, as applicable/necessary.

One year after expiration of demonstration	Final report with consolidated Monitoring and Evaluation requirements

Commonwealth Medicine

Massachusetts Emergency 1115 Demonstration

Draft Evaluation Design

2021

Prepared for: MassHealth

Prepared by:

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PhD, MPS

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Commonwealth Medicine
University of Massachusetts Medical School

4/30/2021

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1. General Demonstration Background

The first case of COVID-19 in Massachusetts was diagnosed in late January 2020, and by March 3rd only one other case had been diagnosed. However, it became clear soon after that a conference held in Boston in late February had led to many cases in Massachusetts (and elsewhere as conference participants returned to their home states and countries). On March 10th, with nearly 100 confirmed cases statewide, Governor Charlie Baker declared a state of emergency in the Commonwealth. The Governor developed a COVID-19 Command Center, to be run by Secretary of the Executive Office of Health and Human Services (EOHHS), Marylou Sudders, and staffed with representatives of many state agencies to coordinate the statewide response.

By late March, the number of cases and deaths in the state was surging and the toll was especially high in the state's long-term care facilities, including the two state-run soldier's homes. To best position the state's Medicaid and Children's Health Insurance Program (collectively known as MassHealth) to respond to the Public Health Emergency (PHE), EOHHS began submitting to CMS Section 1135 waiver requests, Disaster SPA requests, Appendix K requests, and, as described below, an Emergency 1115 Demonstration request. The flexibilities approved by CMS under these authorities have been invaluable in ensuring the continuation of coverage of services for MassHealth's 1.9 million members.

EOHHS submitted a request to CMS on April 24, 2020 for a COVID-19 Public Health Emergency Medicaid Section 1115 Demonstration to authorize certain flexibilities to assist with the state's response to the COVID-19 pandemic. On December 30, 2020 CMS approved waivers and expenditure authority to support four of the items in the state's request. In response to CMS's guidance on monitoring and evaluation of approved Emergency 1115 Demonstrations, Massachusetts has designed evaluation approaches for the approved items utilized by the state during the COVID-19 public health emergency.

This evaluation design addresses three specific areas of the Demonstration: mobile testing, telehealth network providers, and retainer payments to adult day health and day habilitation providers. In addition to the three items accounted for in this evaluation design, Massachusetts received expenditure authority for Long-term Services and Supports (LTSS) services for individuals even if services are not timely updated in the plan of care or are delivered in allowable alternative settings for the period of the public health emergency. The state has not and does not intend to utilize this authority so has not designed an evaluation for this item. However, in the event that the state utilizes this authority, we will amend this evaluation design accordingly.

The Commonwealth understands that EOHHS is required to monitor and evaluate the waivers and expenditure authorized approved under this waiver, to track expenditures, and to evaluate the connection between the expenditures and the cost-effectiveness of the state's response to the COVID-19 public health emergency. The Commonwealth also understands the requirement to submit a final report with a consolidation of the monitoring and evaluation requirements, which is due to CMS one year after the waiver and expenditure authorities under this Emergency Demonstration expire.

The Commonwealth appreciates that, given the time-limited nature of the Emergency 1115 Demonstration waivers, CMS does not expect states to develop an extensive set of monitoring metrics

and evaluation hypotheses for such waivers, but has striven to design an evaluation that will assist future policymakers in responding to crises such as the COVID-19 pandemic.

2. Mobile Testing

2.1 Policy Goal and Objectives

The goal of this Demonstration initiative was to institute timely testing of populations at high risk of COVID-19, particularly residents of nursing facilities and other congregate settings who are unable to travel to testing sites. MassHealth contracted with ambulance providers to perform mobile testing at a variety of sites and to facilitate the transfer of specimens to a laboratory for analysis in order to address this policy goal. CMS supported this effort through the approval of waivers of Statewideness; Reasonable Promptness; Amount, Duration, and Scope; Comparability; and Freedom of Choice through the state's Emergency 1115 Demonstration. The mobile testing effort ran from April 4, 2020 through October 31, 2020, with MassHealth payment for this service in place from April 4, 2020 through August 31, 2020. While the ambulance providers performed mobile testing for everyone at a site, MassHealth was billed just for tests done on MassHealth members.

Individuals residing in congregate group sites such as skilled nursing facilities, assisted living residences, senior housing with shared services, and group sites maintained by agencies within EOHHS and their contractors may have difficulty traveling to testing sites to obtain COVID-19 diagnostic testing and such residents may be especially vulnerable to COVID-19. Because of the nature of congregate living where services are shared among residents, there are also heightened risks of the rapid spread of COVID-19 among individuals at group sites or other similar sites. During the public health emergency, it was critical that residents and staff at these sites have access to prompt testing for COVID-19.

The purpose of using an ambulance provider to provide mobile testing services was to quickly deploy testing resources to congregate settings where large numbers of individuals needed testing, such as nursing homes and congregate facilities run by the Departments of Developmental Services, Public Health, and Mental Health. The mobile testing construct included the deployment of the testing team, specimen collection by trained personnel of the ambulance provider (e.g., EMTs), transportation of the specimens to the laboratory, testing of the specimen by a qualified laboratory contracted by the ambulance provider, and the furnishing of test results to the appropriate parties. A University of Massachusetts Medical School physician was responsible for ordering the tests. MassHealth established a specific bundled rate for the mobile testing services which covered the costs of traveling to an authorized site, obtaining a specimen from an authorized individual, securing testing of the specimen for COVID-19 at a contracted certified clinical laboratory, and communicating the test results to the appropriate parties.

The evaluation of this program aims to describe the implementation of the initiative using descriptive statistics of mobile test use and related program costs and qualitative information to identify facilitators and barriers to success and assess the degree to which the initiative achieved the Demonstration goal. The design is described below.

2.2 Evaluation Questions

A few program design and implementation factors impacted how we determined our evaluation questions. First, this mobile testing was conducted only at specific sites, and data for sites where this mobile testing was not completed is not available for comparison. Second, MassHealth did not collect test result data (which were only returned to the congregate facilities and not to the state) or data on the time lapse between testing and testing results. Third, while the mobile testing was expected to contribute to test frequency and volume of people tested at these congregate sites, many other factors could contribute to positivity rates and mortality rates. For example, no data are available to allow us to analytically control for individuals' adhering to mask and social distancing behaviors and level of interactions with others at the congregate sites (which presents a risk of exposure and virus spread). These factors may have contributed more to the increased positivity rates than mobile testing. Also, the mortality rate may be attributable to individualized human body reaction to the virus as well as the treatment capacity and intensity of mobile testing, amongst other factors.

The key evaluation questions are described below.

1) Did the mobile testing reach the intended populations? For example,
    a. How many tests that were paid for by MassHealth were performed at mobile testing sites?
    b. How did the volume of testing change during the mobile-testing period among those congregate sites?
2) What was the total program expenditure by target sites and populations?
3) What were the experiences with mobile testing among Medicaid program administrators and testing sites? For example,
    a. For program administrators:
        i. What processes were necessary to stand up the program?
        ii. What facilitators and barriers were experienced during program stand-up?
        iii. How were mobile testing sites chosen?
        iv. Overall, how effective was mobile testing to help respond to the PHE?
    b. For mobile-testing site administrators:
        i. Did mobile testing help sites to identify COVID-19 positive residents, expedite testing, and contain the spread of the virus?
        ii. What worked well and not well with mobile testing?
    c. What were the lessons learned to inform future testing for other infectious diseases?

2.3 Data Sources

The data for this evaluation is the following:

- **Ambulance provider[1] test report data.** The data includes the site name, number of tests, test date, agency responsible for the site, # of projected staff/MassHealth members to be tested, number of completed staff/MassHealth member tests. This data will be used to answer several questions about the status of mobile testing.

[1] Two ambulance providers were contracted by MassHealth but only one performed mobile testing.

- **Individual-level invoice/payment data.** This data includes invoices detailing the bundled rate/payment per MassHealth member submitted by the ambulance provider to MassHealth. This data includes member-level information such as Medicaid ID, age, payer status, and payment balance. This data will be used to calculate the total program cost/payment data to the ambulance provider.
- **Qualitative interview data.** Qualitative data (i.e., interviews) from program administrators and mobile-testing site administrators will provide detailed information about program implementation, including facilitators, barriers, satisfaction, and lessons learned.

2.4 Analysis Methods

The analysis will be based on mixed methods data, i.e., both quantitative and qualitative. The analysis period will be from April 2020 to October 2020[2]. That is, the analysis will be post-only because there was no similar mobile-testing before the COVID-19 pandemic.

The quantitative analysis will be descriptive in nature. Test volumes over time and across sites will be analyzed and presented in trend format. The program cost data analysis will be based on member-level costs documented in the invoice data from the ambulance provider. Site- and individual-level data will be transformed into a total program cost.

The qualitative data collection will be conducted with a purposeful sample of MassHealth program staff and congregate site mobile testing administrators. A thematic analysis of qualitative data from interviews will be performed. Data will be coded for content and major themes related to program implementation will be derived, summarized, and reported.

A summary of the measures and analysis methods is included in the table below.

Research Questions	Measures	Data Source	Analysis Methods
1) Did the mobile testing reach the intended populations?	Number and volume over time of tests among mobile testing sites	Ambulance provider test report data; MassHealth invoice and payment data	Descriptive analysis, trend analysis
2) What was the total program expenditure by MassHealth?	Program cost; Cost by site	MassHealth invoice/payment data	Descriptive analysis
3) What were the experiences of mobile testing among Medicaid program	Experiences	Qualitative interview data	Thematic analysis

[2] MassHealth payment is only through August 2020.

Research Questions	Measures	Data Source	Analysis Methods
administrators and congregate site administrators?			

2.5 Anticipated Limitations

A few anticipated limitations of the evaluation are below.

- ***Challenges in identifying comparison sites.*** The mobile testing congregate sites include various kinds of organizations (e.g., group home, community partner, and nursing facility). Identification of sites comparable to these mobile testing sites with adequate characteristics on which to match is not feasible. Therefore, the absence of a comparison group limits our ability to demonstrate the relative effectiveness of mobile testing compared to other approaches.
- ***Post-only analysis.*** COVID-19 is an extraneous event and there was no testing done prior to when COVID-19 hit. Therefore, the analysis can only be done post the onset of the pandemic.
- **Challenges in identifying interview participants.** We may be unable to identify and recruit enough of a sample of congregate site administrators to participate in an interview. This may be due to the inability to identify the point of contact for sites or their unwillingness to participate.

3. Telehealth Network Providers

3.1 Policy Goal and Objectives

The goal of this Demonstration initiative was to enable MassHealth members to remain in their homes to reduce exposure and transmission, to the extent possible, and to preserve health system capacity during the public health emergency. Towards this goal, MassHealth developed a new temporary Telehealth Network provider type and contracted with three Telehealth Network Providers (TNPs). Through the state's Emergency 1115 Demonstration, CMS approved a waiver of Freedom of Choice to permit the state to limit the TNP network to three such providers.

MassHealth contracts with the three TNPs were in place from April 1, 2020 through September 30, 2020. TNPs were required to maintain a network of credentialed physicians licensed in Massachusetts and to maintain a telehealth platform capable of furnishing covered telehealth encounters to all eligible MassHealth members. The TNPs provided a limited set of services to MassHealth members, including COVID-19 screening and counseling and referrals to testing and treatment as appropriate.

During the early days of the COVID-19 pandemic, many Massachusetts residents were seeking answers to questions about symptoms they were experiencing and any next steps they should take. To meet this need, the state contracted with Buoy Health to allow individuals to use its online application for free. The Buoy app asks the user a series of questions to determine symptoms and risk level for COVID-19 and, based upon the responses, would refer the user to the appropriate health care resources which could include their own physician or to a physician contracted with a TNP.

The evaluation of this Demonstration initiative aims to determine the program costs and utilization levels of the TNP program and describe lessons learned about program implementation. Descriptive statistics of measures related to the service and qualitative data to identify facilitators and barriers to success will be used to determine the extent to which the initiative achieved the Demonstration goal. The design is described below.

3.2 Evaluation Questions

TNPs were set up to offer MassHealth members, particularly those who are concerned that they may have COVID-19, better access to physicians who can help address members' COVID-19 concerns and symptoms and recommend/connect them to as-needed medical care. The main evaluation questions are:

1) What is the utilization level of the TNP program and their physicians? For example,
    a. How many MassHealth members accessed the Buoy app over time? What kind of MassHealth members were these (e.g., demographics, geographic location), as data allow?
    b. How many MassHealth members completed the triage interviews in the Buoy app?
    c. What types of follow-up care (e.g., self-isolate, self-isolate and recommended evaluation for testing, emergency room care) were recommended during the Buoy app's triage process?
    d. How many encounters with TNP services were reported to MassHealth as a result of members' interaction with the Buoy app and subsequent referral to a TNP? How did that vary by the three TNPs?
2) What was the cost to MassHealth of administering the TNP program?
3) What are lessons learned about establishing, maintaining, and using TNPs? For example,
    a. What worked well and did not work well from the TNPs' perspective? What were the implementation challenges and successes? If the TNP model were to be utilized in the future, what should be in place to make it successful?
    b. What made Medicaid members choose TNPs versus their own physicians? What were their overall experiences with TNPs?

3.3 Data Sources

The evaluation will be based on the following data sources:

- **Buoy Health data.** The data capture the daily number of interviews (i.e., interactions with Buoy app) from March 26, 2020, to the current date. The data capture triaged outcomes (e.g., self-isolation, recommended for test evaluation) and interviews by county and payer (e.g., MassHealth, commercial payers). Usage of app data (e.g., number of app users, clicks) is also available.
- **TNP encounter and invoicing data reports.** These data contain the invoice data from TNPs to MassHealth. The encounter reports will include information on MassHealth members receiving actual TNP services.
- **Qualitative interviews.** It is useful to collect qualitative data (i.e., interviews) with program managers, TNPs, and Medicaid members who used the Buoy app to understand whether and

how the TNP program worked well or did not work well and what lessons can be drawn about the TNP program implementation to inform future policy.

3.4 Analysis Methods

The TNP is a new type of provider created during the pandemic. The target population was potentially COVID-19 positive MassHealth members. Therefore, there was no pre-COVID-19 data. The analysis period will be from April 2020 to September 2020.

The program was run state-wide and available to all MassHealth members. Therefore, there is no comparison group for this evaluation. The only possible comparison is the interview/member triage results rendered by the Buoy app and triage outcomes by payers (i.e., MassHealth vs. other payers). The analysis of quantitative data will be descriptive in nature. The utilization of the Buoy app and TNPs over time will be tabulated to present the trend. Buoy app interview and triage results will be presented by county and demographic characteristics if data are available.

The total cost data will be based on MassHealth payment to TNPs, which includes a platform fee and a one-time implementation and development fee. The variable cost (i.e., payment based on encounters) will be presented by month.

The analysis of qualitative data will be based on themes arising from interview data. The data collection will be from a purposeful sample of a diverse set of stakeholders, including MassHealth members, TNPs, and MassHealth program staff. A thematic analysis will be performed on interview data. These data will be coded for content and major themes related to program implementation will be derived, summarized, and reported.

A summary of the measures and analysis methods is included in the table below.

Research Questions	Affected Populations	Data and Measures	Analysis Methods
1. What was the utilization level of TNP program and their physicians?	MassHealth members, TNPs	Buoy Health data; TNP encounter and invoicing data reports	Descriptive statistics, trend analysis
2. What was the cost to MassHealth of administering TNPs?	MassHealth members	TNP encounter or invoicing data reports; Interview data	Descriptive statistics, trend analysis
3. What are lessons learned about establishing, maintaining, and using TNPs?	MassHealth program staff, TNPs, MassHealth members	Interview data	Thematic analysis based on interview data

3.5 Anticipated Limitations

A few anticipated limitations of the evaluation are below.

- ***Challenges in identifying interview participants.*** We may be unable to identify and recruit enough of a sample of MassHealth members to participate in an interview. This may be due to the inability to identify Buoy app users or their contact information in the data or users' unwillingness to participate.
- ***Limitation of interview participants' recollection of their Buoy app experience***. Interview participants may be unable to accurately recall the details of their experience using the Buoy app due to the passage of time between the study period and when they may be interviewed. These details include their reasons for using the app and their thoughts and behaviors during interaction with the app.
- ***Limitation of the Buoy Health data.*** The data are self-reported and access to the site is limited to those who have internet access. In other words, Buoy app users are likely skewed demographically and unevenly distributed across age, gender, symptoms of concern, geography, and other factors. This will impact the accuracy of results.

4. Retainer Payments for Adult Day Health and Day Habilitation Providers

4.1 Policy Goal and Objectives

The overall goal of this program was to maintain capacity for and access to adult day health (ADH) and day habilitation (DH) services that were required to temporarily close for a period due to COVID-19 restrictions. CMS approved expenditures for the state to make retainer payments for dates of service beginning in July 2020 and ending after 30 consecutive days to ADH and DH services (that include a personal care component) provided under 1905(a)(13) of the Act to maintain capacity during the emergency.

On March 10, 2020 Governor Baker declared a state of emergency in Massachusetts in response to COVID-19, and on March 23, 2020, the Governor ordered all non-essential businesses to close and directed the Department of Public Health to issue a stay-at-home advisory. As a result, MassHealth-enrolled ADH and DH provider sites were required to temporarily close between March 23, 2020 and June 30, 2020, and such providers had no source of revenue during that period. This forced providers of ADH and DH services to modify both the way they deliver services and the hours and scope of their services.

To help prevent the permanent closure of ADH and DH sites and maintain access to these services after the sites could reopen, MassHealth made retainer payments to ADH and DH providers from April through July of 2020. Through the state's approved Emergency 1115 Demonstration, CMS authorized federal Medicaid funding for the retainer payments made during July. EOHHS utilized CARES Act funding to pay for the retainer payments for April through June.

The retainer payments could only be paid to providers with treatment relationships to members that

existed at the time the PHE was declared and who continue to bill for ADH or DH services as though they were still providing these services to those members in their absence. To receive retainer payments, providers were required to develop or amend individual care plans to meet the members' needs while they remain at home, and the care plans were required to identify the types and anticipated frequency of engagements being provided by the provider's staff to the member during the COVID-19 PHE. For instance, a provider needed to engage with the member at least, but not limited to, once per week and the provider needed to retain enough staff to fulfill these requirements. Ongoing health and safety of members in their homes needed to be ensured by the provider to minimize the risk of decompensation and emergency service utilization. Although the payments were available to all ADH and DH providers, not all providers decided to take on the retainer payments.

The evaluation of this Demonstration goal aims to determine if the retainer payments had a positive effect on ADH and DH service access and helped to maintain enough provider capacity. As such, descriptive analysis of program data and qualitative analysis of data from program staff and providers will be assessed to learn if the policy goal was achieved. The evaluation design for this policy is below.

4.2 Evaluation Questions

The goals of the retainer payments were to maintain the provider network and ensure continuous access for members to needed ADH and DH services after the retainer payment period. An adequate number of ADH and DH providers will allow discharged cases from acute hospitals to be able to find LTSS services in community settings; it also allows those who have already been receiving LTSS services in residential and community settings not to be crowded out by newly discharged hospital cases and continue to receive telehealth to address their health and safety needs.

While the Emergency 1115 Demonstration authorized Medicaid reimbursement only for the retainer payments made in July 2020, we will include the months of retainer payments funded by CARES Act funds (three months before July) in the evaluation as well. The first three months and July had the same retainer payments available to ADH and DH, although payment authority and source of funding differed between the two periods. The findings will be related to the retainer payment mechanism to inform future policies and practices, though the outcomes in July will receive a special review.

The key evaluation questions and sub-questions will include the following.

1) Did caseloads and expenditures during and after the retainer payment period remain consistent with prior caseload trends? For example,
   a. What were the monthly caseloads in ADH and DH providers before COVID-19, during the CARES Act-funded retainer payment period, during the CMS 1115 emergency waiver authorization payment period, and after the retainer period ended?
   b. Was there a difference in the business status (i.e., open/closed) after July 2020 (end of the retainer payment period) of providers who chose to receive retainer payments?
2) How have the retainer payments enabled ADH and DH providers' ability to maintain needed ongoing telehealth services for Medicaid members to ensure health and safety? For example,
   a. Did ADH and DH providers develop or amend individual care plans for MassHealth members as required? If so, how?

b. Did ADH and DH providers ensure the health and safety (e.g., check for COVID-19 symptoms, nutritional services, coordinated care, and activities of daily living for members without formal supports at home) of MassHealth members while they were home, as required? If so, how?

3) What were the lessons learned from administering the retainer payment Demonstration? For example,
   a. What worked well and not as well about receiving retainer payments?
   b. What worked well and not as well for MassHealth in implementing the provider retainer payment program?
   c. What are lessons learned that will help inform future policy related to sustaining ADH and DH providers with retainer payments when a similar emergency condition occurs?

4.3 Data Sources

The data to answer the evaluation questions include both quantitative and qualitative data.

- **Medicaid Demonstration program administrative data.** This is the data from MassHealth used to track provider status change and determine the administrative costs/outlays to providers through the retainer payment period. This data also includes the counts of ADH and DH providers before[3], during, and after the retainer payment period.
- **Qualitative interview data.** It is not feasible to just use quantitative data to determine payment impact, especially when a comparison group is absent and the CMS-approved payment period is very short (only for July 2020). Therefore, this evaluation will collect qualitative data (i.e., interviews) from Medicaid program managers and select ADH/DH providers to help assess how the retainer payment policy affected the states' response to PHE.

4.4 Analysis Methods

The analysis will use both quantitative and qualitative data. The analysis period will be from January 2019 (or the earliest time after this month that the caseload data are available) to six months after retainer payments ended.

The analysis of quantitative data will be descriptive in nature. The measures, such as healthcare expenditure, number of providers, and caseloads of members, will be presented by time periods. Monthly trends will be presented if data permit. The service utilization will be based on various categories of ADH and DH services if data permit.

The analysis of qualitative data will be based on themes arising in interview data. The data collection will utilize a purposeful sample of ADH and DH providers. A thematic analysis will be performed on data from interviews. Data will be coded for content and major themes relating to program implementation will be derived, summarized, and reported.

[3] If the count of providers before the Demonstration period is not available, then Medicaid Management Information System (MMIS) data and encounter data will be used to compile the list of providers.

A summary of the measures and analysis methods is included in the table below.

Research Questions	Affected Populations	Data and Measures	Analysis Methods
1. Did caseloads and expenditures during and after the retainer payment period remain consistent with prior caseload trends?	Providers	MassHealth Demonstration program administrative data	Descriptive analysis, trend analysis
2. How have the retainer payments impacted ADH and DH providers' ability to maintain needed ongoing telehealth services for Medicaid members to ensure health and safety?	Providers	MassHealth Demonstration program administrative data; Interview data	Descriptive analysis, trend analysis; Thematic analysis based on interview data
3. What were the lessons learned from administering the retainer payment Demonstration?	Medicaid program staff and providers	Interview data	Thematic analysis based on interview data

4.5 Anticipated Limitations

A few anticipated limitations are discussed below.

- **Short CMS-approved Demonstration period.** The CMS-approved Demonstration was only one month, which is likely too short to reveal any noticeable differences that the payment policy made. This also increases the risk for external factors to confound program outcomes.
- **Challenges in identifying interview participants.** We may be unable to identify and recruit enough providers to participate in an interview. Some providers may not be willing to participate.

5. Reporting

5.1. Annual Reporting

The duration of the Demonstration is contingent on the duration of the COVID-19 waiver authority, which is unknown currently. If the duration of the Demonstration extends beyond one year, the state will, for each year of the Demonstration, submit the annual report required under 42 CFR 431.424(c). Evaluation and monitoring information included in the report will reflect the evaluation design and methodology described in the state's approved evaluation design. The annual report content and format will follow CMS guidelines.

5.2. Final Report

The final report will consolidate Monitoring and Evaluation reporting requirements for the Demonstration. The state will submit the final report no later than one year after the end of the COVID-19 section 1115 Demonstration authority. The final report will capture data on Demonstration implementation, evaluation measures, and interpretation, and lessons learned from the Demonstration, per the approved evaluation design. The state will track separately all expenditures associated with the Demonstration, including, but not limited to, administrative costs and program expenditures. The annual report content and format will follow CMS guidelines. The state's final evaluation report is expected to include, where appropriate, items required under 42 CFR § 431.428. If the Demonstration authority lasts longer than one year, the annual report information for each Demonstration year will be included in the final report when submitted to CMS one year after the end of the Demonstration authority.